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Documentation compliance through knowledgeable staff and policy

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Have you read the news about the $1 billion lawsuit against eClinicalWorks? The lawsuit stemmed from the patient not being able to determine within his medical records when his cancer first appeared. The plaintiff stated that eClinicalWorks is at fault, because their electronic medical record (EMR) had not saved the updated data entered.[1] Although this case was terminated February 13, 2018,[2] what alarmed me was that I have seen charts very similar to this patient's in EMR systems that are working correctly.

The fault in the defective documentation cannot be placed on the EMR system, but on that of the documenter. For example, I was talking with a friend a while back who was telling me about a state audit that she was overseeing as a liaison for the company she works for. The state auditor had printed out a provider's patient encounters. The encounters all read the same — word for word for every visit. The auditor asked my friend if what she was seeing with the notes was a systems error or a provider error. My friend replied, "Per the metadata, it is not a systems error." My friend could not tell me the result of that audit, but we both agreed that a lawsuit against a health system and a specific provider can easily happen because of current documentation trends. Honestly, if a lawsuit like this isn't in the works, it will be in the future. Health systems can make a few very easy changes to help minimize their risks.

Provider EMR training

Many health systems have teams of people who are experts in their EMRs. Trainers and super-users exist to help guide the providers and ancillary staff in their documentation. These individuals often are professionally trained by the EHR company and hold a certification. They know the tricks of the system and are happy to share the shortcuts to help minimize the time spent charting.

Although highly educated on the system, the trainers and super-users often lack education in medical coding and documentation requirements. "I was trained to document this way," "This is how I was trained," and "I was told it was okay to document this way" are all comments heard by coders or auditors when querying providers about their documentation. Excessive cloning, cut-and-paste, copy-and-paste, carried forward, and overusing templates can be the result of trainers who educate the providers on handy shortcuts.

A couple of solutions exist that can easily be implemented to help minimize the documentation risks. The first solution is to have an EMR trainer and a coder or clinical documentation integrity (CDI) person work in tandem with the provider and ancillary staff. As the EMR trainer goes through the documentation components within the EMR, the coder/CDI individual can provide the education on the documentation guidelines. For example, instead of the Review of Systems (ROS) and the Past Family Social History (PFSH) being pulled forward from another encounter note, the coder/CDI staff can provide the option of "noting the date and location of the earlier ROS

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and/or PFSH."[3] ,[4] The coder/CDI person can follow up this guidance with a helpful reminder that the information from previous encounters must pertain to the current chief complaint to be useful when assigning a level of service for billing purposes.

Another solution is to have all the EMR trainers and super-users go through training to understand the 1995 and 1997 Evaluation and Management Documentation Guidelines.Knowing what's in the guidelines and understanding that the information must be relative to the current encounter visit may help to decrease reliance on easy-to-use options and templates. Instead, the education would be focused on when using those options would be realistic.

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