PROTECTING AGAINST EMR PITFALLS

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IT'S HARD TO BELIEVE, BUT ELECTRONIC MEDICAL RECORDS (EMRS) ARE NOW MORE THAN 40 YEARS OLD.

During that time, they have evolved significantly, with each advancement designed to increase efficiencies in the healthcare system. However, with these changes come challenges, from steep learning curves among users to complexities unearthed while in use.

Today, EMRs could be considered both a blessing and a curse, if not used properly. Many of the time-saving features associated with EMR systems carry risks. Functions such as copy and paste, templates and autocomplete make supporting higher levels of service easier, but they also increase and facilitate scrutiny by payers and governmental entities.

Add to that the fact that accuracy is crucial. A provider's signature on an EMR note validates that he or she has performed the services documented. But in today's healthcare environment, where demand for services is increasing as more people gain access to health insurance and the population ages, reviewing every word in each note is no longer a luxury providers can afford.

Today, it's more important than ever that healthcare leaders actively monitor and mitigate the risks associated with three common EMR pitfalls:

▶PITFALL ONE: AUTOCORRECT

Autocorrect is a relatively new feature that can contribute significantly to the complexity of EMRs. While it can lead to time savings when it works correctly, it can cause significant reporting issues when it doesn't. To mitigate the risk of reporting inaccurate information, physicians using a program that has autocorrect should add all of the medical terms used within their practice(s) to the system. If "IUD" is meant to document "intrauterine device," providers should verify that term is what populates and not, for example, "intrauterine death." Confirming that the source information from which autocorrect pulls is as complete as possible will allow the program to operate smoothly and create the intended efficiencies.

▶PITFALL TWO: PRINTING THE RECORD

Once an EMR is in place, another step that is often overlooked is the printing of records. As the healthcare industry transitions from hard copy to digital, it's important that providers do not lose sight of what the records should and will look like if printed. Why? Many outside entities will continue to request hard copy records for auditing purposes, and there are often significant visual formatting differences between paper and electronic documents, which can include the omission of details or the inclusion of irrelevant data. It's crucial to understand these differences to avoid the lengthy and costly process associated with a claim denial.

▶PITFALL THREE: BASING ASSESSMENTS ON A CODE SET

Basing assessments on a code set is another feature, intended to save time, which can cause issues if not used correctly. Certain EMRs, for example, require providers to select an ICD-9 code for their assessments, which match from the record to the claim. However, if the provider selects the wrong code, issues arise from a coding and auditing perspective. Furthermore, the fast-approaching implementation of ICD-10 has additional implications for EMR coding, particularly given that some payers – those that aren't HIPAA-covered entities (e.g., workers' compensation and auto insurance carriers) – are not required to update to ICD-10.

Combined, these EMR pitfalls can create additional administrative work for providers and, more importantly, put their claims at risk. For example, if a pregnant patient is seen for a condition unrelated to pregnancy, coding guidelines direct providers to add the code V22.2, "pregnant state, incidental." However, consider this scenario: a chiropractor saw a patient and treated the non-pregnancy-related issue, but then completed his documentation and selected a code to represent that the patient was pregnant. The first code to appear when the provider searched "pregnant" was "abdominal pregnancy" because the codes were listed in alphabetical order by code descriptor. He therefore selected the code 633.01, "abdominal pregnancy with intrauterine pregnancy," and it populated his note and claim form with this information. The full descriptor, which the EMR didn't have the character space to accommodate, went on to state that this was an ectopic pregnancy. Now both the medical record and the claim form were incorrect, which meant the provider had to do an addendum and re-document the condition appropriately. This is a prime example of when a time-saving feature created an error that put the claim and documentation at risk, while also creating more work and expending more time and effort than should have been required.

EMRs are great tools, but they are just that – tools. It is up to the individual to correctly use all of the resources at his or her disposal. Being aware of a system's shortcomings, as well as the areas in which they function best, will ultimately help providers reap the greatest benefit from this technology.

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