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Documentation Issues Encountered when Installing a New EMR

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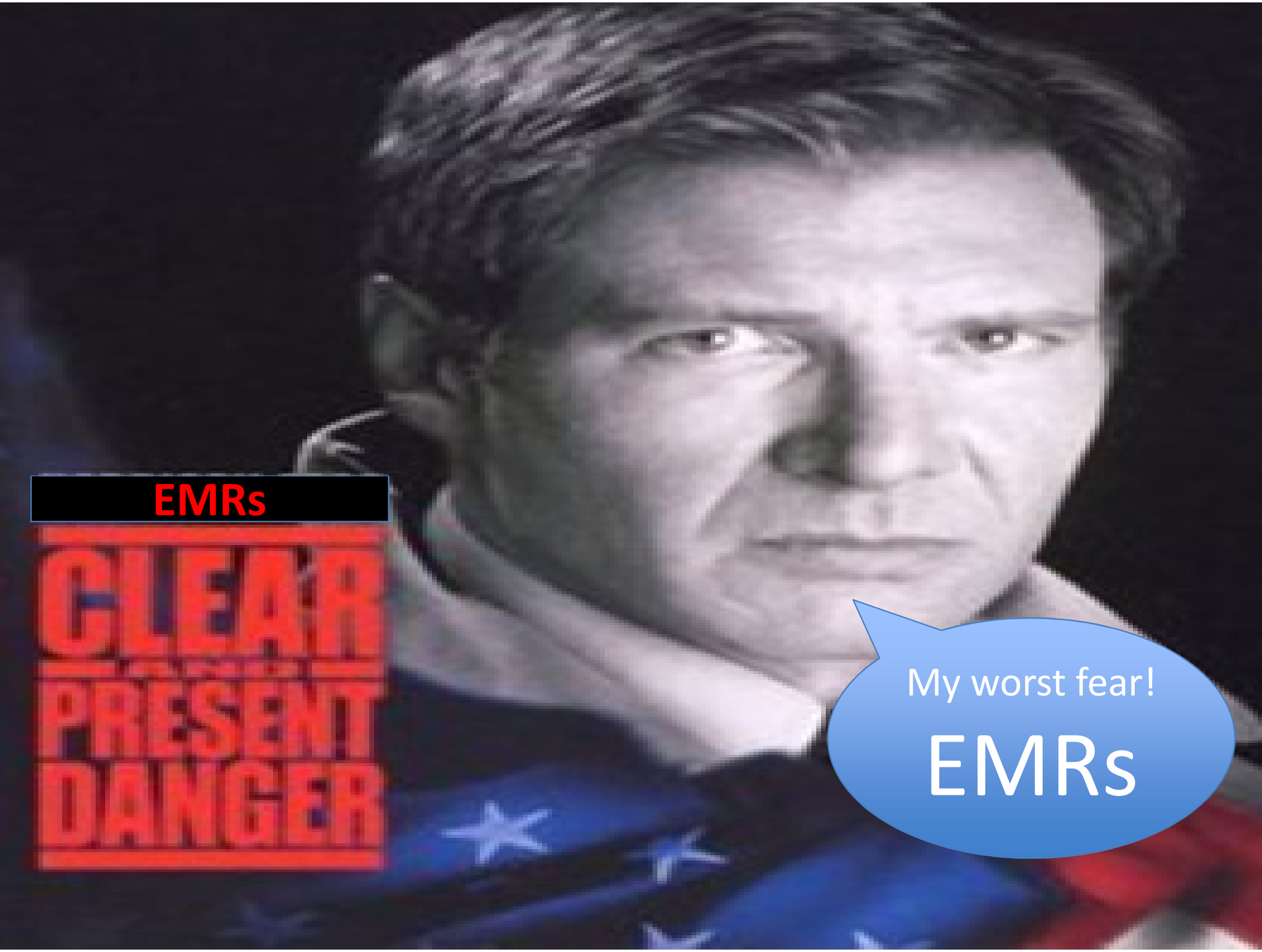
EMRs
CLEAR
PRESENT
DANGER
My worst fear!
EMRs

Massive Amount of Preliminary Work is Required

- Templates
- Smart phrases
- Who has access
- Macros
- TP statements
- Meetings, meetings, and more meetings
- Training
- Rehersal
- “Go Live”

Preliminary Work …

- Typing lessons – 4 words a minute
- Play in the Sandbox
- Secret decoder ring – what do all the terms mean?
- Definitions of copy/paste, cut/paste, make me the author, macro

Tidbit – Hot off the Press

- There was a scribe that was entering data under a physician login. For other reasons, his or her employment was terminated, and the scribe went directly to CMS/CMS contract to report the condition. The provider received a “10 days to rectify” notice, along with required multi-level education. Notice included that if not rectified, they may not be participating in Medicare.

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EMR
Do's and Don'ts
From a Compliance Perspective

Educational Sessions with our Providers

Lessons Learned

EMR…

- **Entries carried forward from a previous visit(s) must be reviewed for accuracy and edited appropriately. Be sure system phrases represent what happened in today's visit and clinical data that was not done in today's visit is clearly indicated.** It is not appropriate to carry forward information if it is not pertinent to the date of service rendered.
- **Be sure the history of present illness and Review of Systems agree** (when using templates/smart phrases and checkboxes to generate review of system documentation.

EMR…

- **Do not use any functionality that presets *all* unanswered items to "no" or "negative" or defaults to "no" or "negative".**

- **Action by provider required in documentation. Do not use templates to pre-populate the entire Review of Systems or Exam sections with "canned" negative findings that do not require positive action.** Positive action can include checking a box, selecting from macros, clicking on a smart set and template documentation, typing free text, or selecting from a drop down menu. Use caution when developing your own macros to ensure the systems reviewed are medically necessary for the patient's complaint.

EMR…

- **Know what this checkbox/statement means!** "Mark as reviewed" are checkboxes that occur through EPIC applications, and "I have updated/confirmed the history" can be found in templates. They mean – **"I have confirmed** this documentation **with the patient/patient's family".** Parts of history may be entered into Epic by any staff, but **MUST** be marked as reviewed by the **physician** to receive credit.
- **Do not copy/use any portion of a Medical Students note other than Review of Systems and Past/Family/Social History.** Federal regulations are clear that the only portions of a note **originally authored** by a medical student that can be used in support of a bill are the ROS and PFSH sections of history. **A resident, CRNP, PA, or attending physician copying the medical student note does not meet re-documentation requirement.**

EMR…

- **Do not copy documentation from another author without proper notation and attribution to the original author.** This includes reference to the date, time and author of the original entry. Failure to properly attribute authorship has the potential risk of becoming a federal or state false claim, including fines and penalties and criminal liability to the individual.
- **Notes must reflect all practitioners' services.** When a combined note is with a CRNP/PA, the medical record must be able to identify that the both saw and evaluated the patient, that the physician reviewed the note, and included patient specific information provided by the MD.
- **Do not over write or delete** any references to the CRNP/PA's participation in the service. It is recommended that the MD, CRNP/PA reference their participation within the body of the note.

EMR…

- **You are responsible for the review/comment on any lab results and other studies imported into your note** and they will not count toward the level of E/M service unless you comment on your review of them.
- Just as is the case with paper records, when billing based on time, **do not combine time with resident or CRNP/PA.** Be sure to include total time, time spent in counseling/coordination of care, and the topics discussed with the patient or patient's family.

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No chart-to-chart copying between patients. Ever!

EMR…

- **Make me the Author (MMTA) –** is a function that changes note authorship to your name so you may electronically sign.
- **NOTE: This function is not approved for FPI use**

EMR…

- **When ordering diagnostic tests**, be sure to link them only to the related diagnoses. **Do not "associate all" diagnoses to each order** unless it is appropriate.
- **Do not leave your note open for someone else to finish it**. You must exit the patient work space after you complete your portion of the note and the next person who is documenting in the note must log in under his/her own login. Nursing notes should not be pended for physicians to edit and complete. Nursing staff must sign and close their own notes, and physicians must create and sign their own note. When a physician adds to a pended nursing note, it appears that the nurse authored the entire note.

Copy/Paste

- When copy/paste functionality is used and an attending edits a resident/fellows note it appears as if the resident/fellow authored the entire note even the TP statement unless the attending creates and signs a separate entry.

Logins

- **Do not share Logins**
- **Always secure or log out** when leaving a work station
- **When logging in to a work station** check to ensure you have opened the correct patient record. Confirm patient name and date of birth.

TP Statements

- Do not type, dictate, or in any way apply a teaching physician (TP) statement to a note if you are not the TP even if you are doing it for the TP to sign it.

Staff and Regulated Space

- Physicians **cannot use** the documentation of hospital staff in regulated space to count toward his/her LOC **unless** the PA has a contract with the hospital to reimburse them for the staff member

Know what is in the Printed Document

- Viewing the information while on line in the EMR environment may look different than the printed record. It is this printed note that will be provided to outside users such as payers, federal and state agencies to support billing for your service.
- Only notes printed using ROI (release of information) should be sent to requestors. Part of your protocol should be to have staff periodically check the printed notes against all billed services to ensure billed services are supported in the document(s).

2012 OIG Work Plan

- We will assess the extent to which CMS made potentially inappropriate payments for E/M services 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 based upon the content of the service and have documentation to support the level of service reported.

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Examples from the Trenches

Medical Record Notes not in Handout