Health Information Compliance Alert

EMR Strategies: Watch Out: Attestations Can Help, But They Can Also Hurt

Avoid generic attestations or expect audits in the emergency department.

While the use of attestations in the emergency chart may have helped physicians decrease their time in front of the computer screen, attestations have also added some real compliance issues that have been problematic in payer audits, particularly where electronic medical records are concerned. Be mindful of these caveats, warns **Todd Thomas, CPC, CCS-P,** of **ERcoder, Inc** in Edmond, OK. (For a previous article on attestations, see Health Information Compliance Alert, Vol. 13, No. 2.)

A big ticket item in recent payer audits has been the use of generic attestations to support billing the services of Physician Assistants and Nurse Practitioners as shared services in the name of the physician, Thomas advises. CMS payers have been clear that a generic attestation will not suffice as documentation to support a shared service.

Required: To qualify as a shared visit, the physician must have a face to face encounter with the patient, and they have to document some portion of the history, exam or medical decision components to be considered a shared service. One CMS carrier gives the following as an unacceptable shared service attestation.

"I have personally seen and examined the patient independently, reviewed the PA's Hx, exam and MDM and agree with the assessment and plan as written."

Also: A physician attestation to support a shared service must include patient specific information from the physician encounter, says Thomas.

As with any medical record documentation, accuracy is paramount. Any documentation in the ED chart that will cause an auditor to doubt the truthfulness of the physician's notes will make it difficult for them to support the physician, says Thomas. Physicians can get accustomed to "clicking the box" for the attestations and end up with an chart that includes incorrect or confusing information, he adds.

Thomas warns that inappropriate use of attestations can lead to trouble. He offers the following examples of audit situations where they have been a curse:

Unable to obtain a history due to patient's chronic dementia.
- Documented in conjunction with the statement "a complete ROS is negative except as documented".

ROS is unchanged from the 12/16/12 ED visit.
- Chart for 12/16 visit not sent to payer, chart downcoded due to insufficient ROS.

I have reviewed and agree with the ROS as documented on the health history form.
- Health history form was blank.

Except as documented, all other systems reviewed and negative.
- Documented on a chart for a patient that presented for a suture removal.

I have reviewed and agree with the Past, Family and Social documented in the nursing notes.
- Nurses notes did not include family or social history. Chart downcoded from 99285 to 99284.

I was present with the resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note.

- No resident involved in case.

I was at bedside while the resident performed the procedure.

- No procedure during encounter.

I have reviewed the EKG tracing and agree with the resident's interpretation.

- Patient presented with corneal abrasion. No EKG performed.

I have reviewed the documentation recorded by the scribe and it accurately reflects the service I personally performed and the decisions I have made.

- Scribe entered visit on wrong patient. This chart contained only nurse's notes and physician attestation.

Bottom line: Attestations can help ease the burden for physicians that are trying to get away from the computer and back to their patients, but care should be taken to ensure that the attestation accurately reflects the patient encounter. Coders can become accustomed to using the attestations to support their code choices, but if the attestation isn't accurate their code may not be either, says Thomas.