Codify
BY AAPC

Health Information Compliance Alert

Compliance: Watch For Compliance in Your Provider Documentation

You could be setting your practice up for paybacks, fines, or worse.

Inadequate documentation is your ticket to unpleasant audit outcomes. Ensure your providers' documentation will stand up to payer and government scrutiny by focusing on these five key areas for improvement.

1. **Start with Authentication Requirements**

Every medical record must have authentication. Every service your medical staff provides or orders should be authenticated by the author, says Marsha S. Diamond, CPC, CPC-H, CCS, coding textbook author and past AAPC National Advisory Board member and past Greater Orlando (FL) AAPC Chapter President in the Audioeducator.com audioconference "Compliance: It's Not Just About Coding." All notes should be dated, preferably timed, and signed by the author.

Authentication must be either a handwritten or an electronic signature. Note that signature stamps are not acceptable for Medicare and many other payers. In the office setting, initials are acceptable as long as they clearly identify the author.

Handwritten signature will be considered a "mark or sign." If the signature is illegible, Medicare shall consider evidence in a signature log. Lack of such supporting documentation will result in claims denial.

Remember: Every note must stand alone, meaning that the performed services must be documented at the onset. The medical record must stand on its own with the original entry corroborating that the service was rendered and medically necessary.

Ensure legibility: Every entry in a patient's medical record must be legible to another reader to a degree that a meaningful review may be conducted. If the signature is not legible and does not identify the author, a printed version should also be recorded.

2. **Check Timing Requirements**

When your providers actually complete their documentation matters. "Documentation should be generated at the time of service or, as Medicare puts it, 'shortly thereafter,'" Diamond explains.

Delayed entries within a "reasonable" period of time are acceptable for the purposes of:

- Clarification
- Error correction
- Addition of information initially not available
- Documentation when unusual circumstances prevented generation of note at time of service (for example, if your EMR system is not working).

Rule of thumb: Payers don't typically give a set timeframe for what qualifies as "shortly thereafter." Diamond explains that the rule is usually that you are in good shape "as long as the documentation is in the chart and documented in the time that the author has 'total recall' of the patient encounter or service."

3. **Be Careful When Making Alterations**

The medical record cannot and should not be altered. Errors must be legibly corrected so that the reviewer can draw an

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inference to its origin. If your provider makes a correction, he should include the date and (preferably) the time of the amended documentation. Then, the person making the change should also legibly sign or initial the entry.

Example: Your provider accidently copies and pastes a sentence from one patient's record into another patient's record. Someone in your practice catches the error later on. "Even if you realize that you put it on the wrong patient's record or that that comment is totally inappropriate for that particular patient, then it should not be taken out of the record, but corrected using an appropriate method such as lining through it and initialing above it and the date [added and a statement] to say that was an error."

Be clear: Delayed written additions/explanations serve for clarification only and cannot be used to add and authenticate services billed and not documented at the time of service or to retrospectively substantiate medical necessity. For example, if your practice did an audit and found that one of your providers was billing based on time but never included the total time spent with the patient in the chart notes, you cannot go back later on and add the time to support the billing.

4. **Know the Rules for Using Scribes**

If a nurse or non-physician practitioner (NPP), such as a physician assistant (PA) or nurse practitioner (NP), acts as a "scribe" for the provider, the individual writing the note or entry in the record should note "written by (name of NPP), acting as a scribe for Dr. (Physician Name)."

The physician should then co-sign and date the record, and also indicate that the note accurately reflects work and decisions he made during the encounter.

"It would be inappropriate for an employee of the physician to make rounds or see patients at one time and make entries in the record and then the provider make rounds later and note 'agree with above,' unless the employee is a licensed, certified provider (NP/PA) billing for services under his/her own name/number," Diamond says.

5. **Watch Out for EMR Pitfalls**

With the introduction of electronic medical records (EMRs) the capability of "carry over," repetitive "fill ins," and cloning has become prevalent, Diamond says.

Remind your providers and coding/billing staff that only medically necessary information is considered when you are deciding on the code to bill based on supporting documentation.

Copy and paste, cloning, and the act of carrying information forward from another record or another portion of the record has the same effect on the integrity of the medical record. Eventually, there will be contradictions in a patient's record. Payers obviously frown on this type of documentation.

Example: First Coast Service Options, the MAC in Florida, prohibited the practice of cloning in its 2006 Medicare Part B newsletter (http://medicare.fcso.com/Publications_A/2006/138374.pdf), which states, "Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. 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."

First Coast further states that discovery of this type of documentation will "result in denial of services for lack of medical necessity and recoupment of all overpayments made."

Bottom line: Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Credibility of the record is compromised and an auditor will be unable to determine what is accurate and how much work was done on one visit versus another.

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