E-BRIEF SERIES

Healthicity

Hidden Documentation Compliance Risks: Part 2

Kristen Poat RHIT, CHPC

Electronic Medical Record (EMR) systems have revolutionized healthcare documentation, allowing for streamlined record-keeping and improved patient care. However, lack of governance over EMR templates means they may contain outdated language that can hinder effective communication, delay revenue due to denials, prompt audits, and/or compromise patient-centric care. Modernizing language within the EMR template is essential to keep pace with an ever-evolving medical industry.

The second documentation risk example: Outdated language in EMR templates.

- *"Telehealth was performed due to the COVID-19 pandemic."*
- *"Over 50% of the visit was spent in counseling/coordination of care."*
- *"12-point review of systems (ROS) performed, otherwise negative."*

While the three examples above may seem rather benign, the bottom line is these blanket phrases use outdated language. As an auditor, seeing routine phrases such as these signal a red flag in effective communication on current coding and documentation guidelines to physicians and/or Advanced Practice Professionals (APPs) within the organization.

The time of drafting this article is July 2024. The US Federal COVID-19 Public Health Emergency (PHE) officially ended May 11th, 2023. Yes, even now we still see patient records that state telehealth was "*performed due to the COVID-19 PHE*".

- *The reason for telehealth can no longer be due to the COVID-19 PHE.*

This is a strong reminder that services must still be medically necessary, but the reasons for telehealth have evolved. Patients may seek care via telehealth for convenience because the patient is unable to leave his/her home due to significant medical problems or he/she experiences transportation limitations. The point is that patients may engage their healthcare providers for telehealth services for many reasons. Unless the patient has a COVID-19 infection and it is the decision of the healthcare provider and the patient to opt-out of presenting to the office in person, using this specific statement is misleading and should not be included in the medical record.

Another prime example of outdated language is: "*___ minutes spent in patient care, over 50% in counseling and coordination of care*". In 2021, the American Medical Association (AMA) revised the Evaluation and Management (E/M) documentation guidelines. These revisions allowed physicians and APPs to document office and outpatient visits based on either Medical Decision Making (MDM) or total time spent on the encounter, without the need to include counseling and coordination of care in the documentation.[1]

- *50% of visit time spent in counseling and coordination of care is no longer required for time-based billing.*

If billing based on time, the healthcare provider should include the total amount of time spent in patient care on the date of service, whether this is face-to-face with the patient or in other activities, such as chart prep, chart review, placing orders, or other tasks specified by the AMA. The easiest way to do this is to create an itemized list to identify how much time was spent in each qualifying activity and include the total number of minutes to justify billing the

[1] Documenting time for specific tasks per 2021 E/M office or other outpatient coding changes | AMA (ama-assn.org)

corresponding E/M level. This is a reminder that time applies only to actual time spent on the date of service that the patient was seen – not

the day before or after. Additionally, time used cannot overlap with other services that fall under the description of another billing code (such as reading an EKG or providing Remote Patient Monitoring (RPM) services).

The last risky blanket statement seen often in medical record documentation is: "*12-point ROS completed and otherwise negative*" or something similar. In the auditing world, we consider this a "cheat" blanket statement. But it is also a liability if all ROS are not truly accounted for during the patient visit.

Consider a patient care situation in which an orthopedic physician documents "*12-point ROS completed and otherwise negative*" but does not review all systems as stated. Later that day, the patient winds up in the hospital after suffering a stroke. Is the physician liable for missing symptoms documented as "otherwise negative" earlier that day? Overlooking this risk is something I assume most healthcare providers would rather not take.

A medically appropriate ROS should be captured and documented.

Along with time-based billing changes in 2021, the AMA removed the requirement for a detailed review of systems and a comprehensive history for billing purposes. Rather, the physician or APP should document a medically appropriate history and ROS. For a dermatologist, a ROS involving the skin may be the only element necessary to be documented – which is acceptable per the 2021 AMA guidelines. It is not necessary for an ophthalmologist to be routinely reviewing patient gastrointestinal symptoms.... you get the idea.

The best practice suggestion from this auditor is to, at the very least, annually review and revise EMR templates that are frequently used in any location where healthcare providers are giving care to patients. Consider engaging help from the local HIM, IT, or CDI department to assist with achieving template integrity and complying with current coding and/or CMS guidelines.

In summary, using outdated language in EMR templates can create extraneous information, or even threaten note quality and patient care. It is important to align EMR templates with current medical practices and regulatory requirements to promote precision, clarity, and relevance. Additionally, this effort assists with ensuring legal compliance, minimizing liability, as well as avoiding misunderstandings or misinterpretations.

Modernizing language within the EMR template is essential to keep pace with an ever-evolving medical industry.

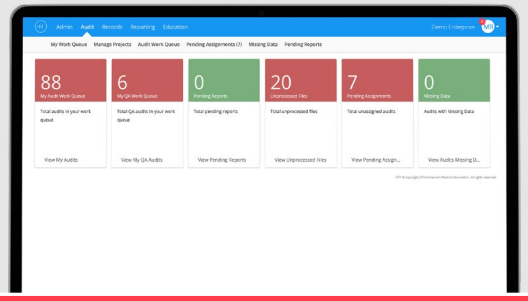
Kristen Poat

RHIT, CHPC

Kristen Poat is an RHIT certified through AHIMA and CHPC through HCCA with 12 years' experience in various roles in the auditing, coding, and compliance environments. She currently serves as a coding compliance educator and subject matter expert who takes a special interest in outpatient physician multi-specialty clinic and ASC settings. Kristen holds memberships with AHIMA, ILHIMA, and HCCA. She aspires to return to school to obtain her RHIA certification and next-level degree.

For more on Healthicity's Audit Services and Solutions, please visit healthicity.com/auditing or call 877.777.3001

AUDIT MANAGER



WATCH ON-DEMAND DEMO

RESOURCE CENTER

EXPLORE FREE RESOURCES