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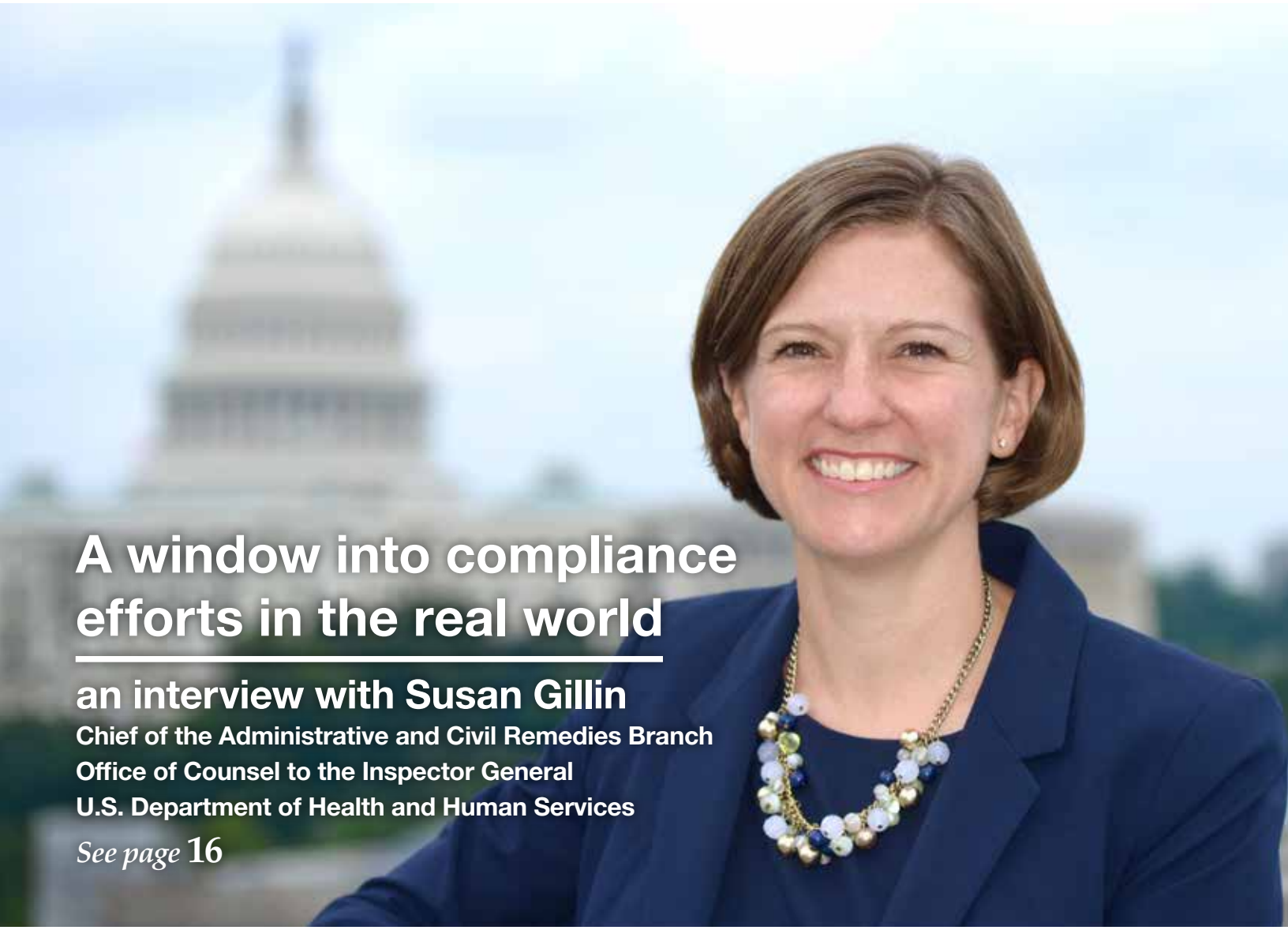

## A window into compliance efforts in the real world

### an interview with Susan Gillin

**Chief of the Administrative and Civil Remedies Branch**
**Office of Counsel to the Inspector General**
**U.S. Department of Health and Human Services**

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> Compliance professionals and the OIG share this challenge of predicting new types of fraud, waste, and abuse; and I hope we can continue to collaborate to share ideas and try different ways of protecting the programs.

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VOLUME 19, ISSUE 10

by Ellis "Mac" Knight, MD, MBA

# Clinical documentation: 10 means for compliance and convenience

» Avoid poor clinical documentation practices that commonly result from limited time for direct patient care and documentation.

» Mitigate the deleterious effect documentation in the electronic medical record can have on face-to-face patient care delivery.

» Ensure compliant documentation of care is accomplished in the most efficient and effective manner possible.

» Prepare for value-based reimbursements, where both clinical documentation and abstraction of performance data from the medical record will be required for billing purposes.

» Step back to re-tool provider clinical documentation processes and procedures.

***Ellis "Mac" Knight*** *(mknight@cokergroup.com) is Senior Vice President/Chief Medical Officer, at the Coker Group in Alpharetta, GA.*

As a long-time practicing physician (internist/hospitalist), I have seen my clinical colleagues over the years use some unusual methods to circumvent the documentation requirements set forth by payers and regulators. Although I don't condone some of these practices, especially when used to justify the up-coding of charges, I do understand the pressures levied on physicians and other providers to document appropriately. Further, I recognize the burden this obligation can cause for the busy caregiver.

Knight

## Common work arounds

Most of the dubious practices I have observed do not seem to emanate from a concerted effort to defraud the system. Rather, they are the result of providers trying to deliver patient care and document their activities within the limited time available. Consider the common practice of "cutting and pasting" portions of the clinical documentation from one visit to another. As a hospitalist, I frequently have seen this done with problem lists and physical exam findings. The danger here is that unless these items are updated, they neither reflect the patient's status, which may result in quality and patient safety issues, nor do they reflect the actual services provided during the visit. Likewise, using templates saves time, but if that comes at the expense of accurate documentation, it may not be worth the extra minutes saved.

Another common error I've observed is for providers to try to bypass the database function of an electronic medical record (EMR) and instead enter all information as free text. This practice seems more comfortable to them, because it mirrors how hand documentation in medical records was done before the development of electronic systems. It also saves time, especially if the free text is dictated into the record, an option frequently used by those who have poor keyboarding skills. The consequence of entering too much free text into an EMR (a sophisticated database with a lot of prescribed fields) is that most systems can't process free text. Thus, the retrieval of data for a variety of purposes (e.g., quality reporting, performance improvement, population health

management) is compromised. At this point, the EMR system essentially becomes a sophisticated but very expensive word processor.

Finally, providers should know better by now, but many of them continue to think they can game the payment system to upcode the encounter to a higher billing level by extensively documenting more information than necessary. Providers who feel that all the patients they see are complicated and complex will often try to justify this claim by adding extraneous information to office notes. Therefore, even if the services rendered during the specific encounter do not justify a higher charge code, the additional (usually irrelevant) information is an attempt to obscure this fact. The irony here is that the additional documentation requires more time—unless other poor practices are used, such as cutting and pasting (see above)—and rarely escapes the eye of an experienced auditor.

## Proven methods for compliant documentation

The question then becomes, how can busy providers document in a compliant fashion that also minimizes the time taken away from direct patient care? There is no doubt that EMR system documentation requirements distract from patient-facing care delivery. For this reason, proven methods for mitigating this deleterious effect need to be described and deployed.

The compliant means of successfully using an EMR without negatively affecting the provider's time with direct patient care are as follows.

### Defining documentation requirements

Far too many providers seem to feel that more is better when it comes to documentation. In fact, the opposite may be true, and most experienced auditors are not fooled when excessive and extraneous information is recorded. All information provided should add to the utility of the clinical note.

### Using scribes

Many providers find that using scribes to document information dictated by the provider (e.g., history, physical exam, diagnoses, and treatment plans) into the medical record can dramatically save time and increase face-to-face interactions with patients. Moreover, some providers have noted that patients enjoy this type of interaction, because the provider's verbal transfer of information to the scribe also informs the patient of the provider's findings, assessment, and plans.

### Using templates

Templated notes can help guide documentation requirements and remind providers of the necessary information to include in each note. Pre-filled templates, however, should be avoided, because they are commonly used as the *default* entry into the note and not properly modified to reflect the actual findings for each exam.

### Dictating notes

Many providers felt that the dictation of notes would become a thing of the past with the advent of EMR systems. However, this has not been the case, and many caregivers (especially those who are not proficient typists) continue to find that dictation, especially using voice transcribing software, can expedite the documentation process. Again, dictating according to default templates should be avoided, and effort should be given to ensuring that each note accurately reflects the actual information, exam findings, diagnoses, and treatment plans for each patient.

### Following guidelines

Although rigid adherence to standardized order sets or treatment plans should be avoided, using evidence-based guidelines can save providers time as they see patients with common conditions or complaints. This approach will help avoid having to develop

diagnostic or treatment plans de novo with each separate encounter. The other advantage of the guidelines approach is that adherence to these standards generally means best practices are being applied to each patient's situation.

**Real-time dictation**

As mentioned, many patients enjoy having their provider dictate a note during their patient visit, either to a scribe or to an electronic transcription service. This technique can also serve to augment communication between the provider and the patient. It also avoids the provider's forgetting key elements of the encounter between the time of the patient visit and the documentation process.

**Coding support**

Providers should work closely with professional coders to ensure their notes include the key documentation elements required for the accurate coding of patient visits for billing purposes, quality and cost measure abstraction, and risk adjustment of performance data.

**Avoiding free text**

Free text entries into the EMR can often best describe clinical situations; however, most EMRs cannot process free text. Therefore, this information is difficult to extract from the EMR for reporting, research, or compliance purposes. Free text entries into the EMR should be limited to the History of Present Illness (HPI) and, in complex cases, to the Assessment portion of clinical notes. Using pre-defined fields with drop down lists can also save time during the documentation process.

**Incorporating patient-generated information**

Patients are now well armed with smartphones, patient portals, and other technological innovations they can use to access and even contribute to the information incorporated into their medical record. This information transfer can occur synchronously, perhaps during a virtual visit, or asynchronously, thus allowing the provider to respond and document the clinical encounter at a more convenient time.

**Turning the EMR into a multi-media recording device**

A picture is often worth a thousand words and photographs of rashes or other clinical conditions can serve to document a clinical event better than a written description. Video recording of events, such as seizures or syncopal episodes, can also be invaluable in both the assessment and documentation component of patient care delivery.

The above list is not all-inclusive, but hopefully it will allow providers to optimize the time spent providing face-to-face patient care and minimize their time spent clinically documenting information that may not be of value.

Providers should avail themselves fully of the technological innovations now in place that can serve to ensure compliant documentation of care is accomplished as efficiently and effectively as possible.

## Conclusion

Compliance with clinical documentation requirements is likely to remain a challenge for all providers, especially as value-based reimbursements (where both clinical documentation and abstraction of performance data from the medical record will be required for billing purposes) become more the norm.

In summary, providers would be well advised to step back occasionally from the demands of patient care and clinical documentation and take a moment to re-tool the processes and procedures they use in these extremely critical efforts. This exercise will serve both to enhance patient and provider satisfaction with the care delivery system.