FORESIGHT
Optometric Documentation & Coding Consultants

Ryan P. Ames, OD, MBA
DrAmes@ForeSightOD.com
888.456.2046

The Evolving Medical Record 2019 January

The Centers for Medicare & Medicaid Services (CMS) has been working to adopt changes to the documentation requirements that better fall in line with how we care for patients in the age of electronic health records (EHR), virtual visits, virtual doctor-to-doctor consults, and simply the evolution of health care over the past 20+ years. In 1995, and again in 1997, we were given documentation guidelines that provided health care providers with a road map to documentation. The guidelines have been one of our references for the past two decades as to how, and what, items needed to be documented in a medical record. Doctors and EHRs have been struggling to make these outdated requirements fit modern care. I envision it's like putting a square peg in a rectangular hole…we can make it fit, but there is a gap. EHRs have the great potential to really revolutionize how we care for patients. And, in many ways, they have. They provide us nearly instant access to trend analysis, historical test results with the push of a button, records are omni-available from any location…and many more advantages. But there are obvious inefficiencies, too.

We currently create exam encounters for each patient visit, pull forward prior elements, review them, edit them, add data, and remove data. Then we sign the chart and freeze that snapshot of care in the hopes that it properly conveys the care provided that day. Sometimes it does a nice job, but I would argue that it frequently over, or under, represents that day's care, too.

I've performed friendly documentation audits for doctors using nearly all the major EHRs available to optometrists. I can attest that none of them are perfect, and they all have limitations. CMS has recognized these issues and has created the "Patients over Paperwork" initiative. Through this initiative, they have proposed several changes and clarifications to documentation requirements that will go into effect over the next few years. Some softer changes took effect on January 1st, 2019. While some more substantial ones will happen in 2021.

Starting in 2019, CMS finalized the following policies:

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit;
- For established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so;
- Additionally, we are clarifying that for E/M office/outpatient visits, for new and established patients for visits, practitioners need not re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information; and
- Removal of potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team for E/M visits furnished by teaching physicians.

The main information to note is that CMS is recognizing that requiring doctors to reenter information that is already in the record, or has been entered by someone else, has no benefit to the patient. As long as the doctor reviews the information, it is just as clinically valuable. We will see how EHRs allow us to implement this into our care. Will the patient be able to enter a chief complaint, ROS, HPI, and medications into a portal and have the information automatically appear in the chart? We will see how it plays out. Even after our systems have completely adapted to the new policies, we are still responsible for

Ryan P. Ames, OD, MBA
DrAmes@ForeSightOD.com
888.456.2046

everything in the record, and everything omitted. The fundamentals of good documentation will not change.