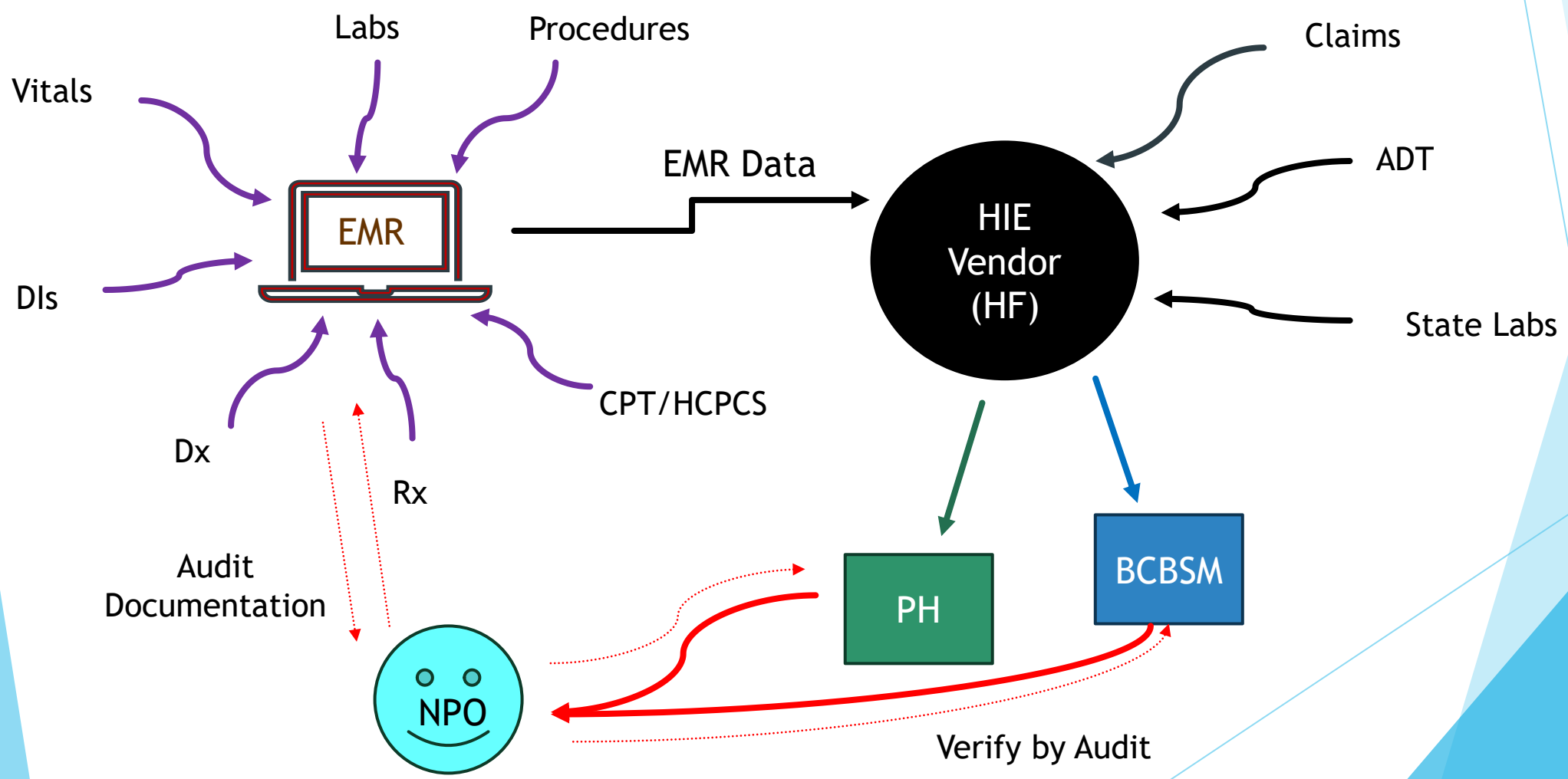
EMR Documentation Tips: Lessons Learned from Payer Audits

05/22/2024

Documenting Data in Your EMR: Accuracy Matters



NPO Supplemental Data Process

- **Health Focus pulls the data directly from the EMR by way of structured data populating a CCDA**
  - Documents stored are not pulled and will not close a care gap.
  - HF identifies the most recent date in the order as the Result Date.
  - Labs/test are identified as “completed” by a date in the structured “Result Date” field and/or a result in the structured “Result” field.
- **Data is submitted by Health Focus to BCBSM, BCN, and Priority Health on a weekly basis.**
  - The timeframes for when the data will be processed and reflected in the reports may vary by insurance companies.
  - It may take 30-60 days to see the data submitted by Health Focus populated in the insurance company’s data.
- **Measures are continuing to move to Electronic Clinical Data Systems (ECDS) submission.**

Common EMR Data Entry Errors

- Incorrect use of **Structured Data Fields** in Lab/DI orders
  - Incorrect **Dates** entered into Lab/DI orders
  - Incorrect **Results** entered into Lab/DI orders
  - **Blank** structured data fields
  - **Free-Typing** into structured data fields
- **Typos**
  - Height entered as 1 inch
  - BP either flipped to diastolic/systolic

The Golden Rule for Data Entry

Use a resulted document to identify the information to enter into structured data fields (e.g., Lab/DI orders)!

- **Resulted documents include:**
  - Lab reports (e.g., HbA1c, Cologuard, etc.)
  - Mammogram reports
  - Colonoscopy op reports
  - Progress Notes (e.g., for in-house labs, etc.)
- **Use the resulted document to identify the following information:**
  - **Sample Collection Date or Test Performed Date**
  - **Result Date**
  - **Lab/Test Result**
- **DO NOT put any information into a structured data field that cannot be found on the supporting lab/test report!**
- **Make sure the supporting lab/test report can be found in the patient's chart in the EMR.**

Document the Correct Dates

- There are multiple dates listed on a lab/test report
  - **Order**
  - **Sample Collection**
  - **Received**
  - **Resulted / Performed**
- **The Order and Received dates are irrelevant for HEDIS reporting**
- **The date on which you are manually entering the information is also irrelevant; Never enter the manual-entry date into a Lab/DI order**
- The correct **Sample Collection** and **Test Result** dates must be entered into corresponding structured data fields

What Dates to Use -

Colonoscopy

Operative/Procedure Report

Type: Operative/Procedure Report
Date: March 17, 2021 9:25 EDT
Status: Transcribed
Title: NMSC Operative/Procedure Report
Performed By: Weick MD, Alexander J on March 17, 2021 9:25 EDT
Encounter info: NM Surg Center, OPS (O/P Surgery), 3/17/2021 - 3/17/2021
Contributor system: WebChartMD - NetMed

CRSC Operative/Procedure Report
Copper Ridge Surgery Center
Formerly Northwest Michigan Surgery Center
4100 Park Forest Drive
Traverse City, MI 49684

OPERATIVE REPORT

Name:

Date of Birth:

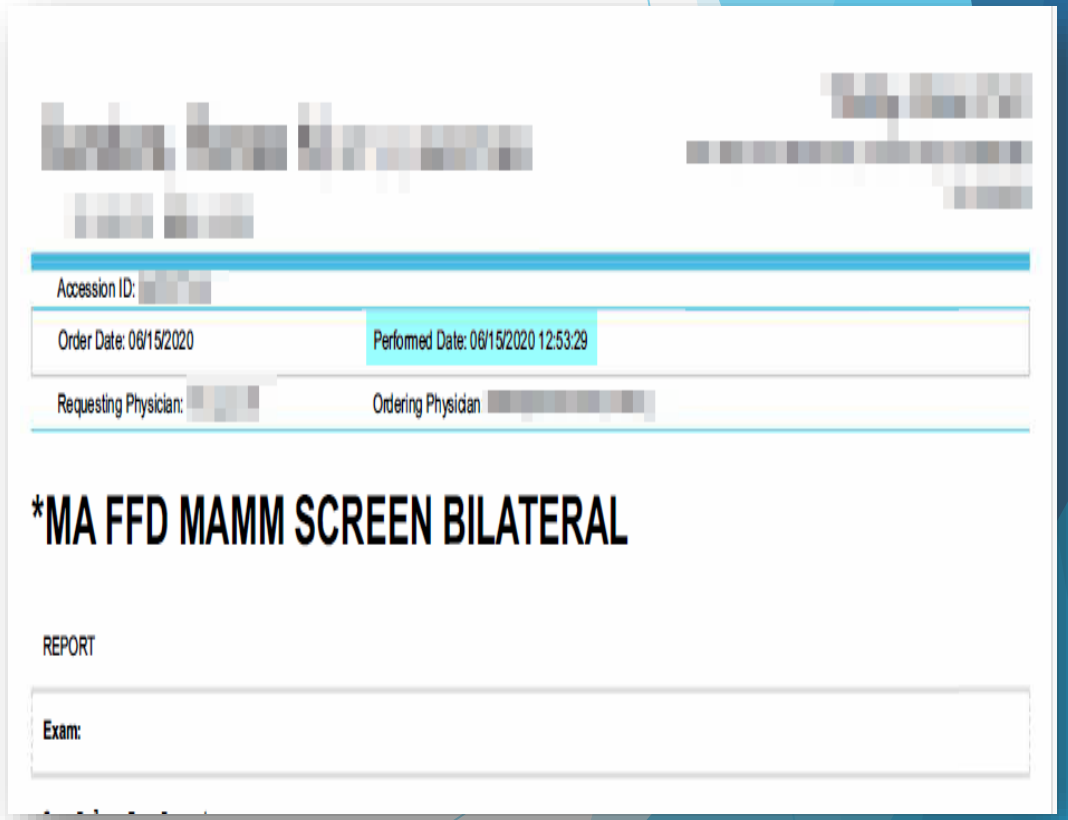
Date: 03/17/2021

Account #:

Surgeon: Alexander Weick, MD

Procedure:
Colonoscopy with cold forceps biopsy.

Mammogram


Accession ID:

Order Date: 06/15/2020 Performed Date: 06/15/2020 12:53:29

Requesting Physician: Ordering Physician

*MA FFD MAMM SCREEN BILATERAL

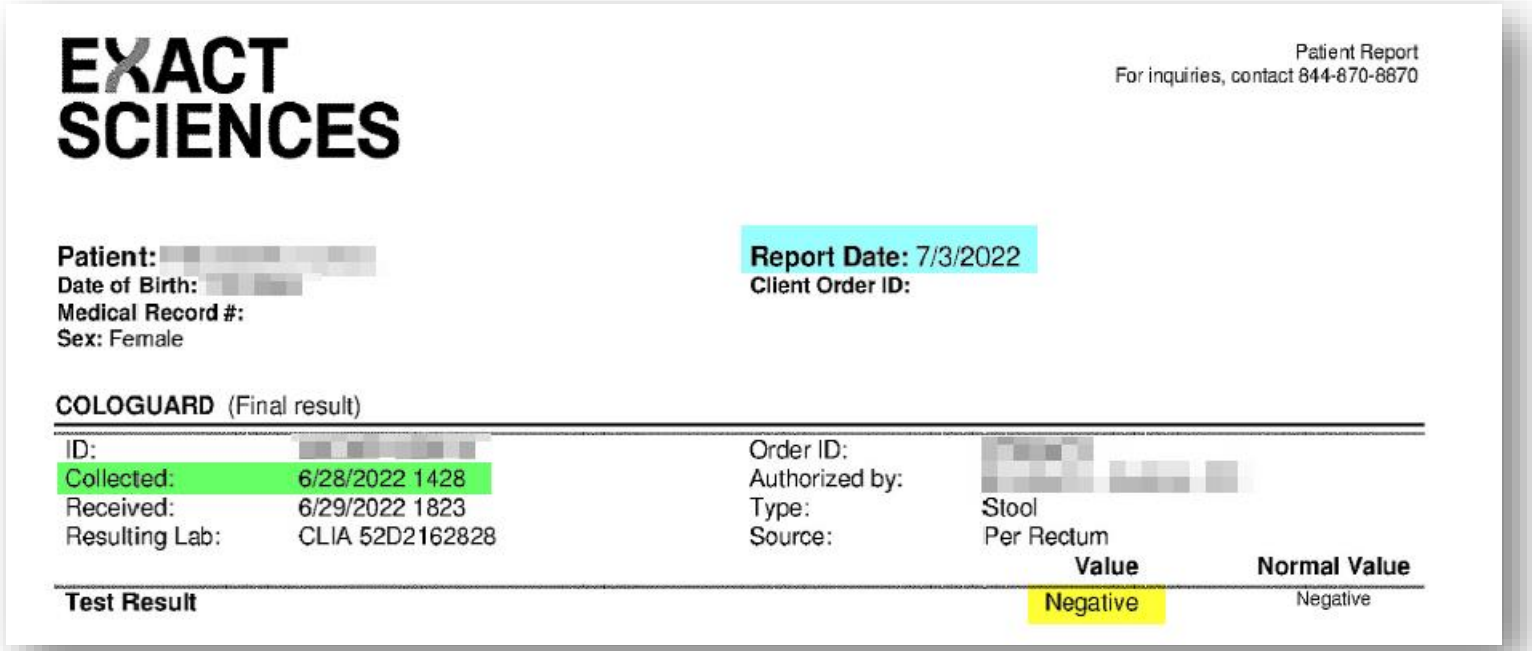
REPORT

Exam:

Performed Date = Result Date

DI

What Data to Use - Cologuard



EXACT SCIENCES

Patient Report
For inquiries, contact 844-870-8870

Patient: [redacted]
Date of Birth: [redacted]
Medical Record #:
Sex: Female

Report Date: 7/3/2022
Client Order ID:

COLOGUARD (Final result)

ID:	[redacted]	Order ID:	[redacted]
Collected:	6/28/2022 1428	Authorized by:	[redacted]
Received:	6/29/2022 1823	Type:	Stool
Resulting Lab:	CLIA 52D2162828	Source:	Per Rectum

	Value	Normal Value
Test Result	Negative	Negative

Sample Collection Date = 6/28/2022

Result Date = 7/3/2022

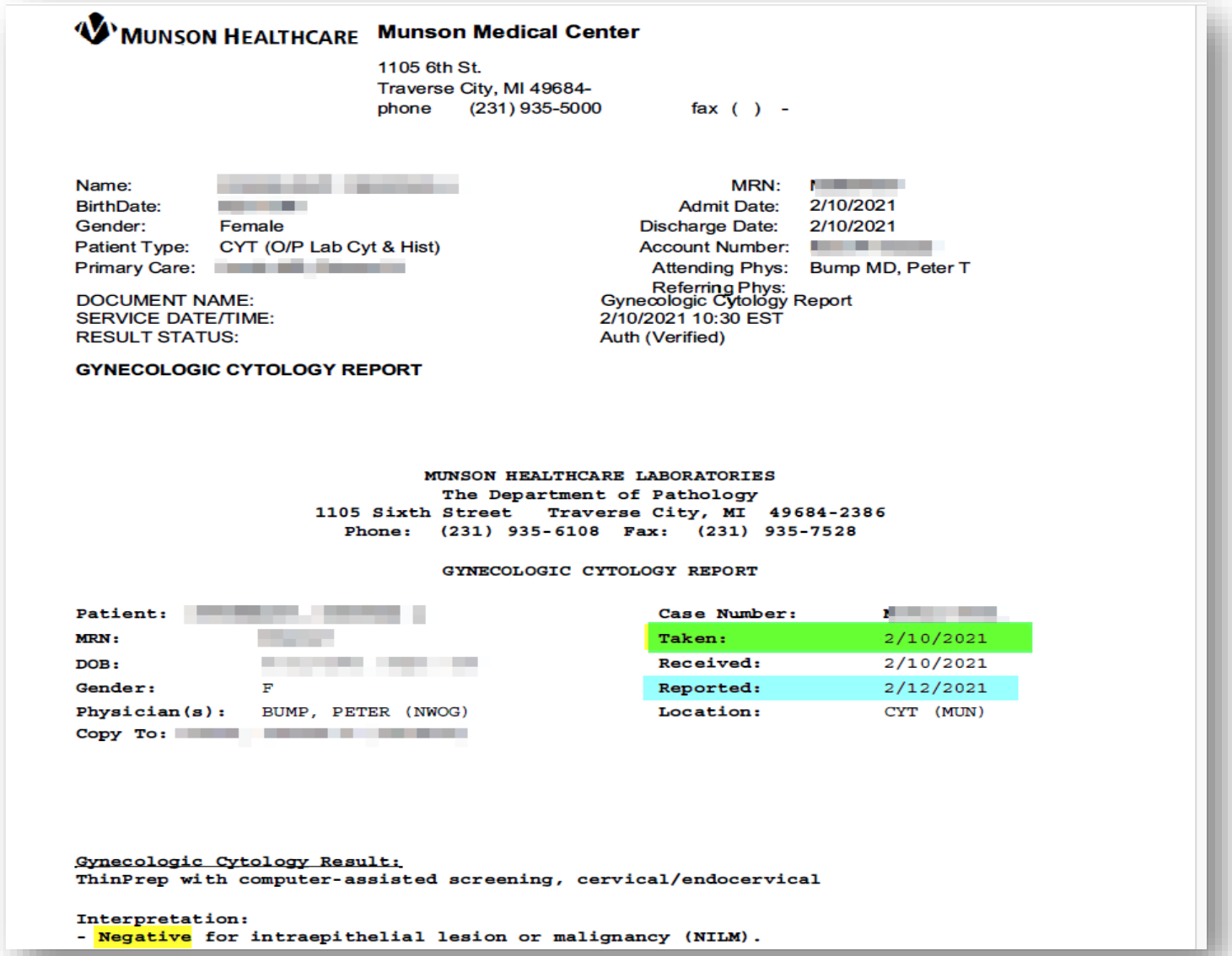
Result = Negative

Collected Date = date patient states the sample was collected

Received Date = date Exact Sciences received the sample in the mail (internal QA)

Report Date = Result Date = date a result was generated and reported by the lab

What Data to Use - Gyn Cyt



MUNSON HEALTHCARE **Munson Medical Center**

1105 6th St.
Traverse City, MI 49684-
phone (231) 935-5000 fax ( ) -

Name:	[redacted]	MRN:	[redacted]
BirthDate:	[redacted]	Admit Date:	2/10/2021
Gender:	Female	Discharge Date:	2/10/2021
Patient Type:	CYT (O/P Lab Cyt & Hist)	Account Number:	[redacted]
Primary Care:	[redacted]	Attending Phys:	Bump MD, Peter T
		Referring Phys:	

DOCUMENT NAME: Gynecologic Cytology Report
SERVICE DATE/TIME: 2/10/2021 10:30 EST
RESULT STATUS: Auth (Verified)

GYNECOLOGIC CYTOLOGY REPORT

MUNSON HEALTHCARE LABORATORIES
The Department of Pathology
1105 Sixth Street Traverse City, MI 49684-2386
Phone: (231) 935-6108 Fax: (231) 935-7528

GYNECOLOGIC CYTOLOGY REPORT

Patient:	[redacted]	Case Number:	[redacted]
MRN:	[redacted]	Taken:	2/10/2021
DOB:	[redacted]	Received:	2/10/2021
Gender:	F	Reported:	2/12/2021
Physician(s):	BUMP, PETER (NWOG)	Location:	CYT (MUN)
Copy To:	[redacted]		

Gynecologic Cytology Result:
ThinPrep with computer-assisted screening, cervical/endocervical

Interpretation:
- Negative for intraepithelial lesion or malignancy (NILM).

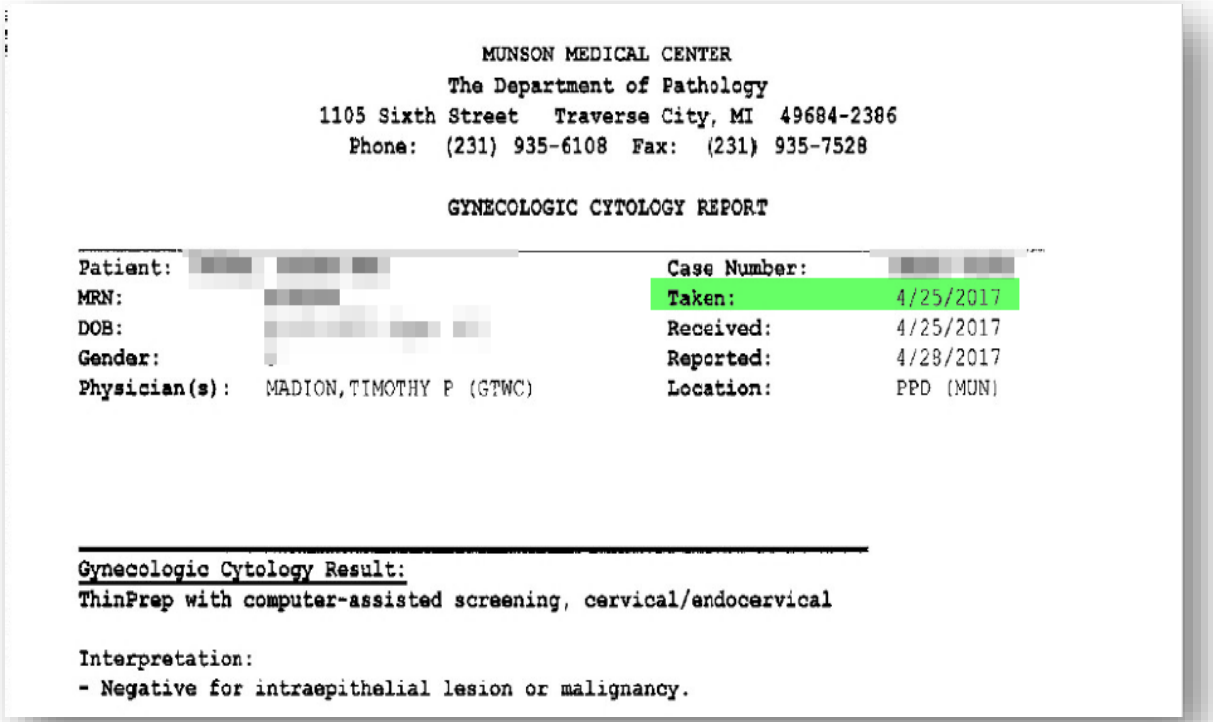
Taken = Sample Collection Date = 2/10/2021

Reported = Result Date = 2/12/2021

Result = Negative

LAB

What Data to Use - HPV



MUNSON MEDICAL CENTER
The Department of Pathology
1105 Sixth Street Traverse City, MI 49684-2386
Phone: (231) 935-6108 Fax: (231) 935-7528

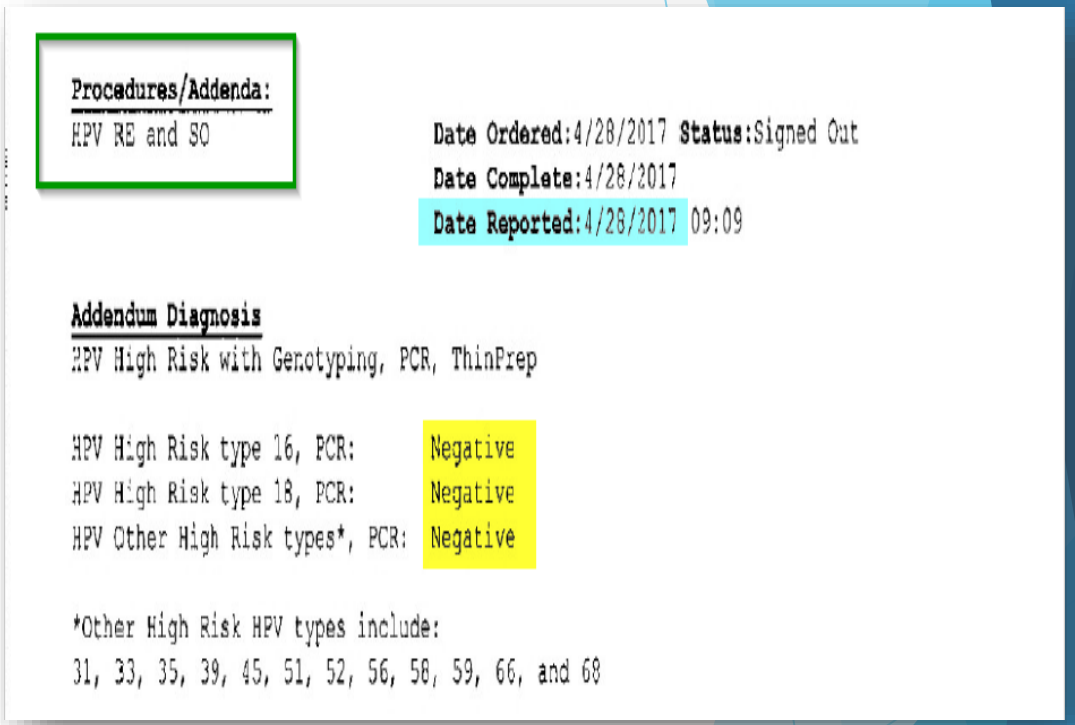
GYNECOLOGIC CYTOLOGY REPORT

Patient: [redacted]
MRN: [redacted]
DOB: [redacted]
Gender: [redacted]
Physician(s): MADION,TIMOTHY P (GTWC)

Case Number: [redacted]
Taken: 4/25/2017
Received: 4/25/2017
Reported: 4/28/2017
Location: PPD (MUN)

Gynecologic Cytology Result:
ThinPrep with computer-assisted screening, cervical/endocervical

Interpretation:
- Negative for intraepithelial lesion or malignancy.



Procedures/Addenda:
HPV RE and SO

Date Ordered:4/28/2017 Status:Signed Out
Date Complete:4/28/2017
Date Reported:4/28/2017 09:09

Addendum Diagnosis
HPV High Risk with Genotyping, PCR, ThinPrep

HPV High Risk type 16, PCR: Negative
HPV High Risk type 18, PCR: Negative
HPV Other High Risk types*, PCR: Negative

*Other High Risk HPV types include:
31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, and 68

Taken = Sample Collection Date = 4/25/2017

Date Reported = Result Date = 4/28/2017

Result = Negative

LAB

Example – Incorrect Date (HPV)

*Audit Fail

Gyn Cyt/HPV Lab Report

GYNECOLOGIC CYTOLOGY REPORT

Patient:	[redacted]	Case Number:	[redacted]
MRN:	[redacted]	Taken:	7/7/2017
DOB:	[redacted]	Received:	7/7/2017
Gender:	F	Reported:	7/11/2017
Physician(s):	MCKAY,DOUGLAS L (GTWC)	Location:	PPD (MUN)
Copy To:	[redacted]		

Gynecologic Cytology Result:
ThinPrep with computer-assisted screening, cervical/endocervical

Interpretation:
- Negative for intraepithelial lesion or malignancy.

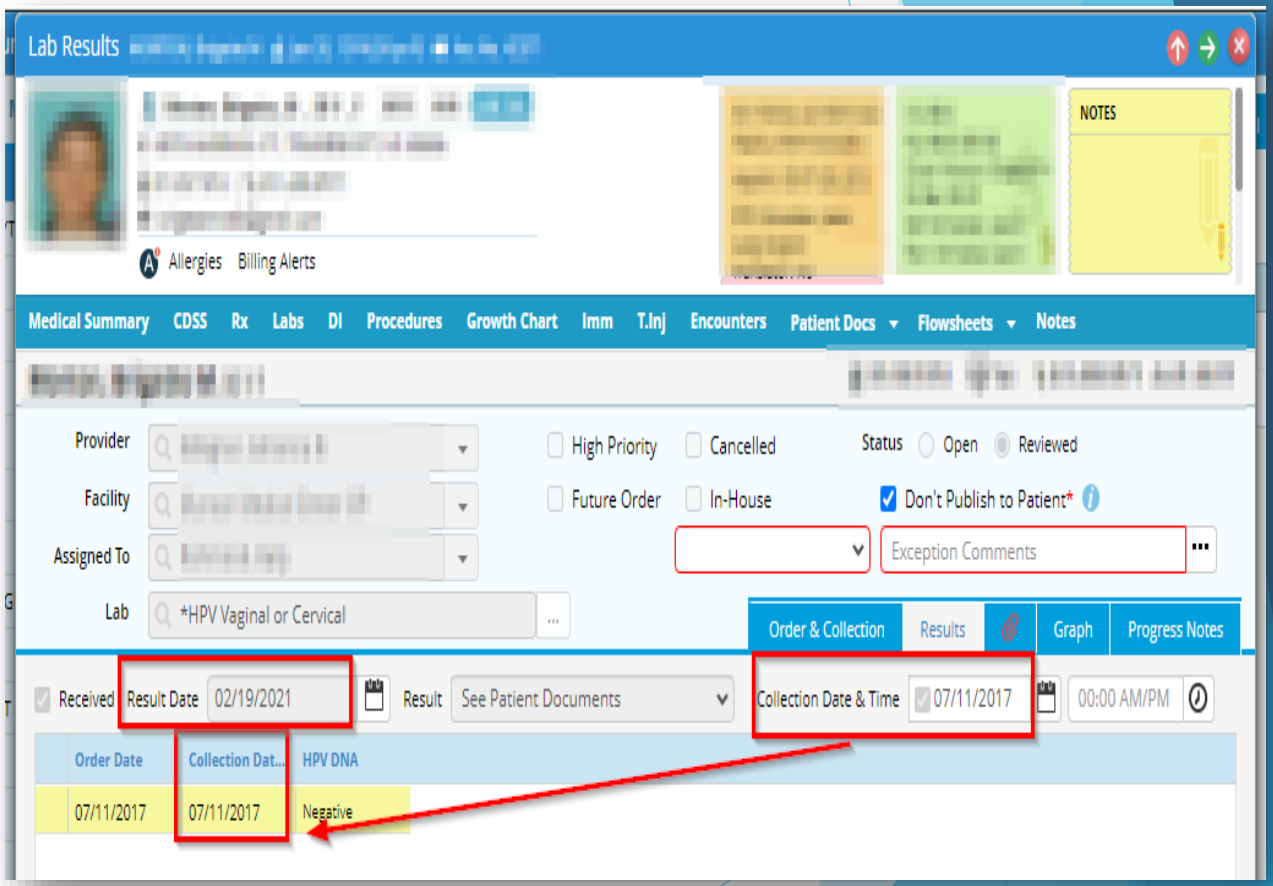
Procedures/Addenda:
HPV RE and SO

Date Ordered:7/11/2017 Status:Signed Out
Date Complete:7/13/2017
Date Reported:7/13/2017 09:06

Addendum Diagnosis
HPV High Risk with Genotyping, PCR, ThinPrep

HPV High Risk type 16, PCR:	Negative
HPV High Risk type 18, PCR:	Negative
HPV Other High Risk types*, PCR:	Negative

Lab Order in EMR



Note collection date and result date entered in EMR versus lab report

Document the Correct **Result**

- **Some quality measures are result-dependent.**
  (e.g., HbA1c lab, retinal eye exam)
  - A result indicates the lab/test was completed
  - The result may determine measure compliance
    (e.g., A1c < 8, A1c ≤ 9)
  - The result may determine test repeat interval
    (e.g., 1 vs. 2 years for DM retinal eye exams)
- **Avoid documenting a result as "unknown", if possible.**
  - If you are unsure of a result, first try to clarify it with the rendering provider.
  - "Unknown" results are non-compliant results for some measures (i.e., HbA1c) or default the lab/test to an annual reporting period (i.e., retinal eye exam).
- **CPT II codes can be added to claims to report results for some Labs/tests (e.g., HbA1c, BMI percentile, Retinal Eye Exam, etc.).**
  - Claims data will trump supplemental data for closing measure care gaps.
  - Make sure the correct CPT II code is submitted for the result documented in the medical record.

*Audit Fail

Example – Incorrect Result (Retinal Eye)

[redacted]	[redacted]	[redacted]	[redacted]	Retinal Exam	2023-07-07	ABNORMAL

← Audit Request

Optical Practice → TraverseVision

336 W. Front St.
Traverse City, MI 49684
Tel: 231-941-5440
Fax: 231-941-0893

Retinal Eye Exam

Pt. DOB

Diabetes & Ocular Pathology Report

Patient Name: [redacted] D.O.B.: [redacted]

Pt. Name

Primary Doctor: [redacted]

Consultant Optometrist: Kowalski OD ← Optical Provider Name & Credentials

Date: 07/07/23 ← DOS

Medication(s) for Diabetes: Trujeo / Insulin

Best Corrected Acuity: Right 20/ 30 Left 20/ 30

Other abnormal result

Slit Lamp Exam: Normal ✓

Other: Mild mixed cataract

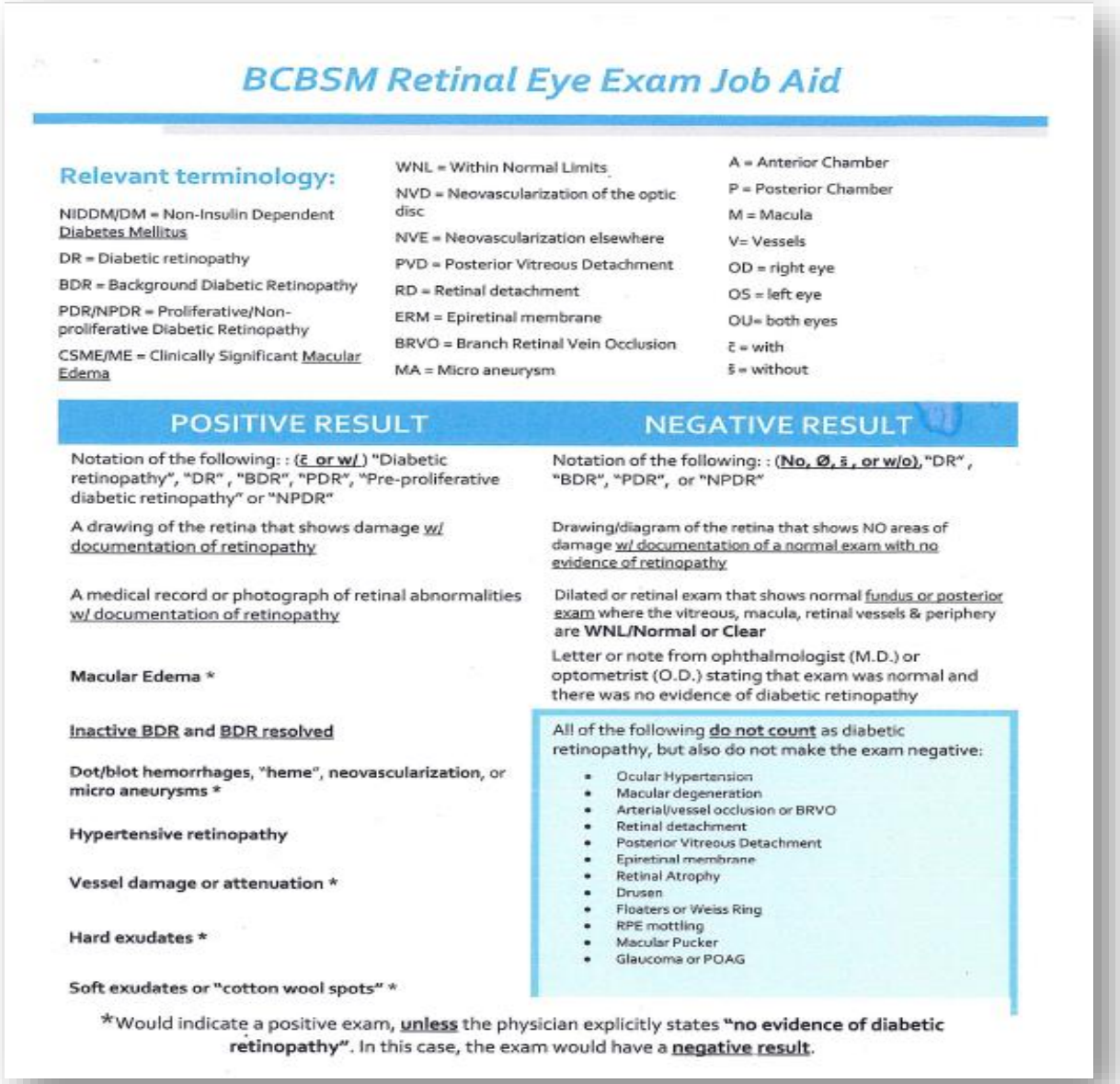
Dilated Fundus Exam: No Diabetic Retinopathy ☑OD ☐OS ← Results

Other

← Retinal Eye Exam Report

*This patient has cataracts but, as far as DM retinopathy goes, the result is normal (No Retinopathy)

Interpreting Eye Exam Reports



BCBSM Retinal Eye Exam Job Aid

Relevant terminology:

NIDDM/DM = Non-Insulin Dependent Diabetes Mellitus

DR = Diabetic retinopathy

BDR = Background Diabetic Retinopathy

PDR/NPDR = Proliferative/Non-proliferative Diabetic Retinopathy

CSME/ME = Clinically Significant Macular Edema

WNL = Within Normal Limits

NVD = Neovascularization of the optic disc

NVE = Neovascularization elsewhere

PVD = Posterior Vitreous Detachment

RD = Retinal detachment

ERM = Epiretinal membrane

BRVO = Branch Retinal Vein Occlusion

MA = Micro aneurysm

A = Anterior Chamber

P = Posterior Chamber

M = Macula

V= Vessels

OD = right eye

OS = left eye

OU= both eyes

c̄ = with

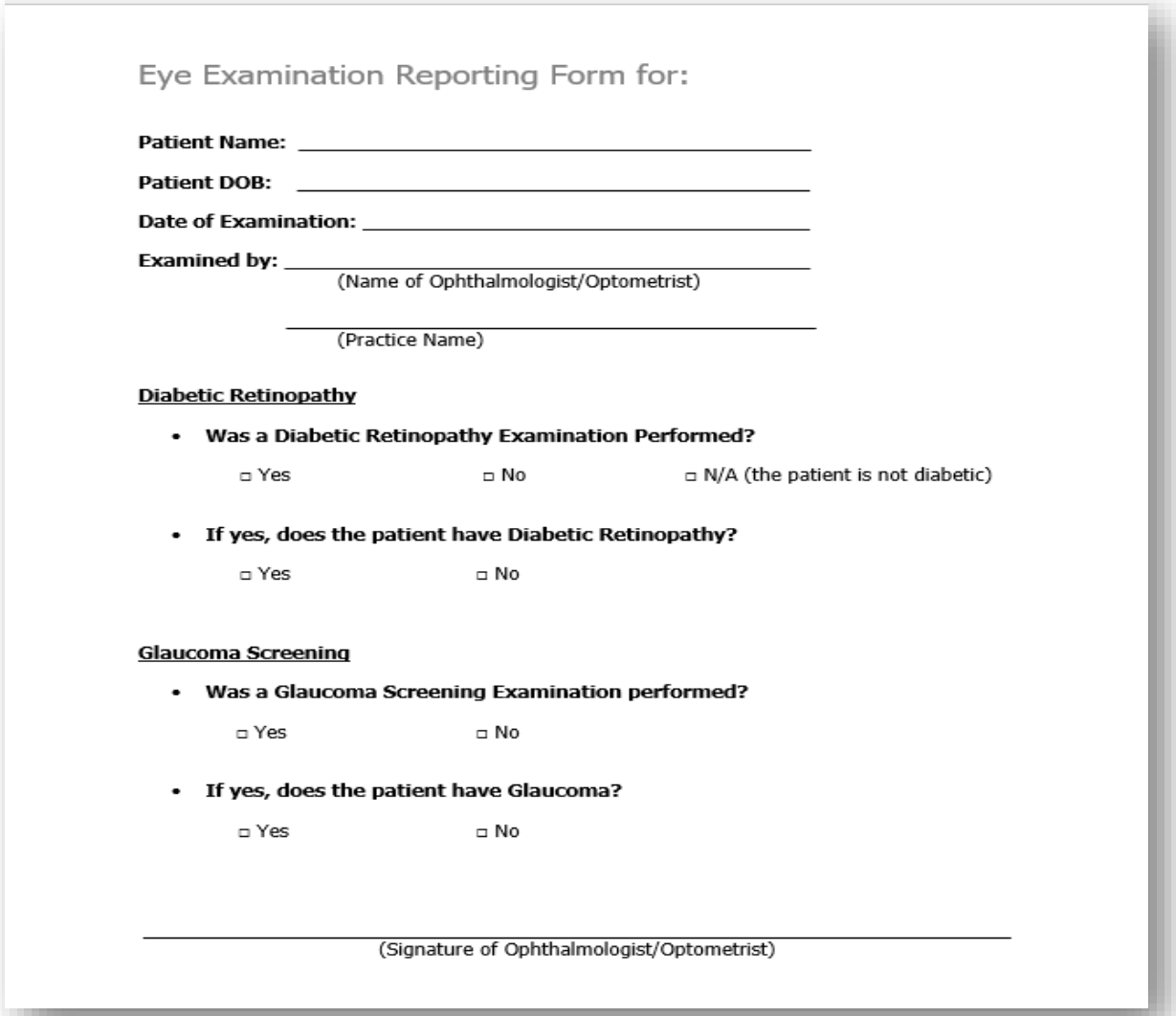
s̄ = without

POSITIVE RESULT	NEGATIVE RESULT
Notation of the following: : (c̄ or w/) "Diabetic retinopathy", "DR" , "BDR", "PDR", "Pre-proliferative diabetic retinopathy" or "NPDR"	Notation of the following: : (No, Ø, s̄ , or w/o), "DR" , "BDR", "PDR", or "NPDR"
A drawing of the retina that shows damage w/ documentation of retinopathy	Drawing/diagram of the retina that shows NO areas of damage w/ documentation of a normal exam with no evidence of retinopathy
A medical record or photograph of retinal abnormalities w/ documentation of retinopathy	Dilated or retinal exam that shows normal fundus or posterior exam where the vitreous, macula, retinal vessels & periphery are **WNL/Normal or Clear**
Macular Edema *	Letter or note from ophthalmologist (M.D.) or optometrist (O.D.) stating that exam was normal and there was no evidence of diabetic retinopathy
Inactive BDR and BDR resolved	All of the following **do not count** as diabetic retinopathy, but also do not make the exam negative:
Dot/blot hemorrhages, "heme", neovascularization, or micro aneurysms *	• Ocular Hypertension • Macular degeneration • Arterial/vessel occlusion or BRVO • Retinal detachment • Posterior Vitreous Detachment • Epiretinal membrane • Retinal Atrophy • Drusen • Floaters or Weiss Ring • RPE mottling • Macular Pucker • Glaucoma or POAG
Hypertensive retinopathy	
Vessel damage or attenuation *	
Hard exudates *	
Soft exudates or "cotton wool spots" *	

*Would indicate a positive exam, **unless** the physician explicitly states **"no evidence of diabetic retinopathy"**. In this case, the exam would have a **negative result**.

***Handout**

Eye Exam Reporting Form



Eye Examination Reporting Form for:

Patient Name: _____

Patient DOB: _____

Date of Examination: _____

Examined by: _____
(Name of Ophthalmologist/Optometrist)

_____
(Practice Name)

Diabetic Retinopathy

- **Was a Diabetic Retinopathy Examination Performed?**

  ▫ Yes ▫ No ▫ N/A (the patient is not diabetic)

- **If yes, does the patient have Diabetic Retinopathy?**

  ▫ Yes ▫ No

Glaucoma Screening

- **Was a Glaucoma Screening Examination performed?**

  ▫ Yes ▫ No

- **If yes, does the patient have Glaucoma?**

  ▫ Yes ▫ No

_____
(Signature of Ophthalmologist/Optometrist)

***Handout**

HEDIS BP Guidelines

- **Compliant BP results must be less than 140/90**
- **Reported BP can be the lowest systolic and diastolic during a single day**

  Example

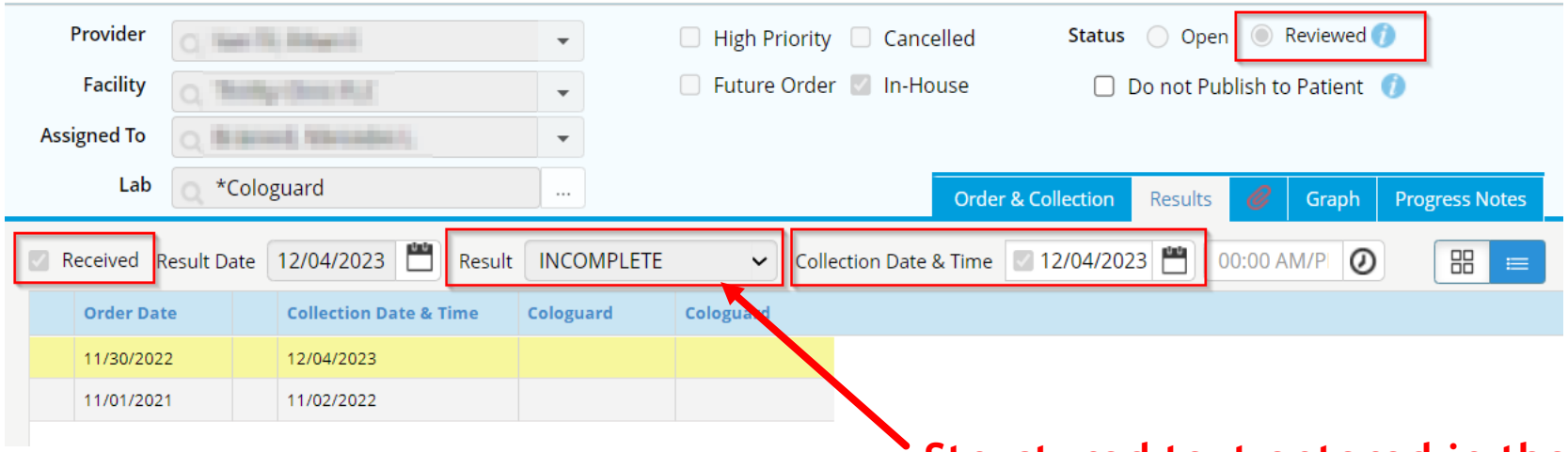
  - BP taken at the beginning of the appointment is 136/92
  - BP taken at the end of the appointment is 140/86
  - BP that would be documented in the structured Vitals field would be 136/86

- **Last reported BP of the measurement year may also be a patient reported BP if documented in the EMR and taken with a digital cuff.**

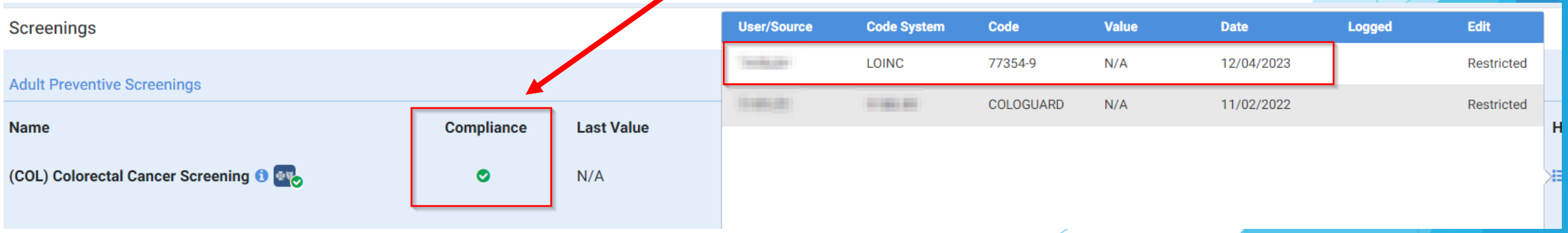
Treat Structured Data Fields with R-E-S-P-E-C-T

- **Non-result-dependent measures (e.g., colonoscopy, mammogram, etc.)**
  - Documentation in the Result Date field of a DI order identifies the test as completed
- **Result-dependent measures (e.g., HbA1c DM retinal eye exam)**
  - Documentation in the **Result** field of a Lab order identifies the test as completed
- **Make sure the structured data fields only contain the information you want reported to Health Focus and the payers**
  - E.g., closing an incomplete DI with a date entered in the Result Date field will trigger the erroneous capture of a completed DI
  - E.g., typing "test not done" in a structured Lab Result field will trigger the erroneous capture of a "completed" lab
  - Use non-structured "Notes" or "Internal Notes" fields to document information such as "test not completed"
  - E.g., If a second BP of the visit is better than the first, put the second BP value in the structured Vitals field. (Don't free-type it elsewhere).

Example - Structured Data Fields

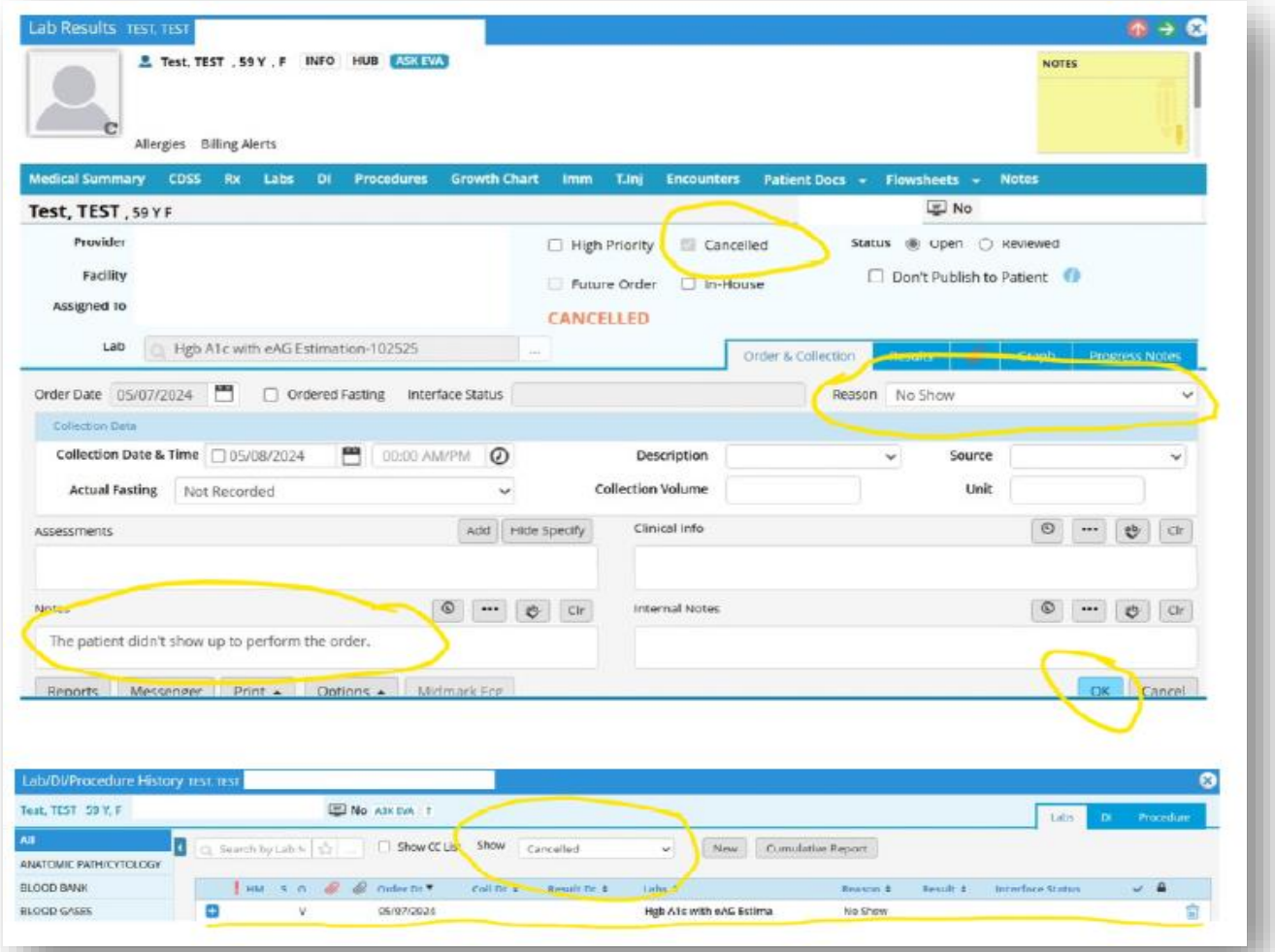


Structured text entered in the result field triggers a completed lab/test in Health Focus



How to Handle Orders for Uncompleted Labs/DIs

- Kona recommends the following: Cancel the Order



>>Patient Hub

>>Labs/DI

>>Open the order

>>Click on the cancelled checkbox

>>Mention the reason in the reason dropdown box

>>Or under the notes “that patient did not complete or do the order.”

>>Ok

-The order will get cancelled and it will show under the cancelled tab

Audit Example - Typos

cervical region. Has MRI today and CT of neck scheduled. No episodes since stopping alfuzosin.

Vital Signs

HT -: 66.75, WT -: 17508, BMI -: 2762.42, FINAL BP -: **126/74**, HR -: 58, Resp: 96% RA.

Examination

General exam:

Health Focus will pull the structured fields exactly how they are entered into the EMR. This data is then sent to the payer on the supplemental file.

User/Source	Code System	Code	Value	Date	Logged	Edit
[redacted]	LOINC	29463-7	174.60 lbs	05/01/2024		Restricted
[redacted]	LOINC	29463-7	17508.00 lbs	01/09/2024		Restricted
[redacted]	LOINC	29463-7	175.00 lbs	12/26/2023		Restricted

Data Entry Process

- Establish a written process that includes proper training of the practice staff with the entry process.
- **Be consistent in that process, especially if multiple people will be entering data.**
- Review entered data prior to locking Lab, DI or Progress Note.

Moving Forward

- Look for The ECDS submission to be accelerated for all measures if the insurance company finds the process to be advantageous.
  - Breast Cancer Screening became an ECDS measure in 2023.
  - Colorectal Cancer Screening is proposed to go ECDS in 2024
- **Work to move more of the process to the front end instead of working from the back by using:**
  - **Exclusion diagnosis codes**
  - **CPT codes**
  - **Structured data fields in the EMR to improve the CCDA data being pulled by Health Focus**
- Most Importantly, be patient
  - Allow time for the submissions of CPT II codes, exclusion codes, and data submitted by Health Focus to reflect in the reports provided by the insurance companies.
  - This change is a process and is going to take time