Health Information Compliance Alert

EMR Strategies: Advice Helps You Steer Clear of Audit Pitfalls In Your ED Charts

Save time and major EHR headaches by using attestations correctly.

Since electronic medical records (EMRs) are here to stay, use them to make your job easier, rather than more complicated. Beware that shortcuts can be dangerous instead of helpful if used uncritically.

Case in point: For the ED physician, an EMR means more time in front of a computer screen. **Todd Thomas, CPC, CCS-P** of **ERcoder, Inc** in Edmond, OK, relates a recent encounter with a group of ED physicians.

While doing some documentation education with a group of 12 ED physicians, the conversation turned to their frustrations with their facilities' EMR. The consensus in the room was that they spend at least fifty percent of their shift entering information into the EMR. With these kinds of demands placed on their time, many physicians are looking for ways to streamline the process of documenting their patient encounters, says Thomas.

Solution: One common streamlining method is the use of attestations. Attestations can be used to appropriately document elements of a patient encounter, provided they are used in suitable situations and worded correctly.

Follow This E/M Attestation Model

Thomas offers the following breakdown of an E/M service and when an attestation can help fill in the blanks:

History If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition/circumstance, which precludes obtaining a history.

Unable to obtain a history due to patient's chronic dementia.

History of Present Illness E/M rules, the 95 Documentation Guidelines, require the EDMD to perform and document the HPI. An attestation, reviewing for instance the nurse's notes, cannot be used in the place of the physician documentation of the HPI. There are exceptions when the HPI is documented by a resident or a scribe (see below).

Review of Systems There are several ROS scenarios that would lend themselves to using an attestation.

A ROS from an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and/or updated the previous information. The attestation must include the date and location of reviewed ROS.

ROS is unchanged from the 12/16/12 ED visit.

The ROS can be recorded by ancillary staff. There must be a notation supplementing and/or confirming the ROS recorded by others.

I have reviewed and confirmed the ROS documented by the triage nurse.

The ROS can be recorded on a form completed by the patient. There must be a notation supplementing and/or confirming that the EDMD has reviewed this information.

I have reviewed and agree with the ROS as documented on the health history form.

Systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible.

Except as documented, all other systems reviewed and negative.

Past, Family & Social History □ There are also multiple PFSH scenarios that would support using an attestation.

The PFSH can be recorded by ancillary staff. There must be a notation supplementing and/or confirming the PFSH recorded by others.

I have reviewed and confirmed the Past, Family and Social documented in the nursing notes.

The PFSH can be recorded on a form completed by the patient. There must be a notation supplementing and/or confirming that the EDMD has reviewed this information.

I have reviewed and agree with the PFSH as documented in the patients intake form.

Examination □ The physical exam must be performed and documented by the EDMD. The only element of the exam that would lend itself to an attestation is the patient's vital signs, which may be measured and recorded by ancillary staff.

Vital signs reviewed, see nurse's flow sheet.

Medical Decision Making □ The MDM refers to the complexity of establishing a diagnosis and/or selecting management options. These complexities can be difficult to capture with an attestation, since every patient and presenting problem has its own idiosyncrasies.

There is a point system for scoring MDM and some of the subcomponents of the MDM scoring for the data element could be captured with a mini-attestation.

"old records requested"

"discussed films with radiologist"

"per my independent interpretation" for EKG and x-ray findings

Cautionary note: Keep in mind that, increasingly, auditors are looking for case specific clinical information to justify the medical necessity for the services reported. A string of minimally acceptable attestations may not paint an adequate picture of the patient's condition.

Don't Forget Special Circumstances For Residents, Scribes and NPPs

In addition to the E/M service, there are other situations that could incorporate an attestation in the ED documentation, according to Thomas.

Teaching Physicians/Residents □ There are three common coding issues that could be addressed with an attestation.

1. Billing E/M services

2. Billing Procedures

3. Billing Interpretations

E/M services billed by teaching physicians require that the teaching physician personally document at least the following:

a. That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and

b. The participation of the teaching physician in the management of the patient.

CMS has published examples of Teaching Physician attestations that they feel comply with these requirements, notes Thomas. They have released attestations for several scenarios, but two of them are the most common to the emergency department:

Scenario 1 – Resident performs E/M service in the presence of the teaching physician and the resident documents the service. The teaching physician must document that they were present during the performance of the critical or key portions of the service and that they were directly involved in the management of the patient. The teaching physician's note should reference the resident's note.

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.

Scenario 2 – Resident performs E/M service in the absence of the teaching physician and documents the service. The teaching physician must independently perform the critical or key portions of the service and, as appropriate, discusses the case with the resident. The teaching physician must document that they personally saw the patient and performed critical or key portions of the service, and participated in the management of the patient. The teaching physician's note should reference the resident's note.

I saw and evaluated the patient. Discussed with the resident and agree with resident's findings and plan as documented in the resident's note.

Procedures performed by residents have a separate set of requirements that would involve an additional attestation from the teaching physician.

For minor procedures that take only a few minutes (five minutes or less) to complete the teaching surgeon must be present for the entire procedure in order to bill for the procedure.

I was at the bedside and provided personal supervision, while the resident performed the procedure.

For procedures lasting longer than five minutes, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.

I was present for the critical and key portions of the procedure performed by the resident.

Interpretations performed by a resident add the need for an additional teaching physician attestation. If a resident prepares and signs an interpretation, the teaching physician must indicate that they have personally reviewed the image and the resident's interpretation and either agrees with it or edits the findings.

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

Scribes in the ED: As emergency departments transition to EMRs, many are turning to the use of scribes to expedite what can be a time-consuming documentation process. There should be two attestations in every chart involving a scribe, one from the scribe and one from the physician.

The scribe's attestation should include:

The name and signature of the scribe.

The name of the provider providing the service.

Record created by Jane Smith, acting as scribe for Dr. Jones.

The provider's attestation should include:

Confirmation the provider personally performed the services documented.

Indication that he/she reviewed and confirmed the accuracy of the information in the medical record.

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

Editor's Note: Watch out for the second part of this article in the next issue.