E-BRIEF SERIES

Healthicity

Hidden Documentation Compliance Risks: Part 3

Kristen Poat RHIT, CHPC

The third and last installment of this series focuses on the part human error plays in conflicting EMR documentation. Conflicting documentation in physician or Advanced Practice Provider (APP) SOAP notes is a significant issue that can lead to miscommunication, errors in patient care, and challenges in medical coding. SOAP notes, which stand for Subjective, Objective, Assessment, and Plan, were designed to provide a structured and comprehensive record of a patient's visit to a healthcare provider. Addressing discrepancies is crucial for ensuring accurate and effective patient care, as well as maintaining the integrity of medical records.

The third documentation hidden risk example: Conflicting information in EMR documentation.

Let us start with a game. What compliance risks can the reader spot in the following SOAP note?

CHIEF COMPLAINT: HEADACHES

Subjective:

Mrs. Smith is a 25-year-old male who presents today with a two-week history of constant, dull, aching head pain. She indicates that she has never struggled with headaches. He has tried Tylenol with minimal relief. She presents to our clinic today as a new patient inquiring about other treatment options. She shares that she started a new job as a school secretary in this two-week period, working approximately 30 hours a week with more than 75% of that time spent in screen-type work. Prior to that, she was employed as a cashier at the local Jewel.

Objective:

Vital signs recorded for today's visit: BP 120/76, height 8'6", weight 125 pounds, BMI 8.4, pulse 72 bpm.

AAO x3, well-nourished female patient who appears appropriate for stated age.

Upon examination, no abnormalities noted for the following: Auscultation of the heart and carotid arteries around eyes, palpitation of the temporal arteries, and examination of the lungs. No obvious trauma or infection detected. No stiffness or tenderness in muscles of head and neck. Palpitation of thyroid gland and TMJ were unremarkable.

There is no imaging on file to review, patient does not recall any previous MRI, CT, or X-rays.

Assessment:

Tension Headaches

Plan:

Consider switching to alternate OTC medication: naproxen sodium (Aleve) or ibuprofen (Motrin). Suggested massage therapy, reduction in screen time at work, ergonomic workstation assessment, hot/cold compresses for mild neck tenderness, and continued exercise with light stretching. Follow up with office if no resolution of symptoms within 1 week.

CODING:

G43.709 Chronic migraine without aura, not intractable, without status migrainosus

99202 New patient office or other outpatient visit, 15 minutes met or exceeded for time based-billing

To the untrained eye, the note and coding for the medical claim above may look satisfactory. To a medical record auditor, there are multiple concerns regarding conflicting documentation and overall documentation integrity. Here is general breakdown of 4 core audit findings:

1. **SUBJECTIVE SECTION: GENDER CONFUSION**

   While documenting "he" instead of "she" is a common mistake, nonetheless, it is still conflicting information that could put the integrity of the documentation into question by another healthcare provider, third-party reviewer, or even the patient. Reminder that patients can now view their own medical records (with some exceptions). To build trust and respect with the patient in the current medical landscape, it is important to not only discuss their gender at birth and current pronoun preference, but to document it accurately as well.

2. **OBJECTIVE SECTION: HEIGHT ENTRY DISCREPANCY & BMI MISCALCULATION**

   Note the error which states the patient stands 8ft 6in, which resulted in a miscalculated BMI of 8.4 (severely underweight). Most EMR systems have a failsafe included to prevent these types of errors from landing in patient notes permanently, but what if this is not a feature included in the EMR of choice for your organization? With a small mistype, data is now skewed, and an inaccurate diagnosis posed (which was neither noted nor addressed during the visit – the physician even documented that the patient appeared to be "well-nourished"). The suggestion from this auditor is to ensure failsafe features such as data validation rules and alerts/warnings are part of any EMR system being utilized by the organization, as well as staff training on manually double-checking entered vitals to ensure accuracy.

3. **PLAN SECTION: SYMPTOM NOT DOCUMENTED IN PHYSICAL EXAM**

   This one is tricky, but important. No neck tenderness was documented as present in the Objective section of the documentation but was clearly documented in the Plan. Scenarios such as this usually mean there was an oversight in updating templated information. The result is conflicting information in the record. This particular example is straightforward, but if a more complicated condition were addressed, it would most likely result in a coding or CDI query before the claim can be processed. Consistency throughout the note is key.

4. **CODING SECTION: BILLING DIAGNOSIS DOES NOT MATCH SOAP NOTE DOCUMENTATION**

   Another common audit finding and perhaps the most important to avoid; the physician's documentation clearly states the final diagnosis as tension headaches (ICD-10 code G44.209), but the billing diagnosis submitted on the claim was chronic migraines (ICD-10 code G43.709). In many EMR systems, the billing diagnosis is part of the SOAP note. Conflicting diagnoses in the same SOAP note or between the SOAP note and the insurance claim will most likely result in a coding or CDI query prior to submission to an insurance company. This example error is again minor, but what if the difference in the diagnoses had been a hierarchical condition category (HCC) code vs. a non-HCC code for a value-based care patient? A small oversight can have large consequences in the world of VBC where diagnosis accuracy is crucial to physician compensation. On the other hand, what if the patient was told by her physician that she had tension headaches, but was confused when she saw that the medical record states she has chronic migraines via her patient portal? Again, for multiple reasons, consistency is key.

Hidden documentation compliance risks can lurk anywhere in the EMR system. Addressing human error regarding conflicting EMR documentation is essential to prevent miscommunication, ensure accurate patient care, and maintain the integrity of medical records. By resolving discrepancies in SOAP notes and taking EMR documentation integrity seriously, healthcare providers can enhance the quality and reliability of documentation in the patient record.

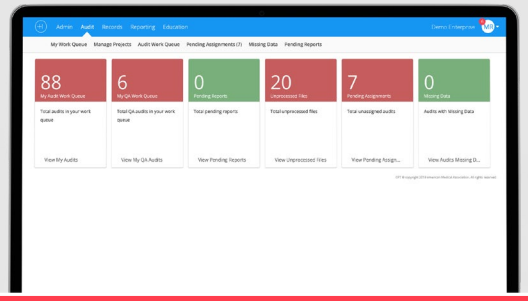
Kristen Poat

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