
PRACTICE PERFECT

COMPLIANCE & RISK MANAGEMENT

Documentation and EHRs: Avoid Some Common Pitfalls

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When properly implemented, an electronic health record (EHR) system can improve your practice in measurable ways. However, as many practices have discovered, EHRs also can make it easier to commit errors that were uncommon (or did not exist) with paper charts. Such problems generally fall into one of two categories—data accuracy and patient privacy/confidentiality. Often, these problems go unnoticed until an audit takes place.

By reviewing how your system is set up and diligently monitoring how it is being used, your practice can prevent these errors from occurring in the first place.

Make sure your templates encourage compliance. With EHRs, “provided the type of exam visit is the same, you will be presented with the same exam template for every patient,” said Janna Mullaney, chief operations officer at Katzen Eye Group, a Maryland practice that employs eight ophthalmologists and eight optom-

etrists. “When you are using the same template again and again, it is important for the template to be designed in a manner that encourages compliance. Otherwise, it is easy to make the same mistake much more consistently than might have been the case with paper charts.”

“If your system is versatile enough to allow customization and you take the time to set it up correctly, prompts can be built in that will encourage proper documentation,” said Julia Lee, JD, executive director of Ophthalmic Partners of Pennsylvania, a multisub-specialty practice in the Philadelphia area. “For example, we designed our system to recognize Medicare patients so that it offers additional choices within the exam template to capture certain documentation unique to Medicare.”

Be careful what you import from the patient’s previous exam. One danger posed by EHRs involves the ability to copy elements from prior exams into the current visit template. This can lead to overdocumentation. “Although there is tremendous utility to copying a previous exam, you should only copy items that were performed at the current exam,” said David E. Silverstone, MD, clinical professor and assistant chief of ophthalmology at Yale University and ophthalmologist at the Eye Care Group in New Haven, Conn.



DO YOU HAVE CONFIDENCE IN YOUR DATA? Your EHR system is only as useful and robust as the data you record. Incorrect data can result in reduced efficiency, decreased reimbursements, medical errors and a variety of serious compliance violations.

“Practices that use the ‘carry forward’ feature in their EHR system should take care to uncheck any boxes or exam elements that are inapplicable to the current visit,” said Ms. Lee. “Even though you see a patient frequently, the information may change from exam to exam, so it is important to review each of the required steps at every visit,” added Paula Vaughan, OCS, office manager of a solo practice in Farmington, N.M.

Include all the elements of the visit. In contrast to inputting too much information, it is also possible to skip



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key elements of a visit—particularly on busy days, when the practice schedule is full or running behind. “It does not happen often, but I sometimes find that patient records may be less complete when we are busy,” said Ms. Vaughan. “Although a particular element was performed, the techs may skip the entry, particularly in the review of systems section of the patient’s record.”

Keep your default settings up-to-date. Keeping current with updates and mandates is essential. Remember, upgrades in your medical equipment may mean that updates also should be made to your EHR system. Ms. Mullaney offered a salient anecdote: “I assisted a practice that had been using a particular medical device for several years but neglected to change the default in their EHR system when the equipment was upgraded. Every time the procedure was performed, it was recorded that the original device was used instead. Although the difference was only about \$7 per person, the loss was significant due to the volume of patients the practice treated and the length of time that the error went unnoticed.”

Don’t forget the lessons you learned with paper charts. As when using paper charts, you also must be able to demonstrate that the level of examination that you coded for a particular patient is justified. “It is your basis for requesting payment,” said Dr. Silverstone. “As such, it is important to document everything that was done during a visit. However, the documentation must be accurate and represent what was actually done during that particular exam.”

Protect Patient Data

Practices should also make sure that their staff members are appropriately trained to protect patient privacy. “Turning off display screens and locking the patient record when it is complete is mandatory,” said Dr. Silverstone. “In our office, we have signs posted on the screens as a reminder for the technicians. It is considered a serious matter if a technician or staff

member fails to protect patient data, and the offense may be recorded in their employee file. System security is equally important—particularly if off-premises access can be gained. Good password protection and electronically recording all those who access the system can reduce the opportunity for a security breach.”

Manage Compliance Internally

Every practice should have a compliance program in place.

Appoint a compliance officer.

Your compliance program should be monitored on a consistent basis by an internal compliance officer. This is one person who is in charge of making sure that all compliance issues are addressed.

Establish guidelines and train the staff. Anyone inputting information into an EHR system should be properly trained in how to follow compliance rules, as well as in how to operate the system. “Each practice should establish a set of guidelines that outlines the required information for every patient,” said Ms. Vaughan. “And the staff should be taught to follow these guidelines every time. This will result in a more complete record and reduce the chance for errors.”

“The best training for using an EHR system is done in a real-world setting,” said Ms. Mullaney. “This does not necessarily mean it should be conducted while working on a patient, but you can still take a real-life scenario and use the system as if you were seeing a patient. When I teach someone who is new to the EHR system, I use the analogy of the old exam forms with various elements to document. In some cases, you do not need to cover all the elements, so some areas could remain blank. It is the same situation with EHRs. Just because a set of templates offers you the ability to enter all the nuts and bolts of an exam, you must be careful to address and record only those issues that relate to the current exam.”

Problems should be addressed promptly. Compliance errors should be resolved as quickly as possible. “I

address any errors as they occur, and it is also important to meet with staff once a month to address any recurring problems,” said Ms. Vaughan, who finds that a reminder usually resolves the issue.

Document any compliance errors.

Dr. Silverstone recommended keeping a journal. He uses this to document any problem that arises, how it is addressed and how it was corrected. “This is particularly useful in the case of an audit. The fact that you identified the problem and took actions to prevent it from happening again is very important.”

Reap the Rewards

EHRs can bring many amazing things to a practice, but they also hold you accountable, said Ms. Mullaney. “If you build an EHR system appropriately and follow all the rules, you can make your practice more effective. You can print reports, get more involved in research studies, communicate better with patients and referring doctors and a variety of other things above and beyond what we could do with paper charts.”

Further Reading

For further tips, read published *Eye-Net* articles at www.evenetmagazine.org/archives.

Tips on Data Security. A Three-Pronged Strategy for Securing Your Practice’s Laptops (Practice Perfect, January 2007) and **Low-Tech, Low-Cost Ways to Heighten Data Security** (Practice Perfect, February 2004).

Tips on Documentation. Chart Smarts: Benefit From Better Documentation (Practice Perfect, September 2004).

Tips on EHR Selection. EHRs: 10 Questions That You Should Ask About a Vendor and Its Software (Practice Perfect, October 2009).

EHR Central. For the AAOE’s online resources—including vendor information, links to articles and much more—go to www.aae.org/aae and select “EHR Central.”