CSI Coding Strategies℠

EMRs Are Great . . .Look at all the Documentation They Do for Me!

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Coding Strategies, Inc

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Agenda

- Why move to an EMR
- Journal of AHIMA Article
- Benefits of an EMR
- Lost in translation
- Technology to distraction

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Agenda

- Sharing the “don’ts” of EMR’s
  - Cloning
  - Importing all available historical diagnoses
  - Creating one template for technique that isn’t supported by body of report
  - Checking the boxes
  - Reporting services that aren’t medically necessary
- Quotes from Department of Defense
- Catheter coding and NCCI edits
- Caution in the Clinical Setting

Why is everyone moving to EMRs?

- Integrated healthcare delivery systems desire to better coordinate patient care by creating one cohesive patient chart
- Incentive payments from CMS to implement and utilize an EMR
- Penalties from CMS for non-utilization of EMR

Journal of AHIMA Article

- 57% of Medicare physicians use an EHR system
- 90% of those will use their system to document E/M services
- Concerns over the EHRs being incorrect have led 88% of the above physicians to avoid EHR code assignment features
  - Choosing to code these manually instead

- Source - Journal of AHIMA September 2012

Benefits of an EMR

- Immediate access to patient records for review of relevant clinical history
- More timely access to results of diagnostic tests
- Reduction in expenses related to the creation, management, maintenance and destruction of hardcopy medical records

What to avoid

- Lost in translation (borrowed from a medical blog):
  - The story starts like this: Local Hospital has been transitioning to an electronic chart system. This morning, while on rounds, I dialed in to the hospital system to dictate a consult. I was stunned to be told that my privileges had been suspended for delinquent medical records. This was a shock, as I treat medical records with an obsession. Every Thursday I stop by medical records and ask if there's anything for me to sign. For the last 6 weeks the girl there has politely checked her computer, then said "Nope, thank you for checking". So I promptly marched down there.

- Imagine the following conversation:
  - Dr. Grumpy: "Excuse me, do I have anything to sign today?"
  - Ms. Helpful: (looking at her computer) "Um, nope. Thank you for checking."
  - Dr. Grumpy: "Well, when I dialed in, it says I've been suspended for medical records delinquency."
  - Ms. Helpful: "That's correct. You have over 60 charts to complete, 28 of which are delinquent"
  - Dr. Grumpy: "WHAT!!! Then why didn't you tell me that?!!"

- Conversation Continued:
  - Ms. Helpful: "You only asked me if you had anything to sign. You have nothing to sign. We are all electronic records now. You don't actually sign anything."
  - Dr. Grumpy (in shock): "Okay... So how do I complete my records?"
  - Ms. Helpful: "You have to log into the e-Chart system."
  - Dr. Grumpy: "No one told me we'd completely switched to e-Charts, or that I had records to complete. How was I supposed to know this?"
  - Ms. Helpful: "Because the first time you sign in to e-Charts it tells you that".

Reminders for Providers

- Technology to distraction
  - Primary focus of the encounter should always be the patient
  - Do not alienate the patient by allowing the EMR documentation process to dominate the practitioner's face-to-face time

"EHR prompt nearly kills prison inmate"

Nursing rep calls California county a 'guinea pig' for Epic implementation

August 16, 2012 | By Dan Bowman

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Reprint

An inmate at a California correctional facility nearly received a lethal dose of heart medication last week at the prompting of a newly implemented electronic health record system. The system--from EHR vendor Epic--reportedly has caused multiple additional headaches for nurses since going live July 1, sparking a record number of complaints and a call for the system to "go away until it's fixed," the *Contra Costa Times* reported.

Contra Costa County officials had visions of seamless connectivity for the exchange of health records between the county's correctional facilities and Contra Costa Regional Medical Center, according to the newspaper. Instead, the $45 million system has been nothing but trouble, claim the nurses charged with its use. Jerry Fillingim, a labor representative for the nurses, told the Times that Epic was treating the county as its "guinea pig."

"I have never, in all my time working with the California Nursing Association seen that many [complaints]," Fillingim told the newspaper of the 142 complaints filed in July alone. "Each day these nurses are fearful that they will kill somebody."

In addition to the aforementioned inmate who nearly received too much heart medication, appointments have been lost and access to vital patient information has been inaccessible. Lee Ann Fagan, a registered nurse at West County Detention Facility in Richmond, Calif., called the environment "dangerous" and "frustrating," and put some of the blame on inadequate training.

Participation in a pair of hour-long sessions in the months leading up to the go-live was the only practice given to the nurses, she said.

Article continued…..

was the only practice given to the nurses, she said.

Regardless, Fagan added, the system wasn't installed well enough for practice at the time.

Poor training isn't just a problem limited to the county's nurses. Researchers from the Alliance for Clinical Education recently found that EHR training for medical students has been lacking, as well. Andres Jimenez, CEO of EHR training provider ImplementHIT, told *Becker's Hospital Review* in May that some of the problems that hospitals and practices are running into with EHR adoption stem from rushed and overwhelming training.

And last fall, a doctor in Lincoln, Ill., claimed that he was removed from his job at Family Medical Center of Lincoln after receiving improper training in the organization's health records system.

To learn more:
- here's the *Contra Cost Times* article

Related Articles:
Medical students' training in EHRs inadequate
EHR training often rushed, overwhelming
Doctor claims poor EHR training may have cost him his job

FILED UNDER Contra Costa County, Contra Costa Regional Medical Center, EHR training, EHRs, electronic health records, Epic

COMMENTS

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DISQUS

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- Current applicable clinical information only
  - The ability to pull the patient's historical clinical information into the current visit should be exercised with caution
  - Clinical history that is not relevant to the current complaint (i.e., medication no longer being taken or diagnoses no longer present)should not be included in the patient's current complaint documentation although it may be appropriate to include in the "History" section

[illegible] function. Of note, he has a right BKA from a nonhealing fracture from several years ago. In the [illegible] room he did complain of

PAST MEDICAL HISTORY:
Right leg BKA.

EXTREMITIES: No angulation or deformity.
BACK: No exit wounds or stepoffs.
RECTAL: Normal tone with no gross blood on the examining finger.
NEUROLOGIC: He has 4/5 hand grip strength bilaterally and 4/5 biceps strength bilaterally. He has 5/5 foot dorsiflexion strength bilaterally.
SKIN: No rashes or eruptions.

Possible work flow disconnect –
author of the ROS
author of the Subjective

FOLLOW-UP PATIENT VISIT

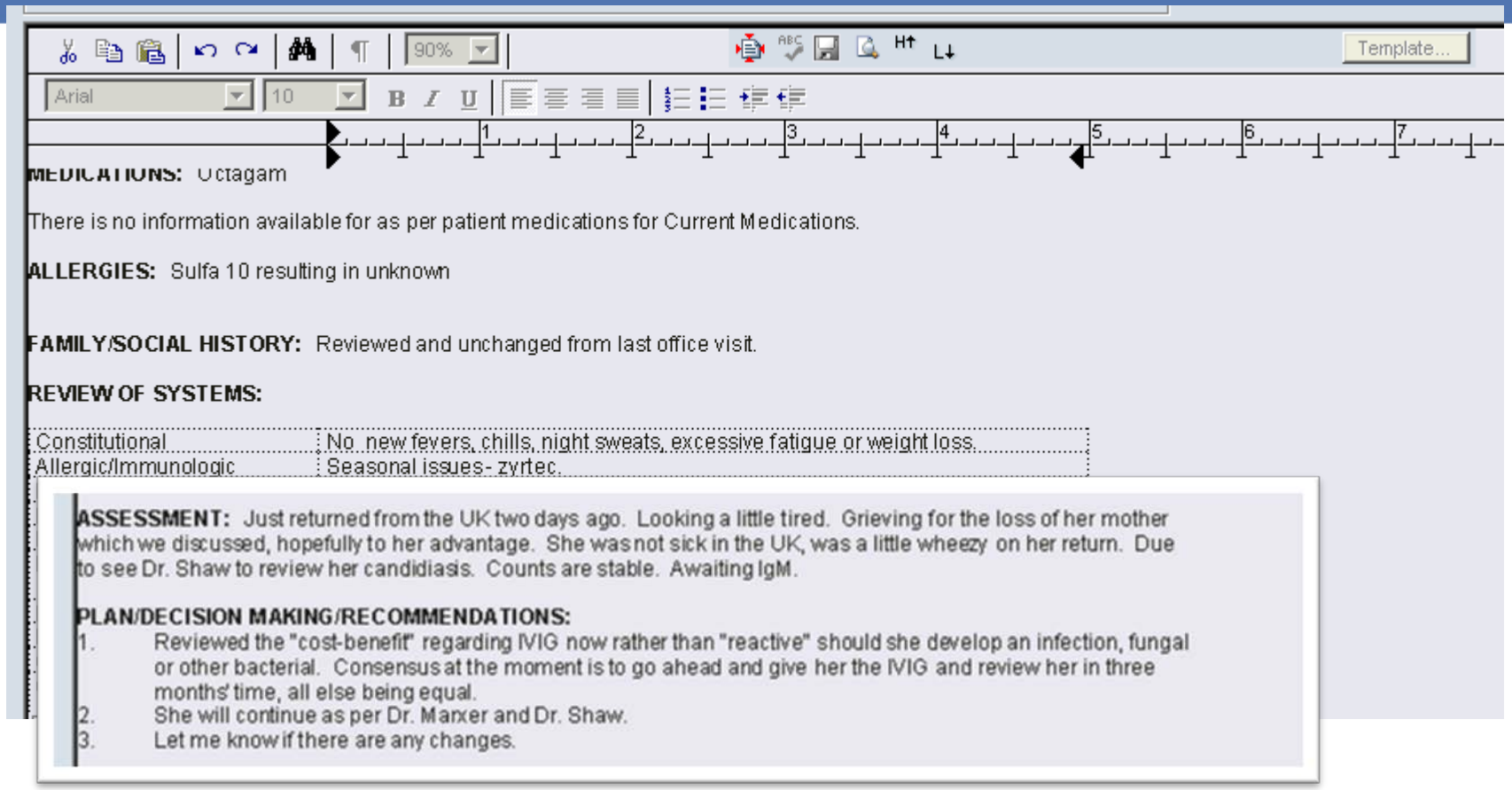
DIAGNOSIS/PROBLEM: Multiple myeloma.

REASON FOR VISIT/CHIEF COMPLAINT: Patient is here for followup visit.

SUBJECTIVE: [redacted] is here today for followup exam. Overall, the patient is feeling fair. Since her last visit, she did develop a superficial deep venous thrombosis and was started back on Coumadin after being discontinued for under a month. Her INR is therapeutic today at 2.6. She is somewhat distressed by having to resume Coumadin. The patient reports anxiety. She is also having some diarrhea and abdominal cramping, which is really interfering

Gastrointestinal	Diarrhea.
Genitourinary (F)	No changes since last seen.
Musculoskeletal	Unable to walk great distances without fatigue.
Integumentary	No changes since last seen.
Neurologic	No headache, blurred vision, sensory changes.
Psychiatric	No depression, anxiety.

"reports anxiety" vs. "no depression, anxiety"



MEDICATIONS: Octagam

There is no information available for as per patient medications for Current Medications.

ALLERGIES: Sulfa 10 resulting in unknown

FAMILY/SOCIAL HISTORY: Reviewed and unchanged from last office visit.

REVIEW OF SYSTEMS:

Constitutional	No new fevers, chills, night sweats, excessive fatigue or weight loss.
Allergic/Immunologic	Seasonal issues- zyrtec.

ASSESSMENT: Just returned from the UK two days ago. Looking a little tired. Grieving for the loss of her mother which we discussed, hopefully to her advantage. She was not sick in the UK, was a little wheezy on her return. Due to see Dr. Shaw to review her candidiasis. Counts are stable. Awaiting IgM.

PLAN/DECISION MAKING/RECOMMENDATIONS:

1. Reviewed the "cost-benefit" regarding IVIG now rather than "reactive" should she develop an infection, fungal or other bacterial. Consensus at the moment is to go ahead and give her the IVIG and review her in three months' time, all else being equal.
2. She will continue as per Dr. Marxer and Dr. Shaw.
3. Let me know if there are any changes.

Family/Social History: "unchanged from last office visit" – but the assessment documents "loss of her mother"

- Cloning records
  - The OIG has included the cloning of medical records to its work plan for 2012 (E/M Identical Records)
  - Medicare contractors have noticed an increased frequency of medical records with identical documentation across services
  - The OIG will review multiple E/M services for the same providers and beneficiaries to identify EHR documentation practices with potentially improper payments

- Cloning records
  - Cahaba GBA (Medicare Contractor) states that they expect to see documentation that supports medical necessity along with changes and/or differences in documentation of the History of Present Illness, Review of Systems, and Physical Examination

Risks with Templates

- Incomplete notes
  - Assessment/Plan was not included
  - Elements reference (as discussed above) do not exist
- Inaccurate notes
  - Data presented as ‘current’ no longer applies
  - Elements of the evaluation not performed during this exam
- Inconsistent notes
  - Conditions documented within the HPI/ROS/PE are not addressed within the assessment/plan

"It's In There"

- **HPI:** reviewed – no changes required (detailed chronological history)
- **Review of Systems** General: discouraged by persistent fatigue and poor stamina for ADL Musculoskeletal: generalized achiness Other Symptoms: recent change from Cymbalta to Prozac which she thinks is contributing to her fatigue. States her current weight has been her approximates baseline for many years.

At-Risk for "Cloned" Note

DOS 05/15/12

Impression & Plan Summary:

Paraproteinemia, monoclonal – Unchanged. James remains clinically stable. No evidence of a rapidly progressive or morbid lymphoproliferative illness or plasma cell dyscrasia. Therefore, continue to classify the patient as having an IgM lambda serum monoclonal gammopathy of unknown significant (MGUS) and have recommended an ongoing every 6-month observation program. Situation reviewed in detail with James who has an excellent understanding of the issues and is in agreement with the recommendations. Other plans as previously outlined.

DOS 11/15/11

Impression & Plan Summary:

Paraproteinemia, monoclonal – Unchanged. James remains clinically stable. No evidence of a rapidly progressive or morbid lymphoproliferative illness or plasma cell dyscrasia. Therefore, continue to classify the patient as having an IgM lambda serum monoclonal gammopathy of unknown significant (MGUS) and have recommended an ongoing every 6-month observation program. Situation reviewed in detail with James who has an excellent understanding of the issues and is in agreement with the recommendations. Other plans as previously outlined.

For Example

- Reason for visit: Postchemo Evaluation
- Chief Complaint: Rectal cancer, stage IIIB

  – *CONSIDER*

- Reason for visit: Postchemo Evaluation
- Chief Complaint: Pt continues to have fatigue and fingers are numb.
- HPI: Completed therapy on 5/29th, continues to have numbness/ tingling fingers esp. with the cold – more so on the right, is unable to type. No bleeding. Pain 3/10.

- Template trouble
  - Documenting higher level E/M services than medically necessary
  - Incomplete documentation or contradictory documentation
  - Inability to customize template to provider specialty and/or setting
  - Unclear authentication – who documented? who performed? who signed?

FOLLOW-UP PATIENT VISIT

DIAGNOSIS/PROBLEM: Malignant neoplasm of the upper outer quadrant of the female breast.

REASON FOR VISIT/CHIEF COMPLAINT: The patient is here for laboratory assessment, review, recommendations and followup of breast cancer.

SUBJECTIVE: [redacted] is feeling fair today. She does complain of increased fatigue and decreased energy level. She has not received her B12 shot since December. She was feeling much better when we had her on B12 replacement. I am going to go ahead and reinitiate that today. She is happy with this plan. Her CBC, although it does not show frank anemia, does show a slight decrease in her hematocrit and microcytosis. Her CA27.29 previous was 37. Today's result is pending. We are continuing to see her on a six-month basis.

MEDICATIONS:
Arimidex

- Reason for the visit – canned statement that misses the patient's perspective.

Consider alternative

- CC: The patient complains of increased fatigue
  - Subjective. Patient's fatigue has increased since her last B12 shot in December. Her CBC, although it does not show frank anemia, does show a slight decrease in her hematocrit and microcytosis.
  - Additionally, her CA 27 (*taken on*) 29 with the previous 37 (*taken on*). Today's result is pending.

FOLLOW-UP PATIENT VISIT

DIAGNOSIS/PROBLEM:
1. Anemia.
   a. Currently on prednisone 10.
2. Leukocytosis with CLL.
3. Thrombocytopenia.
4. Congestive heart failure.

REASON FOR VISIT/CHIEF COMPLAINT: Patient is here for follow-up of anemia

SUBJECTIVE: He was recently in the hospital to get blood. He also has an open right leg wound.

MEASURABLE DISEASE: White count 12.8, hematocrit 27.3, hemoglobin was 8.4, and his platelets were 45. Serum creatinine was 1.2. We do have a ferritin of 87.

- Subjective - possible details to consider adding
  - Patient's assessment of their anemia
    - Better, worse, more fatigue, light-headed, lost weight / gained weight
    - 6 month follow-up / 3 month follow-up (supports duration)
    - Hospitalization – routine, acute exacerbation
      - "recently" – meaning last week, last month ??
  - Open right leg wound
    - Duration
    - Who is managing this condition
    - Severity – can a stage be documented?
- Otherwise (4 elements needed for a detailed history)
  - Location – "blood"
  - Severity – documented within the measurable disease
  - Assoc../Signs – "leg wound"

FOLLOW-UP PATIENT VISIT

DIAGNOSIS/PROBLEM:

1. Stage IIA (T1c pN1a M0), grade 1, infiltrating ductal carcinoma of the left breast, ER positive, PR positive, HER2/*neu* not amplified.
2. Hypertension.
3. Hypothyroidism.

REASON FOR VISIT/CHIEF COMPLAINT: Phlebitis right forearm.

SUBJECTIVE: [redacted] is here randomized on protocol S-1007 protocol, TC therapy, first cycle last week. She has a phlebitis where the Taxotere was administered. She said it was sensitive yesterday and started _____ today. I have recommended putting ice on it and we will have to preemptively put ice on it after she gets the next chemo. On her blood counts today, she did have some Neulasta pain that is now resolved. She took two days of ibuprofen which seemed to relieve it. White count is normal. H/H is normal. Platelets are normal. She also _____ no nausea. She has had some loose stools which have reacted to Imodium.

LAB RESULTS: Test performed on May 14, 2012 10:47

WBC	8.10 10^3/uL	Lymphs %	19.40 %
Mono %	6.30 %	Neut %	74.30 %
Lymphs	1.60 10^3/uL(LOW)	Mono	0.50 10^3/uL
Neut	6.00 10^3/uL	RBC	3.77 10^6/uL(LOW)
HGB	11.70 g/dL(LOW)	HCT	34.20 %(LOW)
MCV	90.70 fL	MCH	31.10 pg
MCHC	34.20 g/dL	RDW	16.00 %(HIGH)
Platelet Count	270.00 10^3/uL	MPV	6.70 fL(LOW)

PLAN: The plan is to follow him for any evidence of renal insufficiency. Check (Dictation ended here)

Technology requires additional attention to the authentication / review process. Do not sign or approve incomplete notes.

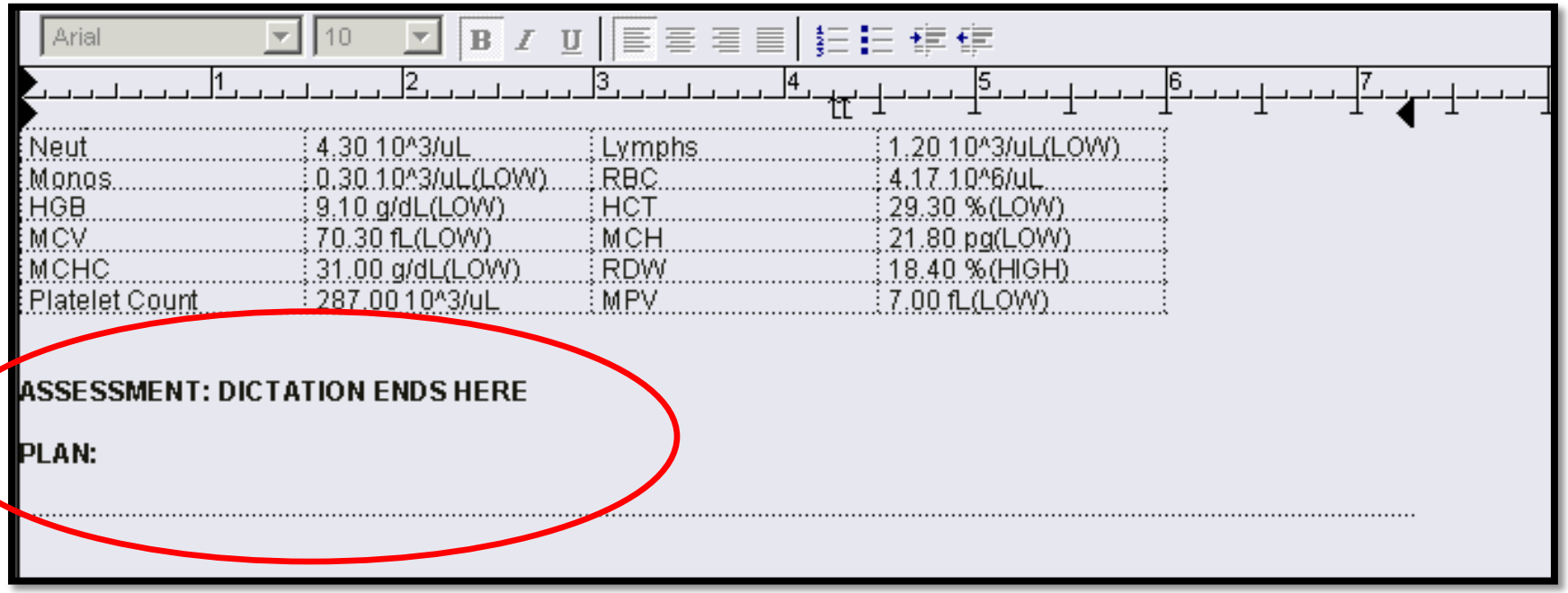
What can we do

- Building templates
  - Don’t . . . Prepopulate historical data into the template for the provider to remove if no longer applicable
  - Do . . . Allow the provider to select specific information to include in the current visit from historical clinical data

- Consistency within documentation

Constitutional	Alert, cooperative, oriented. Mood and affect appropriate. Appears close to chronological age. Well nourished. Well developed.
Eyes	Conjunctivae and sclerae are clear and without icterus. Pupils are reactive and equal.
ENMT	Sinuses are nontender. No oral exudates, ulcers, masses, thrush or mucositis. Oropharynx clear. Tongue normal.
Hematologic/Lymphatic	No petechiae or purpura. No tender or palpable lymph nodes in the cervical, supraclavicular, axillary or inguinal area.
Respiratory	Lungs diminished throughout, on O2 per nasal cannula.
Cardiovascular	Regular rate and rhythm of heart without murmurs, gallops or rubs.
Chest	Chest is symmetric without chest wall deformities.
Abdomen	Non-tender, non-distended, no masses, ascites or hepatosplenomegaly. Good bowel sounds. No guarding or rebound tenderness. No pulsatile masses.
Back/Spine	No kyphosis, scoliosis, compression fractures. Non-tender to palpation.
Musculoskeletal	No tenderness or swelling, normal range of motion without obvious weakness.
Extremities	No visible deformities, no cyanosis, clubbing or edema. Pulses 4+ and equal bilaterally. 1-2+LE edema.
Integumentary	Pale. No rashes, scars, or lesions suggestive of malignancy.
Neurologic	No sensory or motor deficits, normal cerebellar function, normal gait, cranial nerves intact.
Psychiatric	Alert and oriented timesthree. Coherent speech. Verbalizes understanding of

- Complete documentation



Neut	4.30 10^3/uL	Lymphs	1.20 10^3/uL(LOW)
Monos	0.30 10^3/uL(LOW)	RBC	4.17 10^6/uL
HGB	9.10 g/dL(LOW)	HCT	29.30 %(LOW)
MCV	70.30 fL(LOW)	MCH	21.80 pg(LOW)
MCHC	31.00 g/dL(LOW)	RDW	18.40 %(HIGH)
Platelet Count	287.00 10^3/uL	MPV	7.00 fL(LOW)

ASSESSMENT: DICTATION ENDS HERE

PLAN:

- Consistency within documentation

in December.

ALLERGIES: This patient has no documented allergies.

FAMILY/SOCIAL HISTORY: Unchanged.

REVIEW OF SYSTEMS:

Constitutional	Abnormal - RECENT PULMONARY INFECTION... NOW BETTER
Allergic/Immunologic	Abnormal - ALLERGIC TO DARVOCET
Eyes	Normal - No significant visual difficulties. No diplopia.
ENMT	Normal - No problems with hearing, no sore throat, no sinus drainage.
Endocrine	Normal - No diabetes, thyroid disease or hormone replacement. No hot flashes or night sweats.
Hematologic/Lymphatic	Normal - No easy bruising or bleeding. The patient denies any tender or palpable lymph nodes
Respiratory	Normal - No dyspnea, cough, sputum production.
Cardiovascular	Normal - No anginal chest pain, palpatations or orthopnea.
Gastrointestinal	Abnormal - LAST COLON DONE 2 YEARS AGO

What can we do

- Building templates
  - Don’t . . . Create one single template for all providers across all specialties. This will create too much documentation in some cases and not enough documentation in others
  - Do . . . Allow providers to customize templates based on their practice patterns and services provided

What can we do

- Building templates
  - Don't . . . Auto-populate fields with "normal" responses (i.e., ROS, Physical Exam)
  - Do . . . Create charts or lists that:
    - prompt the provider to enter responses on body systems reviewed and/or examined, and
    - prompt for additional information when responses are other than "normal"

FOLLOW-UP PATIENT VISIT

DIAGNOSIS/PROBLEM:

1. Stage IIA (T1c pN1a M0), grade 1, infiltrating ductal carcinoma of the left breast, ER positive, PR positive, HER2/*neu* not amplified.
2. Hypertension.
3. Hypothyroidism.

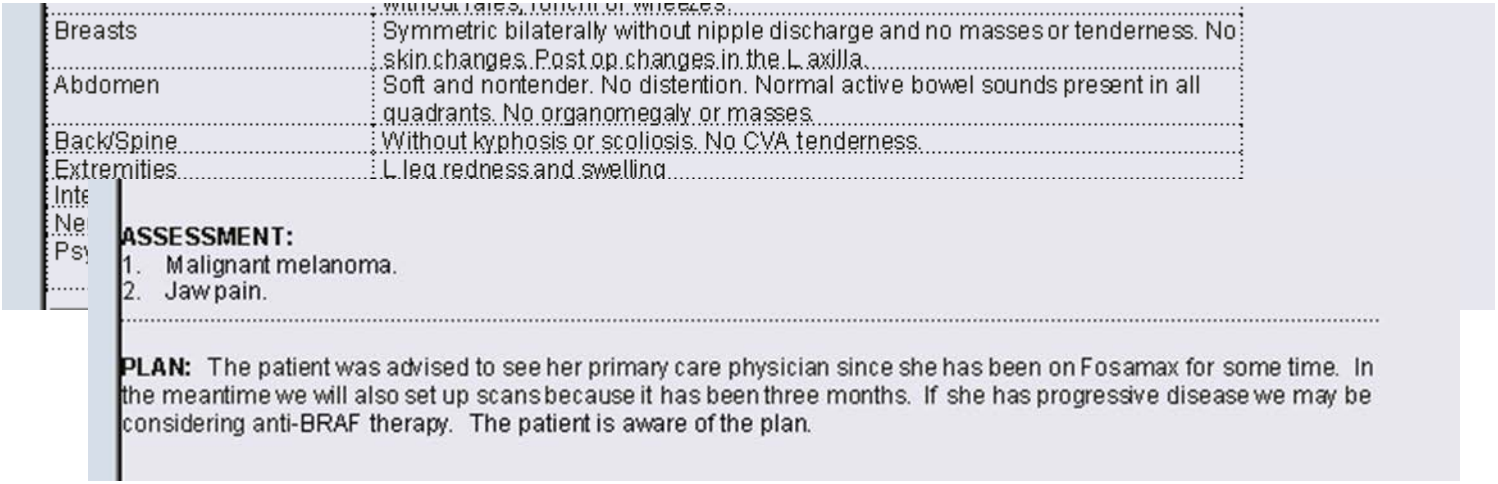
REASON FOR VISIT/CHIEF COMPLAINT: Phlebitis right forearm.

SUBJECTIVE: [redacted] is here randomized on protocol S-1007 protocol, TC therapy, first cycle last week. She has a phlebitis where the Taxotere was administered. She said it was sensitive yesterday and started _____ today. I have recommended putting ice on it and we will have to preemptively put ice on it after she gets the next chemo. On her blood counts today, she did have some Neulasta pain that is now resolved. She took two days of ibuprofen which seemed to relieve it. White count is normal. H/H is normal. Platelets are normal. She also _____ no nausea. She has had some loose stools which have reacted to Imodium.

FAMILY/SOCIAL HISTORY: Unchanged and noncontributory from March 13, 2012.

REVIEW OF SYSTEMS:

Constitutional	No fevers, chills, night sweats, excessive fatigue or weight loss.
Allergic/Immunologic	some antihistamines---> rash
ENMT	No problems with hearing, no sore throat, no sinus drainage.
Endocrine	hypothyroid, replaced
Hematologic/Lymphatic	No easy bruising or bleeding. The patient denies any tender or palpable lymph nodes.
Respiratory	No dyspnea, cough, sputum production.
Cardiovascular	No anginal chest pain, palpitations or orthopnea.
Gastrointestinal	No nausea, vomiting, abdominal pain, change in bowel habits.
Genitourinary (F)	No hematuria, dysuria, increased frequency, hesitancy, or incontinence. No abnormal vaginal bleeding or discharge.
Musculoskeletal	No joint pain, muscle pain or weakness



	without rales, rhonchi or wheezes.
Breasts	Symmetric bilaterally without nipple discharge and no masses or tenderness. No skin changes. Post op changes in the L axilla.
Abdomen	Soft and nontender. No distention. Normal active bowel sounds present in all quadrants. No organomegaly or masses.
Back/Spine	Without kyphosis or scoliosis. No CVA tenderness.
Extremities	L leg redness and swelling.
Inte	
Ne	
Psy	

ASSESSMENT:
1. Malignant melanoma.
2. Jaw pain.

PLAN: The patient was advised to see her primary care physician since she has been on Fosamax for some time. In the meantime we will also set up scans because it has been three months. If she has progressive disease we may be considering anti-BRAF therapy. The patient is aware of the plan.

Pertinent positive/negative findings should be carried through the balance of the evaluation – into the assessment and/or plan. "L leg redness and swelling" without "next steps" may raise liability issues.

Abdomen	Soft and nontender. No distention. Normal active bowel sounds present in all quadrants. No organomegaly or masses.
Back/Spine	Without kyphosis or scoliosis. No CVA tenderness.
Extremities	L leg redness and swelling.
Integumentary	Moles noted on L and R temporal hairline.
Neurologic	Shaky.
Psychiatric	Alert and oriented times three. Coherent speech. Verbalizes understanding of our discussions today.

	supraclavicular, axillary or inguinal area.
Cardiovascular	Regular rhythm. No murmurs, rubs, or gallops.
Chest	Normal chest wall motion with respiration. Breath sounds in all lung fields without rales, rhonchi or wheezes.
Abdomen	Soft and nontender. No distention. Normal active bowel sounds present in quadrants. No organomegaly or masses.
Back/Spine	Without kyphosis or scoliosis. No CVA tenderness.
Extremities	L leg redness and swelling.
Integumentary	Moles noted on L and R temporal hairline.

Over three separate encounters – over three months – dictation becomes at risk for a cloned note.

What can we do

- Building templates
  - Don’t . . . Create a template that is solely selected fields with check boxes or drop downs menus
  - Do . . . Include free form fields where providers can type or dictate details for the current visit

Arial 10 B I U

low-grade mucoepidermoid carcinoma, histologic grade G1, well differentiated, with tumor extending to 0.1 cm from inked margin of the specimen. There was no lymphovascular appearing neural invasion and two lymph nodes were sampled. No metastatic disease was noted. Tumor staging was T1 N0 MX. Of note, her frozen section intraoperatively had revealed no evidence of disease. The patient was seen in followup and it was recommended ultimately to her that she be seen today for discussion of adjuvant treatment to reduce the risk of recurrence. She is here today to discuss the same. Her surgical site and incision have healed well. She has no complaints or concerns of any kind today. She has a family history of lymphoma in her sister, as well as her father dying at the age of 55 of a brain tumor. She has no children, but is hopeful that she can start trying to conceive sometime this year. She is a nonsmoker and nondrinker and works as an administrative assistant currently.

PAST MEDICAL/FAMILY/SOCIAL HISTORY:

Answer question as it applies to you now - No (Entered Apr 19, 2012)Past surgeries: reason, date and location - parotidectomy 3-15-12 (Approved Apr 19, 2012), Biological father died at age - 55 (Approved Apr 19, 2012), Biological father's cause of death - brain cancer (Approved Apr 19, 2012), Biological mother is - deceased. (Approved Apr 19, 2012), Mother's Age - 54 (Approved Apr 19, 2012), Mother's cause of death - congestive heart failure (Approved Apr 19, 2012), # of sisters living - 1 (Approved Apr 19, 2012), Number of children - 0 (Approved Apr 19, 2012), SOCIAL HISTORY: This patient - has never been a smoker (Approved Apr 19, 2012), The patient - drinks alcohol. (Approved Apr 19, 2012), Occupation - administrator (Approved Apr 19, 2012), Are you pregnant? - No (Approved Apr 19, 2012), Changes in Menstrual Cycle - No (Approved Apr 19, 2012), and Change in sexual function - No (Approved Apr 19, 2012)

Data collected from the patient must be "reviewed by" the physician. Cut/paste is insufficient.

REVIEW OF SYSTEMS:

Constitutional	Abnormal - weight gain
Allergic/Immunologic	Normal - No reactions.
Eyes	Normal - No significant visual difficulties. No diplopia.
ENMT	Normal - No problems with hearing, no sore throat, no sinus drainage.
Endocrine	Normal - No diabetes, thyroid disease or hormone replacement. No hot flashes or night sweats.
Hematologic/Lymphatic	Normal - No easy bruising or bleeding. The patient denies any tender or palpable lymph nodes.
Breasts	Abnormal - see hx
Respiratory	Normal - No dyspnea, cough, sputum production.
Cardiovascular	Normal - No anginal chest pain, palpitations or orthopnea.
Gastrointestinal	Normal - No nausea, vomiting, abdominal pain, change in bowel habits.
Genitourinary (F)	Normal - No hematuria, dysuria, increased frequency, hesitancy, or incontinence. No abnormal vaginal bleeding or discharge.
Musculoskeletal	Abnormal - joint pain
Integumentary	Normal - No chronic rashes, inflammation, ulcerations or skin changes.
Neurologic	Normal - No headache, blurred vision, sensory changes.
Psychiatric	Normal - No depression, anxiety.

Documentation by Patient or Staff (CMS guidelines)

The ROS and PFSH may be documented by the patient (typically using a questionnaire) or by ancillary staff (nurses, technologists, etc.).

When the ROS and PFSH are documented by the patient or staff, ***the physician must review the information and write a note "supplementing or confirming" the information***.

What can we do

- Building templates
  - Be wary of fields with yes/no responses (i.e., greater than 30 minutes spent on discharge?)
  - Prompt the provider to document actual time for services based on time (i.e., critical care, extended discharge day services)

What can we do

- Building templates
  - Don’t . . . Document greater level of service than is medically necessary for the patient’s condition
  - Do . . . Document history relevant to the patient’s chief complaint and exams unique to the specific visit

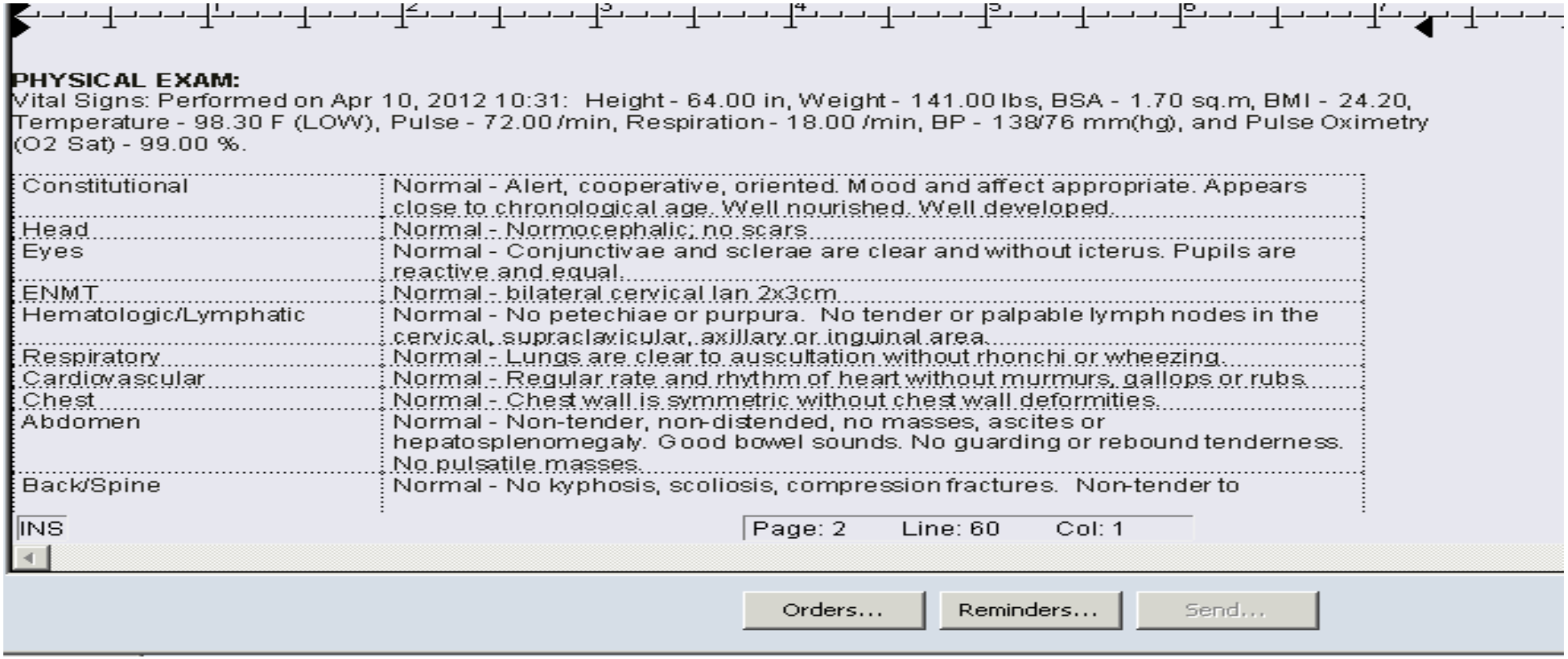
From Actual Education Performed

- Medical necessity (*document)*
  time spent in minutes must be such and such (if more than blah blah) **here you're supposed to write**
- *more stuff on page more stuff on page more stuff* ***write here*** *(more stuff)* ***write here*** *(more stuff)*

Examination

General Physical:

healthy, alert, no acute distress. Head Normal size and shape of cranium. Hair normal distribution, normal coloration, normal texture. Facial features No significant craniofacial anomalies. Eyes normal size, shape, spacing, eye movements, pupils, iris, corneas, and conjunctiva. Ears external ears normal in size, shape and rotation, normal external ear canals, normal typanic membranes. Mouth normal lips, teeth, palate, normal tongue, no excessive drooling. Neck Full range of motion, trachea midline. Chest Clear to auscultation, No respiratory distress, Normal architecture. Heart Normal rate, rhythm, heart sounds, No murmurs. Abdomen soft, flat, non-tender, No masses or organomegaly. Genitalia Not examined today. Back Full ROM, No scoliosis. Skin No pigmentary abnormalities, No evidence of neurocutaneous syndromes. Extremities No dysmorphic features. Congenital anomalies No major or minor anomalies present. Vision/Hearing Appears normal. Neurological Cranial nerves intact by observation/testing, Normal tone/strength for age, DTR's 2+ in both upper and lower extremities, without asymmetry, No ankle clonus, Normal balance, normal gait, Sensory initact by limited testing.



PHYSICAL EXAM:
Vital Signs: Performed on Apr 10, 2012 10:31: Height - 64.00 in, Weight - 141.00 lbs, BSA - 1.70 sq.m, BMI - 24.20, Temperature - 98.30 F (LOW), Pulse - 72.00 /min, Respiration - 18.00 /min, BP - 138/76 mm(hg), and Pulse Oximetry (O2 Sat) - 99.00 %.

Constitutional	Normal - Alert, cooperative, oriented. Mood and affect appropriate. Appears close to chronological age. Well nourished. Well developed.
Head	Normal - Normocephalic; no scars
Eyes	Normal - Conjunctivae and sclerae are clear and without icterus. Pupils are reactive and equal.
ENMT	Normal - bilateral cervical lan 2x3cm
Hematologic/Lymphatic	Normal - No petechiae or purpura. No tender or palpable lymph nodes in the cervical, supraclavicular, axillary or inguinal area.
Respiratory	Normal - Lungs are clear to auscultation without rhonchi or wheezing.
Cardiovascular	Normal - Regular rate and rhythm of heart without murmurs, gallops or rubs.
Chest	Normal - Chest wall is symmetric without chest wall deformities.
Abdomen	Normal - Non-tender, non-distended, no masses, ascites or hepatosplenomegaly. Good bowel sounds. No guarding or rebound tenderness. No pulsatile masses.
Back/Spine	Normal - No kyphosis, scoliosis, compression fractures. Non-tender to

INS Page: 2 Line: 60 Col: 1

Orders... Reminders... Send...

Patient seen for biopsy proven cancer at the base of the tongue. PE/ENMT "normal" - even with details of 2x3 cm ? the canned phrases place the note at risk for being considered a clone.

FOLLOW-UP PATIENT VISIT

DIAGNOSIS/PROBLEM: Other and unspecified coagulation defects.

REASON FOR VISIT/CHIEF COMPLAINT: The patient is here for laboratory assessment, review, recommendations, and followup of coagulopathy, and Coumadin adjustment based on INR.

SUBJECTIVE: [redacted] feels well. She is without complaint. Her INR is therapeutic today at 2.4. She remains on 2 mg of Coumadin daily. I have advised that she needs to be checking her PT/INR in between office visits. I have given her a goal to have it checked in six weeks at LabCorp. She will return to see me in three months.

MEDICATIONS:
Coumadin
Omeprazole
Lisinopril-Hydrochlorothiazide
Lipitor
Levothyroxine Sodium

ALLERGIES: No Known Allergies.

Combining the Subjective / Assessment / Plan may risk sufficient documentation to support the level of care provided, or may risk disconnects with pre populated sections

Department of Defense

- *The EMR tools drive documentation excessive for the severity of the presenting problem*
- *The EMR tools generate questionable documentation*
- *The templates generate multiple records with nearly identical text*
- *The templates default to multisystem reviews and exams whether physicians do them or not*
  - *2010 UBO/UBU Conference – Briefing: Coding for Compliance – E/M Leveling*

Department of Defense

- *Be aware of the pitfalls associated with the electronic medical health record, stay educated*

Healthcare Fraud Defined

- Healthcare fraud is defined as an “intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party.”1 EHR users should not expect unintentional deception or misrepresentation to be viewed more gently by payers, evaluators, or litigators. However, one of the many changes HIPAA legislation rendered is that the standard is now “known or should have known.” This shifted burden significantly by including the concept that those submitting claims have a due diligence obligation to proactively identify and prevent fraud, as the burden now is that the deception or misrepresentation need not be known or intentional but should have been known.

Article citation:

AHIMA e-HIMTM Work Group: Guidelines for EHR Documentation Practice. "Guidelines for EHR Documentation to Prevent Fraud." *Journal of AHIMA* 78, no.1 (January 2007): 65-68.

AHLTA Impact on Compliance Plan

- *E/M leveling enormous problem in audits*
- *Procedural Coding with the click of the mouse*
- *Business Plan drives RVU hunt*
- *Physicians deal with:*
  - *Structured documentation, slow response time*
  - *Free text not captured*
  - *Template development*
- *AHLTA (Armed Forces Health Longitudinal Technology Application) application contradicts/conflicts with documentation guidelines*
- *Result:*
  - *Auditors struggle to "unravel" pertinent documentation*
  - *Difficult to inspire compliance with physician*

AHLTA E/M Factors

- *Automated AHLTA E/M Calculation include but not limited to:*
  - *Vital signs data*
    - *BP, HR, RR, Temp, Ht and Wt – eliminates need for the provider to document —"vital signs reviewed"*
  - *The Total face-to-face option >50%*
  - *AutoCited Information, i.e., problems, allergies, meds, hx, lab/rad results*
  - *Diagnosis and Procedures for Medical Decision Making (MDM)*
  - *Orders for MDM Calculation*
  - *Service Type &*
  - *Patient Status*

Compliance Clarity for E/M Leveling

- *DoD Rule*
  - *AHLTA Documentation: Autocite information will not be considered when determining the appropriate ICD-9-CM, E/M, and/or CPT code to be assigned to the encounter, unless pertinent findings are acknowledged within the body of the providers' notes.*

Source: Military Health System Coding Guidance: Professional Services and Specialty Coding Guidelines Version 3.2, *Effective date: 1 Aug 2009*

Compliance Clarity for E&M Leveling

- *DoD requires the utilization of medical decision making as a mandatory component of an established patient E/M assignment. The facility may choose between History or Physical Exam for the second component to*

Source: Military Health System Coding Guidance: Professional Services and Specialty Coding Guidelines Version 3.2, *Effective date: 1 Aug 2009*

Catheters and NCCI Edits and the impact of EMRs

NCCI Policy Manual

- A physician should not report CPT codes 75722 or 75724 (renal angiography) unless the renal artery(s) is (are) catheterized and a complete renal angiogram including the venous phase is performed and interpreted. *(and documented)*

NCCI Policy Manual con't…

- In order to report angiography CPT codes 75625, 75630, 75722, 75724 or others with a cardiac catheterization procedure, ***the angiography procedure must be as complete a procedure as it would be without concomitant cardiac catheterization***.

PROCEDURE DESCRIPTION:
Right Renal 1st order: (36245) Nonobstructive Left Renal 1st order: (36245) Nonobstructive.

CPT Codes:
Coronary Angiography only, Peripheral Angiography, (CORS) Coronary Angiography, selective (93545), and S-I,all other Injec Procs (93556)

CATHETERIZATION REPORT
Coronary Angiography only, Peripheral Angiography, and Coronary Angiogram.

PROCEDURE DESCRIPTION:
S and I, Renal, bilateral with flush: 75724.26Non obstructive.

- Without documentation of a selective catheter placement, non-selective study should be reported
- Separate procedure note will be expected by most payers

CPT Codes:
S-I,all other Injec Procs (93556), STENT-LD, single vessel (92980LD), X STENT-LD,each addl vessel (92981LD), DISTAL PROTECTION (93799), Intra-Aortic Balloon Place. (33976), and Temporary Pacemaker (33210)

COMPLICATIONS:
* Emergency PCI Procedure was complicated with noflow which was resolved into slow flow by insertion of IABP, temporary pacemaker, and pronto catheter aspiration

- Pronto Catheter – thrombectomy
- Description of the procedure would be necessary

Caution to be used in the Clinical Settings

CSI Coding Strategies℠

Close to the "Lion's Share"

- What exactly is the "region of interest" ?

Procedure: Clinical assessment was performed and informed consent obtained. The patient was brought to the CT suite and placed prone on the table. A focused CT with localizing skin markers was performed.
The overlying skin was marked, prepped, and draped in the usual sterile fashion. The skin and subcutaneous tissues were anesthetized with 1% lidocaine. A Bonopty needle was inserted through to the region of interest under CT guidance. Core biopsy specimens were obtained and submitted to pathology. The vertebral body demonstrates increased sclerosis and deemed amenable to percutaneous biopsy.

All needles were removed. No immediate post procedure complications.

Sedation: 150mcg of fentanyl and 3mg of midazolam were used for conscious sedation.

Indication: T12 BIOPSY LESION. Back Pain. Percutaneous CT-guided biopsy is requested.

CSI Coding Strategies℠

New Direction from AHA

- Question: Since our facility has converted to an electronic health record, providers have the capability to list the ICD-9-CM diagnosis code instead of a descriptive diagnostic statement. Is there an official policy or guideline requiring providers to record a written diagnosis in lieu of an ICD-9-CM code number?

- Answer: Yes, there are regulatory and accreditation directives that require providers to supply documentation in order to support code assignment. Providers need to have the ability to specifically document the patient's diagnosis, condition and/or problem. Therefore, it is ***not appropriate for providers to list the code number or select a code number from a list of codes*** in place of a written diagnostic statement.

Primary – Secondary – Mets

CT HEAD WITHOUT & WITH CONTRAST

CT BRAIN WITH \T\ WITHOUT CONTRAST

CLINICAL INFORMATION: ERECORD: Known tumor

PROCEDURE: Multidetector acquisition scanning is performed, and 3 mm axial images are obtained from the skull base to the vertex prior to, and after intravenous contrast administration without immediate reaction. The dose and formulation of contrast can be retrieved from the Image cast system if needed.

COMPARISON: Head CT from Highland hospital dated 11/17/2005.

FINDINGS: There are no extra-axial fluid collections.

Examination of the brain parenchyma is unremarkable without evidence of acute intracranial hemorrhage, mass lesion or abnormal subdural collection. There is no abnormal enhancement in the brain parenchyma or meninges.

The ventricular system is unremarkable.

CSI Coding Strategies℠

Facility vs. Physician

CT ABDOMEN & PELVIS WITH CONTRAST

Jun 12, 2012 9:57:00 AM BODY FDG PET/CT SCAN
DIAGNOSTIC CT OF THE CHEST, ABDOMEN AND PELVIS WITH INTRAVENOUS CONTRAST

CLINICAL INDICATION: Esophageal cancer, Restaging.

TECHNIQUE: The patient was imaged in the fasting state, and the blood glucose was 123 mg./dL. 72 minutes following the intravenous injection of 14 mCi F-18 FDG, PET images were acquired from the skullbase to the proximal thighs. A CT scan was performed for PET attenuation correction and localization of PET findings.

A diagnostic CT of the chest, abdomen and pelvis with intravenous contrast was ordered and performed as a separate procedure. Those findings will be reported together with the PET/CT findings in an integrated report for clarity.

COMPARISON: PET/CT 03/23/2012, CT abdomen 03/06/2012

IMPRESSION/FINDINGS:

CSI Coding Strategies℠

Dictate the ACTUAL Technique

CT ANGIO CHEST

CT CHEST PULMONARY ANGIOGRAM

DATE PERFORMED: Jun 12, 2012 2:40:00 PM

INDICATION: Pleuritic chest pain: Evaluation for PE is requested.

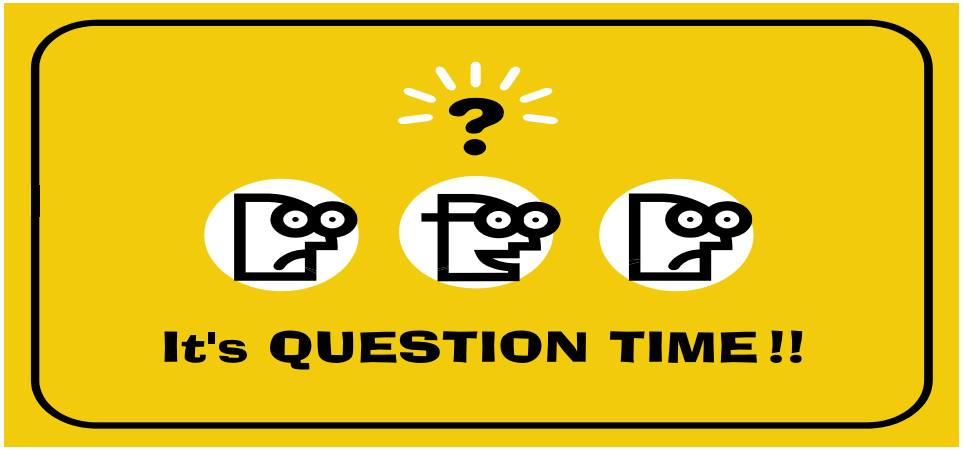
COMPARISON EXAMS: Chest radiograph from earlier today

PROCEDURE: Images were acquired from the level of the thoracic inlet through the upper abdomen. The patient received 75 mL of Optiray 350 intravenously without complication. CT angiographic technique performed through the pulmonary arteries. Images are displayed in 2 and 5 mm slice thickness. In addition, imaging post-processing such as 3D reconstructed images are provided.

FINDINGS:

Lymph nodes and mediastinum: Mildly prominent thymic tissue. No lymphadenopathy.

QUESTIONS?



THANK YOU!!!!

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