COSMOS
Navigate the Compliance Universe

Report on Medicare Compliance Volume 31, Number 19. May 23, 2022 In Auditing, Metadata and Shadowing Providers May Help Tell a More Complete Story

By Nina Youngstrom

When a complaint came into the compliance department about employees at a clinic improperly documenting for physicians, the compliance professionals reviewed the documentation for several encounters and walked through the process with physicians and nurses—who documents what and when. Everything checked out. Just to make sure, compliance compared a printout of the medical records from the day of the encounter to the final notes when they were signed by the physician nine or 10 days later. It was a good move: a lot of information had been added to the medical records after the date of the encounter, but not as an addendum or late entry, and there was no way to identify the person who added the information by looking at the face of the record, said Amy Bailey, principal of HBE Advisors LLC.

That's when compliance turned to the metadata, which is information about the information. "It's a fantastic tool," Bailey said at the Health Care Compliance Association's Compliance Institute March 29.[1] Compliance "assumed the physicians just needed education on late entries, except metadata showed it wasn't that at all." Information, including patient history, patient exams, orders for diagnostic tests and patient education, had been added to the medical records after the fact by remote clerical staff, who weren't scribes or transcriptionists, Bailey said. "It was a really big problem. Everything came to a screeching halt."