Dermatology Coding Alert

Documentation: Avoid Billing E/M Service Based on Cloned Documentation, Or the OIG Will Come Knocking

Ensure your EMR is not setting you up for failure.

If you have reviewed the HHS Office of Inspector General (OIG) hot list of areas it will be scrutinizing for 2013, you know that evaluation and management billing makes the top 10.

In its 2013 Work Plan, released on Oct. 2, the OIG indicates that it intends to go back in time all the way to 2010, to be exact, when reviewing E/M claims.

"We will determine the extent to which CMS made potentially inappropriate payments for E/M services in 2010 and the consistency of E/M medical review determinations," the Work Plan states.

The OIG also plans to review multiple E/M notes for each provider to determine whether electronic medical records (EMR) errors are creating cloned notes across services.

Your EMR system may make things easier for your practice in many ways, but it won't make your E/M claims entirely "audit-proof." In fact, in some cases, your EMR could be setting you up for an audit or OIG scrutiny.

Bottom line: If your physician is documenting each patient identically rather than documenting based on the patient's condition and medical necessity, that's a red flag for the OIG. Read on to get the details and see how you can avoid the EMR cloned documentation pitfall.

Make Medical Necessity Your Key Factor

While it may be easy to check boxes or fill in bullets in an EMR, the provider notes and documentation need to ultimately explain why the patient is seeing your physician and what your provider plans to do for the condition as well as demonstrate medical necessity.

In black and white: "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code," CMS says in Section 30.6.1 of the Medicare Claims Processing Manual.

Therefore, any documentation of a comprehensive history and exam in an EHR may cause the system to automatically assign 99215, but that doesn't mean your documentation will back up that code selection.

Keep this in mind: Most coding and billing experts recommend that you not let your EMR do your E/M coding for you. Your EMR can't judge your physician's medical decision making. The fact is, when you get audited, the EMR won't be on the stand in your defense. The EMR won't pay your take-backs or fines.

Watch for 'Electronic Upcoding'

In addition to not being audit-proof, the EMR may also create the additional concern of "electronic upcoding" related to templates and cloned documentation. You may enter some elements of the history and physical exam, and the computer may generate a more complete history and physical than may be medically necessary. This represents another area of potential EMR coding liability.

Example: "The biggest issue I see in family medicine and internal medicine is that now, with electronic medical records, the physicians are merely 'clicking and pasting' to populate fields in the Exam section of the encounter, but not actually doing the work," says **Terry A. Fletcher, BS, CPC, CCS-P, CCS, CEMC, CCC, CMSCS, CMC,** of Terry Fletcher

Consulting, Inc. in Laguna Beach, Calif. "The records start to look like 'cloned' records."

Caution: Be careful what physician work you count in determining E/M level, warns **Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE,** president of Maggie Mac-Medical Practice Consulting in Clearwater, Fla. "Only work that is considered necessary to evaluate, treat and manage the patient should be used to determine E/M code assignment," she says.

Even if the physician sees seven patients with the flu on the same date of service, they won't all have the same history, symptoms, treatment recommendation, or prognosis, so copying documentation from one patient to the next is inappropriate. The notes should be tailored to each patient's individual case.

Even if your provider is seeing a patient repeatedly to follow a particular illness or injury, the documentation for each encounter must refer to "what you did today, not going back and just cutting and pasting each time," says **Margie Scalley Vaught, CPC, CPC-H, CPC-I, CCS-P, ACS-EM, ACS-OR,** healthcare consultant in Chehalis, Wash., in the November 2012 AudioEducator conference "2013 OIG Work Plan for Physician Practice." (Visit www.audioeducator.com/coding-updates/oig-work-plan-update-for-2013-112812.html to get the entire audioconference.)

Payer guidance: Back in May 2006 First Coast, a MAC in Florida, published a bulletin about cloned documentation. "Cloning of medical notes documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries," the bulletin states. "Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment. Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement 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."

In August 2012 National Government Services (NGS), another MAC, put out similar documentation about cloned records. NGS states that documentation is considered cloned when it is worded exactly like or similar to previous entries. The payer warns that "Individualized patient notes for each patient encounter are required," Vaught explains.

Change the Documentation Wording

Although you might think of "cloned documentation" as only existing when using EMRs, the truth is that even paper records can be considered "cloned," if they are all worded exactly alike. The answer? Help providers remember to document things differently, so they don't look like carbon copies.

"Whether the cloned documentation is handwritten, the result of a pre-printed template, or use electronic health records, cloning of documentation will be considered misrepresentation of the medical necessity requirement for coverage of services," says **Carrie Weiss,** senior provider education consultant with Palmetto GBA, a Part B MAC in seven states.

Bonus tip: Avoid "follow-up" as a catch-all complaint. All E/M documentation must include a chief complaint, but what your physician lists as the chief complaint may not fit your payer's requirements.

"The chief complaint is a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the E/M encounter," Weiss says. "It is typically stated in the patient's own words. An example would be a sore throat, or chest pain. Just stating 'follow-up' is not appropriate."