

# Physician

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Historically, medical records have been in a paper format, but recent years have seen more and more clinicians moving to an electronic health record (EHR; sometimes referred to as electronic medical record, or EMR). Since there is no doubt that the EHR will be the standard going forward, it is crucial that physician practices use these great tools to their best advantage.

An EHR can often solve many problems for a practice, but it can also bring with it a new set of problems. High on the list are unfortunate entries in the medical record, including this memorable one: "Patient is a 46-year-old woman with a soft and supple prostate." Funny to read, maybe, but not so funny when one considers the importance of the medical record as part of quality health care. Attention to detail from the beginning stages of EHR implementation, as well as ongoing monitoring as physicians "go live" on the system, will go a long way toward alleviating some of the potential problems.

## First steps

Many physicians view the EHR as the proverbial

## Genie in a bottle, or Pandora's box?

### *EHR lessons learned*

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"genie in the bottle" and think that all their coding and documentation problems will be solved once they have the new system in place. In fact, the EHR does not eliminate the need for good documentation. On the other hand, it can be very beneficial if used wisely.

Involving the right staff from day one will help ensure that templates are built properly and formatting issues are dealt with before they become a bigger issue. Having a coder involved in the development of history templates might enable them to catch, for example, that no field for family history was included—before hundreds of claims are sent in with missing information that might be needed to support the code(s) billed.

An initial decrease in the level of physician productivity is to be expected when implementing an EHR. This is often due in

part to physicians having limited computer (or typing!) experience. The basics of using current technology can be a hurdle. Training—early and often—is the answer, along with available support when needed.

## Potential trouble spots

Not all EHRs are created equal, and ease of use varies—sometimes resulting in frustration for physicians. Here are a few common trouble spots.

**Data entry and screen views.** Data entered may not always appear where the user thinks it will. We have seen notes where new data (e.g., a medication dosage adjustment made that day) is printed at the beginning of the note, but as part of the patient's medication history—leaving the reviewer to wonder when the dosage adjustment was actually made. Other systems include a variety of different screen views, some

of which may not include all of the documentation for the encounter. If a third-party payer is auditing and wants to check for adequate documentation for the billed services but does not select (or is not provided) the correct screen view, the results could be problematic. Having the right people involved during the design and implementation phase may help avoid these problems. Spot-checking to ensure EHR formats are appropriate is also recommended.

**Automatic populating of data fields.** A potential issue with some EHRs is the automatic populating of various fields. While this feature can be a definite time-saver, it needs to be used wisely. For example, a common entry in the medical record is for the Review of Systems (ROS) portion of obtaining the patient's history. If the physician has performed a complete ROS, it is acceptable for coding and billing purposes for the physician to specifically document pertinent positives and negatives along with a statement that the remainder of the complete ROS is negative. With the EHR, however, it is easy for the physician to click on "WNL" (within normal limits), resulting in the system

automatically populating the ROS—even though a complete ROS may not have been done or may not have been appropriate based on the patient's chief complaint.

Another area of patient history where the EHR can streamline the process for the physician is Past, Family, and Social History (PFSH); but, again, users should exercise caution. Recently our firm conducted a review where several hospital admission notes included an entry that said, "Social history not on file." That was likely a "default" field in the EHR. Since the admissions had been coded at higher levels, where social history is a required component, the services had to be down-coded.

Sometimes the automatic populating of various fields results in "canned" statements that are not applicable to the patient's age or gender—for example, "Patient does not smoke" (in the EHR for a 5-year-old) or "Psychiatric exam: patient shows good insight" (in the EHR for an infant). That type of documentation could result in an auditor questioning the integrity of the entire record. Focused training is necessary so that physicians understand how easily these types of issues can occur. It may not hurt to remind physicians that they "own" entries such as these, and it is in their best interest to be accurate.

**Contradictory, duplicative, or erroneous information.** Contradictory information in the EHR is a common concern, often resulting from the physician not understanding how to use the system correctly and allowing old information to be pulled forward that is no longer correct. For example: A patient presents with a chief complaint of shortness

of breath, but the ROS documentation states, "Respiratory: negative"; or a patient presents for follow-up after having a head laceration sutured in the emergency room, but the exam documentation states, "Head normocephalic with no signs of trauma." In both cases, the physician unintentionally "picked up" old information that appeared in the new entry.

In addition to contradictory information, it is also common to find duplicative, erroneous, or just plain nonsensical entries in the EHR, often due to the physician not reviewing the note prior to signing.

**Excessive documentation.** When reviewing EHR documentation, it is obvious that many notes are much more voluminous than was typically seen in paper records. This often occurs when a "carry forward" function is utilized, causing the patient's entire history, or perhaps even a previous encounter's documentation, to appear in a note. In such cases, it may be unclear what services were provided on which date. This also could be a potentially dangerous practice if the extensive documentation causes the visit to be coded at a higher level than is supported by medical necessity. In addition, physicians themselves often comment that they dislike having to weed through their colleagues' excessive documentation to determine what is currently going on with the patient.

This is often a training issue. Physicians should be alert to carrying forward only information that is "in sync" with the reason for the patient's visit. If it is a common practice to carry information forward, vendors may be able to assist with tying correct

dates to that information.

More is not always better; sometimes it is just more.

**Legal issues.** The law has not really adapted to the changes in medical record-keeping that have emerged from EHR technology over the last few years. Requirements for retention of records, provision of records to patients and payers, and the legal practices that have grown up around record-keeping—physician signatures, how to make changes and modifications, and, more broadly, what the medical record means—all these are simply derived from the private law governing paper records. Many states have laws that restrict when a paper record may be stored electronically or on microfilm or fiche. These laws and rules are out of date, and it will be some time before the law adequately catches up. At the same time, HIPAA and related privacy and security laws have added another layer of legal complication to EHR management.

In dealing with these rules in flux, practices should adopt some bedrock principles regarding their electronic health records systems:

- The physician should think of medical documentation as being read by a number of different readers. Documentation should be done not just with a view to what other physicians or third-party payers will read, but what an outside regulator or jury might see in a note.
- Medical record documentation should be as contemporaneous as possible with the actual work. Notes that are out of date, either preceding or succeeding the actual event, are less valuable.

- In general, substantive changes in documentation should be done in a transparent manner, so that one can tell the time and date of the change, and find earlier documentation.
- Security rules should be analogous to the rules for paper records.
- Most importantly, the record needs to be functional. The worst legal risk is a record that confuses or misleads other physicians, potentially compromising the care rendered by subsequent caregivers.

### Key strategies

Electronic health records are here to stay and have the potential to offer numerous benefits to physicians and patients alike. As with any new technology, however, there are lessons to be learned. In the case of EHRs, there are several fundamental rules that apply to the system implementation experience:

- Ensure that every effort is made to set up the system properly.
- Provide extensive training for all users.
- Implement ongoing monitoring to ensure the EHR documentation is complete, accurate, and compliant.

Starting with those key strategies can help medical practices have a "benevolent genie in a bottle" experience—rather than opening a Pandora's box of computer woes. ☐

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