EHR Issues: Documentation Risks, Record Requests and Telemedicine Parity

Adam D. Romney
Partner
1201 Third Ave., Suite 2200
Seattle WA 98101
W: (206) 757-8238 W: (213) 633-6801 C: (303) 845-2915
adamromney@dwt.com

Davis Wright Tremaine LLP
DEFINING SUCCESS TOGETHER

Today's Agenda

1. EHR Documentation Risks

- The law that applies to EHR documentation
- Increase government and payor scrutiny

2. Telemedicine in Washington

- Medical Board Changes
- Medicaid Coverage
- Parity law

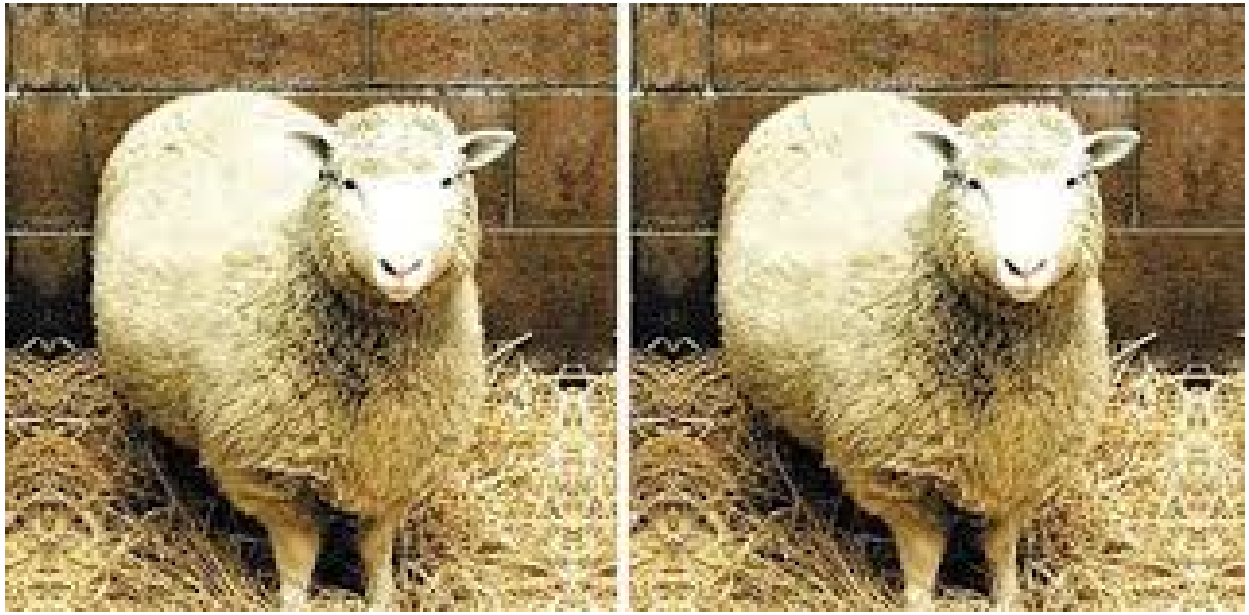
3. Record Requests

- Why you are getting so many
- What to do about it

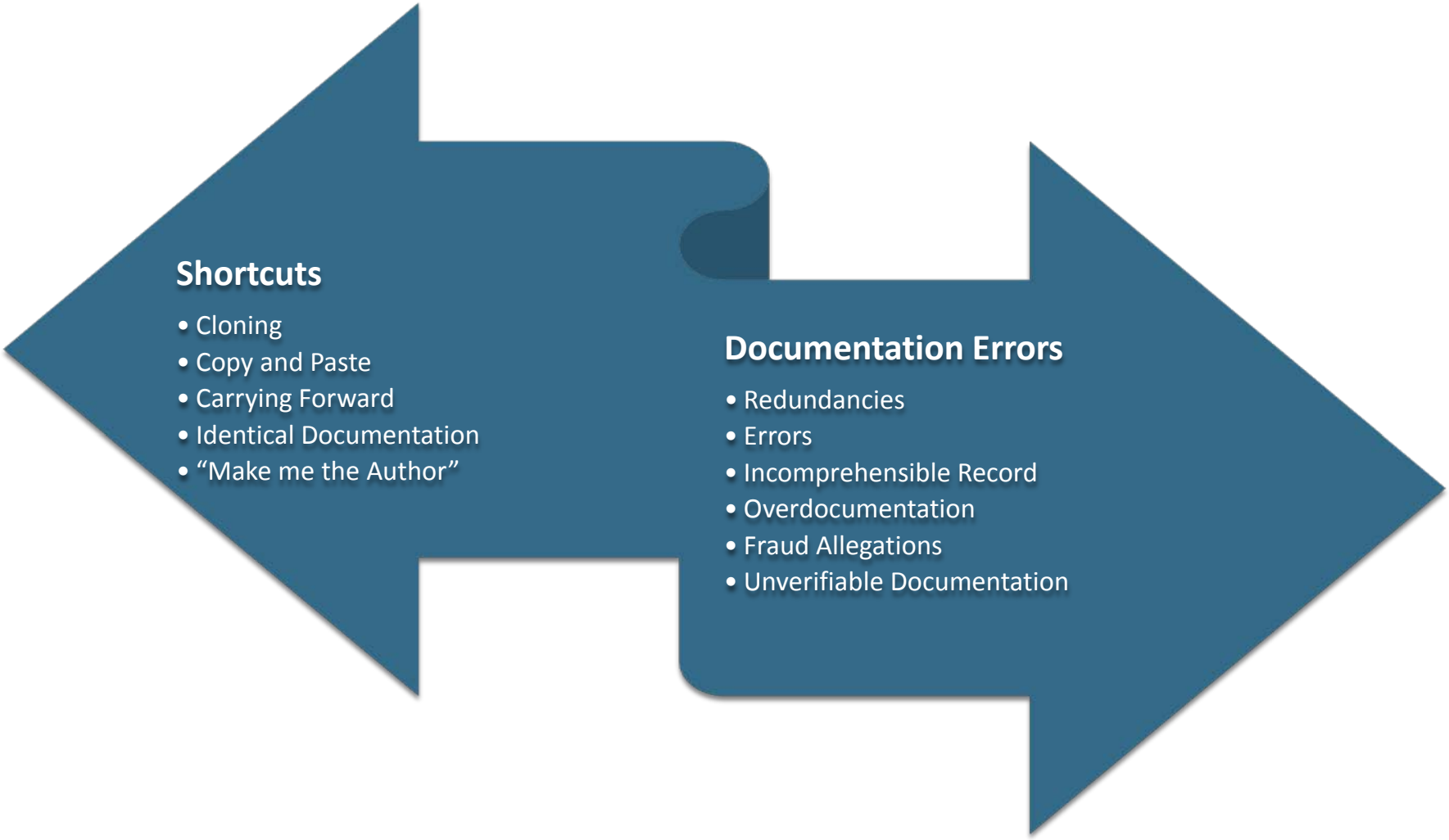
EHR DOCUMENTATION RISKS

Davis Wright Tremaine LLP
DEFINING SUCCESS TOGETHER

What is Cloned Documentation?



EHR Shortcuts v. Documentation Errors



So What is the Law?

- Medicare
- Medicaid
- Agency Guidance
- Government Contractors
- State Licensing
- Commercial Payors
- Accrediting Organizations

Letter from U.S. Attorney General and Secretary of DHHS (Sept. 24, 2012)

- Excerpts
  - "There are troubling indications that some providers are using this technology to **game the system**, possibly to obtain payments to which they are not entitled.
  - "**False documentation** of care is not just bad patient care; it's illegal."
  - "These indications include potential '**cloning**' of medical records in order **to inflate** what providers get paid."
  - "A patient's care information must be **verified individually** to ensure accuracy; it **cannot be cut and pasted** from a different record of the patient, which risks medical errors as well as overpayments."

Medicare Documentation Laws

- **Social Security Act § 1833(e)**: "No payment shall be made to any provider of services or other person under this part unless there has been **furnished such information as may be necessary in order to determine the amounts due** such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period."
- **42 C.F.R. § 424.5(a)(6)**: "*Sufficient information.* The provider, supplier, or beneficiary, as appropriate, must furnish to the intermediary or carrier sufficient information to determine **whether payment is due** and **the amount of payment**."

Medicare Manual Guidance

- **Program Integrity Manual Ch. 6, §15.2D**: "Section 1833(e) of the Social Security Act prevents Medicare from paying for services unless necessary and sufficient information is submitted that **shows that services were provided** and **to determine the amounts due**. A provider may submit progress notes to document the services that have been provided. The progress note should include a description of the nature of the treatment service, the patient's response to the therapeutic intervention, and its relation to the goals indicated in the treatment plan."

Medicare Administrative Contractors (The Good)

- **FAQ:** What is Cahaba GBA's stance on cloning of medical documentation and what constitutes appropriate editing of a note that has been copied / pasted into a medical record?
- **Answer**: The medical necessity of services preformed must be documented in the medical record and Cahaba GBA would expect to see **documentation that supports reasonable and medically necessary services** and any changes and or differences in the documentation of the History of Present Illness, Review of System and Physical Examination. The **medical record must be authenticated by the provider of services**. CMS acceptable signature methods are hand written and electronic signatures. Stamp signatures are not acceptable.

Medicare Administrative Contractors (The Bad)

- Palmetto GBA: “Medical Record Cloning” (10/31/2014)
  - “The word ‘cloning’ refers to documentation that is worded exactly like previous entries. This may also be referred to as 'cut and paste' or 'carried forward.’”
  - “While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter.”
  - “**Cloned documentation does not meet medical necessity requirements** for coverage of services.”
  - “**Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made**.”

Medicare Conditions of Participation

- (b) Standard: Form and retention of record. … Medical records must be **accurately written**, promptly completed, properly filed and retained, and accessible….
- (c) Standard: Content of record. The medical record must **contain information to justify** admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.
  - (1) All patient medical record entries must be legible, complete, dated, timed, and **authenticated** in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

42 CFR 482.24

Washington Medicaid

- Providers must:
  - (1) Maintain documentation in the client's medical or health care records to **verify the level, type, and extent of services** provided to each client to fully justify the services and billing
  - (2) Keep legible, **accurate**, and complete charts and records;
  - (4) Assure charts are **authenticated** by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains;

  WAC 182-502-0020

Washington Medicaid – Physician Provider Guide: E/M Documentation and Billing

- Documentation must:
  - Be legible to be considered valid
  - **Support the level of service billed**
  - **Support medical necessity** for the diagnosis and service billed
  - Be **authenticated** by provider performing service with date and time
- Keys to documenting medical necessity to support E/M service:
  - Document all diagnoses managed during the visit
  - For each established diagnosis, specify if the patient's condition is stable, improved, worsening, etc.
  - Document rationale for ordering diagnostic tests and procedures
  - Clearly describe management of the patient (e.g., prescription drugs, over the counter medication, surgery)

Washington Licensing Rules

- Hospitals must:
  - Initiate and maintain a medical record for every patient assessed or treated **including a process to review records for completeness, accuracy**, and timeliness;
  - Create medical records that
    - Have **clinical data** to support the diagnosis, course and results of treatment for the patient
    - Have **accurately** written, signed, dated, and timed entries
    - Indicate **authentication** after the record is transcribed

WAC 246-320-166

Commercial Payor in Washington

- Each applying its own standard
- One has said during an audit that it will disregard any narrative documentation that appears to be exactly the same as other dates of service
  - We argued this point on appeal and settled favorably for the provider

Dec. 2013 OIG Report: "Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology"

- Study looked at hospitals receiving EHR incentive payments.
- **Audit Logs:** OIG recommends that
  - 1) ONC propose a **change to its EHR certification criteria** to require that EHR technology keep audit logs operational whenever these are available for update or viewing; or
  - 2) CMS **update meaningful use criteria** to require providers to keep the audit logs operational whenever EHR technology is available for update or viewing.
- **Comprehensive Fraud Plan:** ONC and CMS should develop a formal strategy to detect and reduce fraud in EHRs.
- **Copy and Paste Feature:** CMS and ONC should develop guidelines for using the copy-and-paste feature in EHR technology and should specifically consider whether the risks of copy-paste practices outweigh their benefits.

Jan. 2014 OIG Report: "CMS and its Contractors Have Adopted Few Program Integrity Practice to Address Vulnerabilities in EHRs"

- **Detecting Fraud:** CMS should provide guidance to its contractors on detecting fraud associated with EHRs. OIG states that the agency could work with contractors to identify best practices and develop guidance and tools for detecting fraud associated with EHRs.
- **Audit Logs:** CMS should direct its contractors to use providers' audit logs. The report discusses how audit log data distinguish EHRs from paper medical records and could be valuable to CMS' contractors when reviewing medical records.

EHR Documentation Takeaways

- Don’t abandon all use of EHR documentation tools
- Policies regarding EHR documentation
- Education regarding EHR documentation
- Utilize EHR audit tools when possible to track
  - Method of documentation entry
  - Author of entry
  - Date / time stamp
  - Authentication of entry
  - The original source of any imported documentation

TELEMEDICINE IN WASHINGTON

Davis Wright Tremaine LLP

DEFINING SUCCESS TOGETHER

Overview

- Licensure standards
- Medicaid Coverage
- Parity Law

Washington MQAC: Guidelines for the Appropriate Use of the Internet in Medical Practice

- **Licensure**. Provider must be licensed in Washington
  - Exception for "The practice of medicine by any practitioner licensed by another state or territory in which he or she resides, provided that such practitioner shall not open an office or appoint a place of meeting patients or receiving calls within this state" does not apply
- **Standard of Care**. Practitioners will be held to the same standard of care as practitioners engaging in traditional settings
- **Practitioner-Patient Relationship**. The relationship is clearly established when the practitioner agrees to undertake diagnosis and/or treatment of the patient and the patient agrees that the practitioner will diagnose and/or treat, whether or not there has been or is an in-person encounter between the parties.

Guidelines for the Appropriate Use of the Internet in Medical Practice (Cont.)

- **Informed Consent**. It is best practice for the informed consent to include:
  - Reasonable understanding by all parties of the enabling technologies utilized, their capabilities and limitations, and a mutual agreement that they are appropriate for the circumstances;
  - The credentials of the practitioner.
- **Patient Evaluation.** An appropriate history and evaluation of the patient must precede the rendering of any care, including provision of prescriptions. Not all patient situations will be appropriate for Telemedicine
- **Allowable Treatment Parameters**. The Telemedicine practitioner may provide any treatment deemed appropriate for the patient, including prescriptions, if the evaluation performed is adequate to justify the action taken. The practitioner is responsible for knowing the limitations of the care he or she can provide, no matter how the care is delivered.
- **Prescriptions.** Especially careful consideration should apply before prescribing DEA-controlled substances.

Washington Medicaid Covered Telemedicine Services

- Covered Services
  - Consultations (CPT codes 99241–99245 and 99251-99255)
  - Office or other outpatient visits (CPT codes 99201-99215)
  - Psychiatric intake and assessment (CPT code 90791 or 90792)
  - Individual psychotherapy (CPT codes 90832, +90833; 90834, +90836; 90837, +90838)
  - Visit for drug monitoring
- Not Covered
  - Email, telephone and fax transmissions
  - Installation or maintenance of any telecommunication devices or systems
  - Home health monitoring

Washington Medicaid Coverage Conditions

- Patient must be located in an approved Originating Site
  - Physician Office
  - Hospital/CAH
  - Rural Health Clinic
  - FQHC
- Eligible providers
  - Physicians
  - ARNPs

Washington Telemedicine Parity Law

- Signed: On April 17, 2015, Washington signed S.B. 5175
- Takes effect on Jan. 1, 2017
- Scope: The law defines telemedicine as health case services provided via "interactive **audio and video** technology, permitting real-time communication" for purposes of diagnosis consultation or treatment.
- DOES NOT INCLUDE services delivered w/o a video component, such as:
  - Telephone
  - Email
  - Text
  - Facsimile

Payors

- Applies to:
  - Health Care Service Contractors (PPO, POS and Indemnity plans)
  - Health Maintenance Organizations
  - Medicaid Managed Care Plans
  - Disability Insurers
  - Entities offering health plans to state employees and their dependents
- Does not apply to
  - Traditional Medicaid
  - Workers Compensation

Parity of “Coverage” Required

- (1) If the payor would cover the health care service if it was provided to the patient in an in-person setting
- (2) The health care service is medically necessary
- (3) The health care service is recognized as an essential health benefit under the Affordable Care Act

DOCUMENTATION REQUESTS

Davis Wright Tremaine LLP
DEFINING SUCCESS TOGETHER

Example One: Deficit Reduction Act

- "The Federal Deficit Reduction Act (DRA) of 2005…requires any entity receiving or making annual Medicaid payments of $5 million or more to establish and adopt written policies about federal and state false claims laws for all its employees, contractors and/or agents as stated in the 1902(a)(68) Social Security Act."
- "It has been determined that your business entity is required to comply with section 1902(a)(68) of the Social Security Act. The law requires that Providers must establish written policies and/or procedures to include:
  - "Detailed information about the Federal False Claims Act, including references to the State False Claims Act.
  - "Handling and protection of whistleblowers, including QUI TAM relator settlement percentages and how and where to report fraud."
  - "How to detect and prevent fraud, waste, and abuse. Includes definitions of what is a false claim."
  - "State statutes regarding civil or criminal penalties for making false claims and statements."

Example Two: Government Contractors – Fraud, Waste and Abuse Attestations

- "CMS requires us to oversee our health care providers, vendors, and other organizations that assist us in providing services for our Medicare beneficiaries. In order to fulfill the requirements imposed by our contract with CMS, we are asking that you sign 2014 attestations for the following:

  1. "Medicare Compliance Training "
  2. "Compliance Program and Code of Conduct"
  3. "Fraud Waste and Abuse Training "
  4. "Review of OIG/GSA Exclusion Lists"

- "Attached are eight attestations for your review and signature. Please read and complete each attestation, and return the completed forms to us by facsimile, US Mail, or email. We would appreciate receiving the completed attestations right away."

Example Three: Medicare Advantage Audits

- **Final Rule – 60-Day Rule for Medicare Part C & D**
- "An organization can identify or assess that there is a problem with data submitted to CMS, and determine that it is incorrect data, prior to actually calculating what the payment impact is of that erroneous data. For example, a risk adjustment diagnosis that has been submitted for payment but is found to be invalid **because it does not have supporting medical record documentation would result in an overpayment**. Under this provision, the day after the date on which the organization has confirmed an identified overpayment—because the organization knows that the diagnosis is not supported by documentation—is the first day of the 60-day period for reporting and returning the overpayment."

Questions?

- Over 500 lawyers
- Full-service transactional, litigation and regulatory practices
- Strong industry teams, particularly in communications, media, technology, health care, energy, financial services, hospitality and life sciences