EMR Documentation
Making it Believable

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Donna McCune is a consultant for Corcoran Consulting Group and acknowledges a financial interest in the subject matter of this presentation.

Tracy Kenniff is a Practice Administrator for the Eye & LASIK Center and has no financial interest in the subject matter of this presentation.

Objectives
• Describe EMR documentation failures that undermine credibility
• Discuss EMR best practices
• Develop a method to avoid criticism of EMR documentation

EHR: The Hope
• Universal access to timely, accurate, detailed patient information
• Point-of-care clinical decision support
• New patient-centric care delivery methods
• Data analysis opportunities
  • Individual patient
  • Population studies

Benefits of EHR
• Data is generally readable
• Data is either present or not present
• Quantity of documentation increases, so too little information is less frequent
  • Good for supporting coding
  • Good for medical-legal reasons
• Altering the medical record is more difficult
• Chart records are easier to find; fewer missing

EHR Survey
• American College of Physicians and American EHR Partners evaluated data from survey of 4,200 clinicians
  • 34% “very dissatisfied” with ability of EHR to decrease workload
  • 32% have not returned to normal productivity
• Surgical specialists were least satisfied group
• 39% would not recommend EHR to a colleague

Source: DecisionHealth Daily 3/7/13
**Medical Record Defined**

- Critical tool for patient care
- Essential to the proper functioning of the practice
- Utilized in planning, evaluating, and coordinating patient care in inpatient and outpatient settings
- Describes the facts applicable to the patient
- Documents the performance of billable services
- Serves as a legal document that describes a course of treatment

Source: AMA – Medical Record Auditor

**Documentation and Correct Coding General Principles**

- The medical record should be complete and legible
- Each patient encounter should include:
  - Reason for encounter and relevant history
  - Physical examination findings
  - Prior diagnostic test results
  - Assessment, clinical impression or diagnosis
  - Date and legible identity of the observer

Source: Evaluation and Management Services Documentation Guidelines – AMA and CMS

**Best Practices Log in / Log out**

- Assign unique log in for each staff member and physician(s)
- Do not permit “sharing” passwords
- Determine what areas of EMR can be accessed by whom
- Develop policies and procedures for opening and closing medical records

**Eye & LASIK Center Policy**

- Every Physician and Staff Member has a personal log-in that is not even shared with Administration
- Each Team member is categorized as to what permissions they will be allowed to access on both the EHR and Practice Management System
- Super Users – have all access and can change parameters of any user (2 Owners, Administrator, Clinic Manager and Assistant Clinic Manager, and Business Services Manager)

**Policy Continued**

- Providers – full access
- Techs (Scribes and Work Up Techs) – access medication refills, charts and message orders
- Front Desk, Medical Records, Optical and ASC Staff – review of medical charts and message orders only
- Password Protection
  - Each Provider and Team member must sign an authorization and promise to not share usernames and passwords

**Policy Continued**

- Opening and Closing of Medical Records
  - Access limitations are set within the EHR and if the permissions are not there for a unique identifier, they will not be able to enter or change information, they can view only.
EHR Documentation Issues
“Garbage in . . . Garbage out”

Problematic Chief Complaints
Examples
- “Decreased vision in both ears”
- “Patient complains, no complaints”
- “Diabetes in both eyes 4 years”
- “Borderline diabetes, it affects vision, not affected”
- “IOL eval in both eyes for one year”

Problematic HPI Issues
- Drop down boxes contain small number of choices
- Inappropriate categories utilized for patient’s HPI
- Free text is not an option
- No attestation for who performs the HPI

Best Practices
Chief Complaint

Complaint
Location
Quality
Severity
Modifying Factor
Timing
Context
Duration
Associated Signs

Complaint
Recheck AMD per Dr. Smith

Location
OU

Quality
Blurry vision at near

Severity
A lot

Modifying Factor
Timing
Context
Duration
Associated Signs
Problematic ROS Issues

- Documenting pertinent positive(s) and "all other systems negative" when other systems were not reviewed
- Amount of ROS documented does not comport with patient chief complaint
- Not all payers accept "all others negative"

Best Practices
Past, Family, Social History

- Avoid default indicating "reviewed PFSH"
- Only indicate reviewed if done and pertinent
- Document each separately

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- Chief Complaint (CC) –
  - Must be a free text dictation of what the patient is presenting with, in the patient's words. There is no access for drop down options.
- History of Present Illness (HPI) –
  - The Work Up Tech will enter the information and the Provider will need to verify and confirm to enter next step in the examination.

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- Past, Family, Social History (PFSH) –
  - A change must be made in order to proceed to the next step
  - At this point to attest for Stage 2 Meaningful Use, all options are now codified values and must be updated.

Problematic Exam Documentation
Examples

- CVF – fixes and followsOU – patient is monocular
- Lens – "clear OD" – patient is scheduled for cataract surgery OD
- External / lids – "WNL OS" – Procedure note for epilation of lashes LLL
- SLE – blank – impression indicates corneal ulcer OD
- VA = 20/20 OS – Patient had enucleation OS 3 mos. prior

Potential Problems
Examination

- Use caution:
  - Defaults (WNL)
  - Copy forward (prior notation)
  - Symmetrical entries (same for both eyes)
  - Universal completion (all elements always noted)
**Best Practices**  
**Examination**  
- Make original entries  
- Use drop downs  
- Note each eye separately  
- Verify entries before closing the record  
- Preserve credibility

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**Best Practices**  
**Assessment**  
- Make primary diagnosis agree with the CC  
- Record relevant systemic illness (e.g., DM)  
- Don’t use diagnoses that no longer apply

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**Eye & LASIK Center Policy**  
**Patient Exam & Assessment** -  
- Drop Downs are used and each eye is done separately; certain areas with duplicate entries (such as same information for manifest refraction) are highlighted to re-check entry.  
- Ensure that the Assessment matches the Chief Complaint

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**Eye & LASIK Center Policy**  
**Plan**  
- The Plan must reflect the Chief Complaint and HPI with coordinating diagnosis, recommendations and treatments if indicated.

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**Potential Problems**  
**Diagnostic Tests**  
- Examination indicates normal exam elements – plan includes an order for fundus photos  
- Order for test documented after test performed based on the time stamp  
- Interpretation templates not utilized

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**Best Practices**  
**Diagnostic Tests**  
- Record an order for the test  
- Chart an “interpretation and report”
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• Diagnostic Testing
  • Before any test is done with the patient, the Tech must confirm the order in the exam. A review is done 48 hours prior to the patients coming in.
  • After the tests are completed, they are sent to the ordering physicians in-bin and they will interpret within 24 hours.
  • Until the provider signs off on the interpretation, it stands in an incomplete status, this will satisfy the original order.

Best Practices

Physician Signature

• Only the physician "signs" the chart

Signature Guidelines

“For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used shall be a hand written or an electronic signature. Stamp signatures are not acceptable.” . . .

“Providers using electronic systems need to recognize that there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and software products which are protected against modification, etc., and should apply administrative procedures which are adequate and correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bears the responsibility for the authenticity of the information being attested to. Physicians are encouraged to check with their attorneys and malpractice insurers in regard to the use of alternative signature methods.”

Source: CMS Transmittal 327, March 16, 2010

Documentation About Scribes

• Several MACs have published specific documentation requirements when using scribes

Example:

“Documentation of scribed services must include the following:

Who performed the service:

Physician co-signs the note indicating the note is an accurate record of both his / her words and actions during that visit

Example: I, Dr. __________, personally performed the services described in this documentation, as scribed by __________ in my presence, and it is both accurate and complete.

Who recorded the service:

Record entry notes the name of the person "acting as a scribe for Dr. X."

Example: I, __________, am scribing for, and in the presence of, Dr. __________.

Qualifications of each person

Signed and dated by both the physician and the scribe”

Best Practices
Coding

• Use both E/M and eye codes
• Do not “add” information to support higher LOS if not medically necessary
• Carefully select encounter pertinent diagnosis codes
• Monitor practice patterns regularly

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• Coding and Compliance –
  • Great efforts are made to train Physicians and Scribes and have certified coders on staff.
  • Preferred Practice Patterns from AAO are reviewed on a quarterly basis and when coding updates happen they are distributed to all staff.

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• The Bottom Line –
  • Every part of the patient visit is a team effort. All members of the physician team are human and we need to support one another to make the best patient experience while adhering to the standards set forth for practicing medicine.

More help...

For additional assistance or confidential consultation, please contact us at:

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