EHR Documentation
Avoiding the Hazards

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Financial Disclosure

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 documentation challenges in EMR
• Develop a method to avoid criticism of EMR documentation

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

Differences between Electronic Medical Records and Electronic Health Records

• EMR contains the standard medical and clinical data gathered in one provider’s office
• EHRs go beyond the data collected in the provider’s office and include a more comprehensive patient history
• EHRs are designed to contain and share information from all providers involved in a patient’s care. EHR data can be created, managed, and consulted by authorized providers and staff from across more than one health care organization.

Source: http://www.healthit.gov/providers-professionals/electronic-medical-records-emr

Benefits of EHR

When fully functional and exchangeable, the benefits of EHRs offer far more than a paper record can. EHRs:
• Improve quality and convenience of patient care
• Increase patient participation in their care
• Improve accuracy of diagnoses and health outcomes
• Improve care coordination
• Increase practice efficiencies and cost savings

Benefits of EHR in Practice

- 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

Benefits of EHR for Eye & LASIK Center

- Allows the exchange of information in a timely (instantaneous manner) between multiple locations
- This has increased efficiencies in all departments from Front Desk to surgical scheduling and the Optical
- Elimination of courier services for the transportation of charts to all locations
- Elimination of Providers harboring paper charts never to be found again!
- Increased security with not transporting live charts
- Communication of Diagnostic Testing to the exam

Medical Economics Survey

- 73% of the largest practices would not purchase their current EHR system. The data show that 66% of internal medicine specialists would not purchase their current system. About 60% of respondents in family medicine would also make another EHR choice.
- 67% of physicians dislike the functionality of their EHR systems.
- Nearly half of physicians believe the cost of these systems is too high.
- 45% of respondents say patient care is worse since implementing an EHR. Nearly 23% of internists say patient care is significantly worse.

Medical Economics Survey

- 65% of respondents say their EHR systems result in financial losses for the practice. About 43% of internists and other specialists/subspecialists outside of primary care characterized the losses as significant.
- About 69% of respondents said that coordination of care with hospitals has not improved.
- Nearly 38% of respondents doubt their system will be viable in five years.
- 74% of respondents believe their vendors will be in business over the next 5 years.

Eye & LASIK Center Survey

- Would you go back to paper? If you ask the owners, they would in a heart beat and figure that we would have made much more money
- Have you considered changing systems? No Way – The mere thought is overwhelming in the time and expenses put into the installation and training.
- How many have changed systems?

Eye & LASIK Center Survey

- Average cost per exam brings yields $187.50
- We had to reduce the providers schedules by an average of 12 patients per day for a loss of $2,250 per day
- There is an average of 20 days per month = $45,000 in lost revenue
- YET we spent more in additional staff by hiring scribes at an average of $43K per year (they have to be certified now!) Plus IT support and equipment maintenance that averages about $27K per year per provider –
- SO, a loss per provider of $115K per provider – did I tell you I have 16 of them!!! That’s close to a loss of $2 million per year X 4 years now – Would we go back???
Target for Scrutiny
E/M: Potentially Inappropriate Payments

“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. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service on the basis of the content of the service and have documentation to support the level of service reported.”

Source: HHS OIG Work Plan

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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

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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
EHR Examples

• "68 yo female presents for evaluation of Complete Exam in the right eye and left eye. The symptom is constant. It occurs all the time. Pt has no complaints."
• "67 year old female complains of left eye in left eye for months."
• "Decreased vision in both ears"
• "Borderline diabetes, it affects vision, not affected"
• "IOL eval in both eyes for one year"

Best Practices
History of Present Illness

• Get into the habit of using at least 4 HPI elements
• For the HPI, the physician must “perform” this part of the history, but the scribe can “document” it
• Use an attestation if the scribe types the information in the record

Complaint
Recheck AMD per Dr. Smith

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<tbody>
<tr>
<td>Quality</td>
<td>Blurry vision at near</td>
</tr>
<tr>
<td>Severity</td>
<td>A lot</td>
</tr>
</tbody>
</table>

Modifying Factor

Timing

Context

Duration

Associated Signs

Best Practices
Past, Family, Social History

• Avoid default indicating “reviewed PFSH”
• Only indicate reviewed if done and pertinent
• Document each separately

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
History of Present Illness

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<thead>
<tr>
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<tr>
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<td>Associated Signs</td>
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</table>
**Eye & LASIK Center Policy**

- **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.

**Problematic Exam Documentation Examples**

- CVF – fixes and follows OU – 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

**Best Practices Examination**

- Make original entries
- Use drop downs
- Note each eye separately
- Verify entries before closing the record
- Preserve credibility

**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

**Eye & LASIK Center Policy**

- **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.
Eye & LASIK Center Policy

• Plan
  • The Plan must reflect the Chief Complaint and HPI with coordinating diagnosis, recommendations and treatments if indicated.

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

Eye & LASIK Center Problems with Diagnostic Tests

• All of the following examples are caught at the time of charge entry:
  • There was no order for a test performed – this occurs when the Provider calls for a test at the time of examination due to a diagnosis found (there is no schedule order entered)
  • The wrong test was performed even though the correct test was ordered (human error)
  • Sometimes the test is actually not medically necessary which is why interpretation is needed prior to billing

Best Practices Diagnostic Tests

• Record an order for the test
• Chart an “interpretation and report”

Eye & LASIK Center Policy

• 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.

EMR, MU2, and Scribes

• Meaningful Use Core Measure 1
  • A licensed healthcare professional enters orders into an electronic medical record for purposes of satisfying CPOE objective in MU2, or…
  • A credentialed medical assistant enters medication (>60%), radiology (>30%), and laboratory (>30%) orders into EHR to satisfy MU2 thresholds
  • COA, COT, COMT, CO, CMA are certified and credentialed medical assistants
  • ACMSS certified scribe (CMSS)
  • AAMA credentialed scribe for assessment-based recognition in order entry

Source: CMS, MU2 Measure 1, October 2012
**Best Practices**  
**Physician Signature**

- Only the physician "signs" the chart  
- Name of scribe is identified in the medical record

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**Eye & LASIK Center Policy**

- This holds true for our policies to the point that if the chart makes it all the way to the charge entry screen and the physician signature is not applied, the chart can not be charged out.  
- A message is then sent to the Provider in question and CC’d to the Business Services Manager.
- Every week a report is run for missing tickets at which point the Providers will be contacted to complete the charts.
- The transmissions are kept as part of our compliance program.

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**Documentation About Scribes**

- Published April 15, 2014
- If ancillary staff is present while the provider is gathering further information related to the patient's visit (e.g., the three key components), he/she may document (scribe) what is dictated and performed by the physician or non-physician practitioner. The provider needs to review the information as it is written, documented, recorded or scribed. The provider also needs to write a notation that they reviewed the documentation for accuracy, add to it if supplemental information is needed and sign his/her name. The name of the scribe must be identified in the medical records. Note that although not required, the date of the signature should be noted.


**Documentation About Scribes (cont.)**

- EMR/Dictated Note:  
- Identification of scribe:  
  - 'Dictated by ____'
- Notation from physician/NPP that he/she reviewed for accuracy:  
  - ‘I agree with the above documentation’ or ‘I agree the documentation is accurate and complete’


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**RAC Audits of E/M Services**

- EHR users increase utilization of 99214, 99215 because physicians are able to document better  
- RAC audits of these codes based on HHS OIG report – Coding Trends of Medicare Evaluation and Management Services, May 2012  
- OIG states: “Although many EHR systems can assist physicians in assigning codes for E/M services, we found that most Medicare physicians manually assigned E/M codes.”

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**Established Patient Office Visits**

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Established Patient Office Visits
2 of 3 Key Components

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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

Eye & LASIK Center Policy
• 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.

Best Practices
Editing / Amending
• Discuss with EHR vendor process of editing and amending
• Develop policies and procedures on how to edit and amend a patient encounter

Eye & LASIK Center Policy
• Editing / Amending –
  • Charts are not to be unsigned and amended after 48 hours
  • Any Amendments after 48 hours are now progress notes in the patients chart
  • To limit editing and amending – the charts are not signed at the completion of the exam and held in the providers bin to finish by the end of the day.

Altering Medical Records
• A world of trouble….
  • Professional liability insurer could cancel coverage
  • Possible criminal charges for fraud or perjury
  • Might lose your medical license.
  • Alteration might be viewed as professional misconduct

Source: Medical Economics, June 6, 2003
Best Practices Correspondence

• Review and edit computer generated “letters”
• Determine what is necessary to send when patient requests records transfer
• Consider security issues if correspondence is sent electronically

Eye & LASIK Center Correspondence Policy

• All Clinically Summaries for the patients exams are sent immediately from the exam to the patients secure portal.
• Any letters to outside physicians are sent after the scribes for the provider have reviewed the chart and sent via a secure fax.
• Direct secure messaging is utilized for other providers that are linked to our system.

Eye & LASIK Center Policy

• 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.

Thank you

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