EMR Documentation

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Introduction

- Benefits
- Risks
- Preparation
- Implementation
- Post-implementation

Benefits

- Documentation
  - Legibility
  - Reduced transcription costs
  - Voice recognition
  - Storage
  - Immediate access to patient notes/test results
- Physician Quality Reporting System (PQRS)
- E-Prescribing
- Stimulus rewards for implementation

Risk

- Higher levels of service documented
- Templates that are not customized
- Lack of medical necessity documented
- Fragmented notes
- Automatically populated fields
- Cloned documentation

Preparation

- The best way to ensure successful EHR implementation is to ensure that every area of the practice is represented when choosing your EHR.
  - Physician
  - Management
  - Front Desk staff
  - Nurse
  - Coder/Biller
- On the front side of implementation it will be a challenge to have all of these people involved because they will be each will be focused on what will work best for them, but the end result will provide:
  - Buy in from all areas
  - A sense of ownership
  - Determination to make the transition successful and seamless

Preparation

- Important steps for preparing for implementation
  - Build templates – CUSTOMIZE
  - Attend training sessions – A LOT
  - Do not rush!
- Don’t allow the EMR to run your practice
  - The EMR will only be as good as the people using it
  - Be sure adequate training has been provided to all staff members
  - Be sure providers have basic understanding of coding guidelines
    - The EMR should NOT be the official coding source
- Think about future needs of your practice as well
  - ICD-10-CM

Implementation

- This will be a very stressful time for the entire practice
  - Lighten the patient load for the first week
  - Allow time for everyone to become familiar with the new processes- Productivity will decrease for a short period of time
  - Be sure the vendor is on sight initially to overcome problems
  - Don’t expect things to be perfect for the first week, this is a huge transition and will take some time to perfect
  - Provide lunch for the office
  - LAUGH A LOT!!!!
    - Most important step in the process

Post-Implementation

- The implementation process is not over when everyone is using the electronic record without major breakdowns
- Once everyone is familiar with the process and things start getting into a “normal” flow, it is time to reassess the EHR
- The next step is to ensure that the process is working how it was intended to work
  - Review processes to make sure work flow is efficient
  - Have a “super user” shadow other users to ensure everyone is aware of the amazing capabilities of the system
  - Review documentation to make sure the story makes sense
  - Audit documentation to ensure compliance – this should be an ongoing process!

Documentation awareness

- It is very important to consistently assess the quality of the data that is being generated from an EMR as documentation provides the best defense against audits
- Copy and paste or bringing information forward from a previous visit
  - May be necessary to bring information forward from a previous visit- use this option wisely
  - All notes cannot look exactly the same because not all patient's are treated the same way
  - May result in cloned documentation

Office of Inspector General 2011 Work plan

Payments for Evaluation and Management Services

We will review the extent of potentially inappropriate payments for E&M services and the consistency of E&M medical review determinations. CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 12, § 30.6.1 instructs providers to "select the code for the service based upon the content of the service" and says that "documentation should support the level of service reported." Medicare contractors have noted an increased frequency of medical records with identical documentation across services. 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. *(OEI; 04-10-00181; 04-10-00182; expected issue date: FY 2012; work in progress)*

Medical Necessity

The Center for Medicare and Medicaid Services define Medical Necessity in their Evaluation and Management Billing Guide as follows:

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

Medical necessity

- The amount of work that was NECESSARY to treat the patient for the illness that brought them to the provider that day is what should be documented
  - Document all conditions the patient reports
  - Be sure to provide an assessment for each condition assessed
  - The chief complaint or history of present illness, and the assessment and plan should match to show the complete process of the treatment plan

Supporting medical necessity

- The complexity of MDM should be documented accordingly and not inferred or implied.
- For each encounter, an assessment, clinical impression, or diagnosis should be documented.
  - Physician MDM is critical to determine the overall level of care provided during a patient encounter. MDM may vary on a visit-to-visit basis depending on the patient's condition and what the physician performed that day.

Supporting medical necessity

- The fact that the patient has an underlying disease or co- morbidity is significant only if their presence significantly increases the complexity of the MDM.
  - Only conditions that impact the encounter are determining factors that affect the level of E/M service.
  - Example: Diabetic patient

Supporting medical necessity

- The current status of the patient’s diagnosis is also a determining factor i.e. stable, improved, worsening etc.
- Diagnoses count in the MDM leveling only if they impact the presenting problem.
- Generally, decision making with respect to a diagnosed problem is less complex than an identified but undiagnosed problem.

EMR Systems

- A good EMR will have the capability to allow the user to document in various ways
  - Templates
  - Voice recognition
  - Free text

- This provides an open avenue for physicians and providers to customize each note to each individual patient
- Conveys a story as opposed to a checklist

Notes

- Problems arise when information in the note is conflicting
  - Patient complaining of skin rash
    - Detailed HPI
    - ROS states negative for skin abnormalities
    - Assessment and plan indicates patient is most likely developing URI, however the exam stated “breath sounds normal, no nasal flaring, no respiratory distress”

Notes

- Patient suffers fall, injures nose and knees, also notes whitish drainage from eyes for past several days
  - ROS states eyes: negative for visual disturbance (no mention of drainage), MS positive for gait problem (patient reports chronic balance difficulties)
  - Exam states MS: normal ROM, skin: no rash noted
  - Assessment and plan: Mild bruising of bilateral knees and nose, nothing about eyes, but conjunctivitis is added to the number of diagnoses managed

Summary

- EMR’s can be a very effective tool for helping a practice to become more efficient, provide better quality care to patient’s, and assist in improved documentation
- Each practice must customize the EMR to their needs
- Use of coding tools

Questions?

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THANK YOU!!