Health Information Compliance Alert

EMR Implementation: The Good, the Bad, and the Ugly of EMRs: Keep This Advice Handy And Make A Potentially Bad Situation Better

Watch out for cloned documentation, appropriate scribe attestation to be sure you are in compliance.

Background: The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on Feb. 17, 2009 to promote the adoption and meaningful use of health information technology. HITECH outlined the government's idea to improve medical care while reducing cost using technology such as Electronic Medical Records (EMRs), says **Michael A. Granovsky, MD, FACEP, CPC**, President of LogixHealth, a medical coding and billing company in Bedford, MA. Among the expected benefits from this plan where:

- Improved documentation and legibility of medical records
- Improved clinical practice and reduce medication errors
- Improved focus on key risk, safety and quality parameters
- Application of clinical rules in real time
- Improved implementation of best practices
- Immediate access to past medical history, labs and other critical data
- Streamlined order entry
- Enhanced workflow.

As a provider, you can appreciate the concept of an electronic medical record (EMR) as it provides a robust account of everything that transpired during the encounter in a nice typed format that is easy to read.

Drawback: However, not every EMR delivers on that concept, at least not right away. Common complaints about EMRs are that they cause more documentation problems than they fix, they are long and cumbersome (making it hard to locate the information needed for coding the chart), and they create a significant loss of physician productivity, says Granovsky.

Advice Helps You Transition from Templates

For those coders used to a templated charting system, with all the elements of history, physical exam and medical decision-making laid out in a standard easy to find format, being faced with an EMR that may run well over 10 pages can be very daunting. If you are held to a production schedule of a certain number of charts per hour, having to hunt through multiple pages to find the needed documentation can be a problem, he warns.

On the plus side, Granovsky adds, there is a lot of content for the encounter that might not have been captured under the previous system and legibility should not be a problem. Since every test and order must be authenticated, they will not be left out of the documentation record.

Scribes: Help or Hindrance?

Most facilities experience a significant decrease in productivity when they introduce a new EMR. A study in the Journal of the American Informatics Association found the time spent in computerized physician order entry more than doubled. This is mostly due to the ramp up time to learn the system and the need to be at the relevant workstation to enter information. For this reason the use of scribes has become more prevalent. Although relying on scribes brings its own set of compliance issues, in general scribes help create a more detailed and accurate account of what actually transpired during the patient encounter (see the April 2012 issue of Health Information Compliance Alert for the article "Using Scribes in the ED: What Documentation Can Be Counted by the Attending Doctor?"). Most facilities see a return to typical

levels of productivity after six months of using the EMR system, notes Granovsky.

Beware Clones and Macros

One of the hottest areas for payer audits is looking for cloned documentation, meaning the EMR allows the attending physician to cut and paste documentation from a non-physician practitioner, medical student, or PA into their own chart note. Although it is reasonable to expect the chart notes of various providers examining the same patient to be similar, if they are word for word identical due to cloned documentation, the credibility of the attending doctor's documentation becomes suspect, Granovsky adds.

EMRs can facilitate using macros, and this is one of the advantages to documentation when using these systems. However, in the OIG Work Plan for 2011, the agency noted that Medicare contractors have seen an increased frequency of medical records with identical documentation across services. The OIG will review multiple E/M services for the same providers to identify electronic health records (EHR) documentation practices associated with potentially improper payments, Granovsky warns.

This should not be interpreted that you can't use macros at all. In Transmittal 811, Granovsky advises, CMS is on record as saying that it is acceptable to use a macro; however, the physician must provide customized information that is sufficient to support a medical necessity determination. The note in the electronic medical record must sufficiently describe the specific services furnished to the specific patient on the specific date and should contain case specific information about the HPI, differential diagnoses, patient reassessments, responses to treatment and disposition. If every chart looks similar, you can have a problem, he adds.

Bridge the HPI to HIPAA Gap

Because the medical record is electronic and can be readily accessed from any authorized location, an EHR can expedite access to the medical chart for coding and billing purposes, says Granovsky.

Similarly, it can be much easier to access old records for review to get those MDM points under amount and complexity of data reviewed. Calling up prior EKG tracings or x-rays can also help in diagnosing the current presenting problem. Keep the HIPAA requirement in mind when dealing with EMRs. You may want to review your relevant business associate agreements (BAA) to make sure they are up to date and cover all data formats you and any other entities in your coding and billing process may encounter, advises Granovsky.

Watch Regulatory Rules for Your Future

Medicare has created significant incentives for hospitals to adopt EMRs. The hospital can earn a significant bonus, often several million dollars, for meeting "meaningful use" standards. In the initial years, a full bonus can be earned, but that percentage drops to 75 percent in 2014, 5 percent in 2015 and 25 percent in 2016. Penalties begin for not implementing your EMR in 2015, so if you don't code from an EMR now, you probably will soon, says Granovsky.