Teaching Physician Compliance ALERT
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AAMC EHR Advisory

The Association of American Medical Colleges (AAMC) Compliance Officers Forum has prepared an advisory about the use of data that can be copied and moved from one place to another within the electronic health record.

When used appropriately, the copy function can be a valuable tool. Used inappropriately, however, it may produce a flawed medical record, and poor patient care. On the billing side, inappropriate use could suggest that services were provided that in fact were not, resulting in the submission of an unsupported bill.

Identified Risks of Inappropriate use of Copy Function in EHR

- **A note may be populated with outdated, conflicting, incomplete or inaccurate information.** This can result from many of the copy functions available in an EHR. For example, the ability to default or auto-populate checkboxes (primarily in review of systems and physical exams) to 'no' or 'negative' upon starting a new note or closing a note may inadvertently include conflicting information in a single note; for example, a negative finding in the review of systems, and a positive chief complaint.

- **The EHR may no longer identify the original author.** This may be a risk to patient safety if the provider using the entry is not aware that additional scrutiny may be warranted because the entry was created by a medical student or RN, for example.

It may also result in the use of documentation originally authored by individuals (e.g., medical students, RNs) whose documentation is limited or barred for billing purposes.

- **The original date of note creation may be obscured.** This may result in risk to patient safety (through confusion about patient status) or make it difficult to retrieve the note during the billing process to determine medical necessity.

- **Notes may become repetitive, inconsistent or identical.** Such notes do not further the care of the patient and over time are more likely to be ignored by caregivers due to stagnant information. Repetitive notes may call into question the medical necessity of the care, and result in insurance payment denials, audits, or investigations. When patterns of identical notes are detected ("cloned" or "canned" notes), the documentation may not be accepted by payors to support payment.

- **Notes that are too long and contain irrelevant information.** When a note is long and cluttered with "canned" text, the reader is likely to miss the important parts ("note bloat"). This increases the risk that pertinent, new and critical information is overlooked, or may not be read by other providers, leading to poor communication, duplication of services or a delay in the patient receiving appropriate care.

- **Misleading or false attribution of work performed by others, incorporated into the current note.** While it may be convenient to routinely import labs and diagnostic test results into a note for review, it is important that the note clearly indicate when tests were performed and who performed them.

The advisory also highlighted common challenges:

- Ensuring that a note that contains reused/scripted/templated/defaulted information is accurate for the patient on the specific date of service. This is because editing written material requires a different and less accurate cognitive process than writing.

- Preserving the ability to identify original author(s), date and time of entry, and/or services performed during the encounter.

- Implementing the decision to selectively limit what information can be copied and which users may copy it. For example, an organization may want to restrict the ability to copy medical student notes to past/family/social/history and review of systems portions of the history in accordance with federal limitation on the use of such notes in support of a bill.

- Restricting copying privileges by clinical role so that, for example, medical students have more limited ability to copy than physicians.

Although the government has provided no specific guidance about using copy functionality federal officials do seem aware of the risks. The 2011 HHS OIG work plan includes a new targeted area of searching for identical entries among evaluation and management services in EHRs.

Late Entries in Medical Documentation

Have you ever wondered if it is acceptable to add medical record documentation after the service has been provided and if so, how long after the service was rendered it is appropriate to add information? This issue has been addressed in the Center for Medicare and Medicaid Services (CMS) Program Integrity Manual (PIM) which provides guidance to contractors hired by CMS to audit medical record documentation.

The PIM instructs Medicare auditors to give less weight when making review determinations to documentation created more than 30 days following the date of service. The guidance goes on to state that providers who have a pattern of making entries more than 30 days after the date of service may need to be referred to the Medicare contractor responsible for investigating potential fraud cases.

The following tips apply to late entries in the medical record:

- Identify the new entry as "late entry."

- Enter the **current** date and time. Do not try to give the appearance that the entry was made on a previous date or time.

- Identify or refer to the date and incident for which the late entry is written.

- If the late entry is used to document an omision, validate the source of additional informa tion as much as possible (e.g., where you obtained the information to write the late entry).

- When using late entries, document as soon as possible. The more time that passes, the less reliable the entry becomes.

TMS Requirement for NPPs

It is a state requirement that all PAs have a supervision agreement with a physician, and that LNMs have a clinical relationship agreement with an ob-gyn physician. It is a state and federal requirement that APRNs have a collaboration agreement with a physician. Agreements for each of these practitioners need to be reviewed, signed and completed on an annual basis.

If you are an APRN, PA or Midwife, we now use the Training Management System (TMS) to document annual renewal of these agreements. NPPs may access the agreement at this link:

https://bmsweb.yale.edu/tms/tms_enrollments.offerings?p_crs_id_2490

The TMS requirement is intended to provide a friendly reminder to NPPs to update the agreement. It is also important to retain copies of the agreements, as some external audits can request to review them.

Are you in compliance with Teaching Physician documentation guidelines?

The Center for Medicare and Medicaid Services (CMS) has specific guidelines about the documentation required in the medical record from a teaching physician when an ACGME resident or fellow is involved in the care of a patient.

Documentation

If the resident provides the documentation, the teaching physician is required at a minimum to personally document that he/she performed the service or was physically present during the key or critical portions of the service and that he/she was actively involved in the management of the patient. The teaching physician note needs to support the fact that he/she saw the patient, evaluated the patient and participated in the plan. When health records are reviewed, the combined documentation by the resident and teaching physician is used to support the medical necessity of the services provided.

Unacceptable Teaching Physician Documentation:

- 'Agree with above', followed by legible counter signature or identity.
- 'Rounded, reviewed, Agree', followed by leg ible countersignature or identity
- 'Discussed with resident, Agree' followed by legible countersignature or identity
- 'Seen and agree' followed by legible countersig nature or identity
- 'Patient seen and evaluated' followed by coun tersignature or identity
- A legible countersignature or identity alone

Minimally Acceptable Documentation

- I was present with resident during the history and exam. I discussed the case with the resident and agree with findings and plan as documented in the residents note.
- I saw and evaluated the patient. I reviewed the residents note and agree, except that (personalize the note).

Remember:

- The teaching physician documentation should be personalized to the patient. A generic attestation alone is not sufficient and does not support the medical necessity of the teaching physician involvement.
- Dictation should indicate who dictated the note
- Each person contributing to the documentation should sign the note

The only services provided by a medical student that the teaching physician can use is documentation of the **review of systems and/or past family and social history.**

Aetna Emails to Faculty for Training –Medcare Advantage

We have been notified that Aetna is sending emails to our faculty informing them that they must complete Aetna's compliance training program. Given that the Yale Medical Group has a robust internal Compliance Program, we are working with Aetna to have this requirement removed. Once our discussion with Aetna is complete we will communicate the result to faculty.

ANTHEM 'Incident to' Services

Effective 11/1/2011 Anthem will require all MDs and NPPs who have been assigned their own NPI to bill for their services under their own NPI. Separately reportable 'Incident to' services are only eligible for reimbursement under the supervising provider's NPI if the specific type of NPP who rendered the services is ineligible to submit claims directly to Anthem. This rule even applies when a provider is in the process of applying for an NPI. If the provider is a type who is eligible to receive an NPI and is eligible to submit claims directly to Anthem, then while the provider is waiting to receive an NPI, his/her services are not eligible for reimbursement as 'Incident to' services.

In the News

"EYE' on FRAUD 

Former Chair Convicted of Fraud

Dr Joseph J Kubacki, former chairperson of the Ophthalmology Department of the Temple University School of Medicine has been convicted of 150 counts of health care fraud, wire fraud and making false statements in health care matters. Between 2002 and 2007 Dr. Kubacki caused thousands of false claims to be submitted to health care benefit programs with false charges totaling more than $4.5 million for services rendered to patients whom Kubacki did not personally see or evaluate. In fact, Dr. Kubacki was outside of Pennsylvania in other locations on some of the days that he claimed to have treated patients, including Las Vegas, Sarasota, Florida, and Indian Wells, California. Dr. Kubacki faces more than 87 months in prison, a fine of up to $36 million, mandatory restitution and three years supervised release.

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