Lessons Learned from Teaching a Provider Documentation Remediation Course

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Objectives

• History of the Documentation Remediation Program
• Basic Curriculum of the Documentation Remediation Program
• Statistics on Course Participants
• The Coding Educator’s Perspective
• The Doctor’s Perspective
• Answering Your Questions
History

Intensive Course in Medical Documentation: Clinical, Legal and Economic Implications for Healthcare Providers

Developed and first conducted in 1998 but revised to the current curriculum in 2013

Created to fulfill the need for comprehensive education for providers wanting or needing to improve their documentation skills, with particular regard to clinical communication, legal risk, regulatory compliance, and appropriateness for reimbursement.

Basic Curriculum

• Instruction on the Purpose of Clinical Documentation in the Medical Encounter
• Instruction on the Documentation and Coding Requirements for Evaluation and Management Coding
• Current Topics in Documentation (MACRA/MIPS, Quality, Risk Adjustment)
• Legal Settings involving Documentation and Medical Records
• Legal Consequences from Poor Documentation and How to Respond in an Audit
• Documentation involving Controlled Substance Management
• Addressing EMR Concerns and Constraints
• Practice on Video Vignettes
Statistics

Degree of Participants

Medical Schools

Gender of Participants

Age Distribution

Statistics

**Gender of Participants**

<table>
<thead>
<tr>
<th></th>
<th>Course Participants</th>
<th>US Physicians</th>
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<tbody>
<tr>
<td>Male</td>
<td>76.1%</td>
<td>64.7%</td>
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<tr>
<td>Female</td>
<td>23.9%</td>
<td>33.5%</td>
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<tr>
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<td>1.8%</td>
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Statistics

**Medical Schools**

<table>
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<th>Course Participants</th>
<th>US Physicians</th>
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<tr>
<td>US Medical Schools</td>
<td>70.9%</td>
<td>76.0%</td>
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<tr>
<td>International Medical Schools</td>
<td>26.4%</td>
<td>22.7%</td>
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<td>1.3%</td>
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</table>
Statistics

Age Distribution

- Less than 30: 1.9%
- 30 - 39 years: 21.9%
- 40 - 49 years: 23.0%
- 50 - 59 years: 23.9%
- 60 - 69 years: 31.6%
- 70+ years: 30.7%
- Unknown/No answer: 1.2%

Course Participants vs US Physicians

Statistics

Years in Practice

- 0.0% years: 3%
- 0.5 - 10 years: 15%
- 10.5 - 20 years: 27%
- 20.5 - 30 years: 22.3%
- 30.5 - 40 years: 13%
- 40.5 - 50 years: 8%
- 50.5 - 60 years: 5%
- 60.5 - 70 years: 2%
- Unknown/No Answer: 0%

Environment for Training in Clinical Documentation (Writing Notes)

- Medical School/Internship: 4%
- Residency: 4%
- Post-Residency: 4%
- While in Practice: 4%
- Never: 7%

Environment for training in CPT Coding (Visits and Procedures)

- Medical School/Internship: 6%
- Residency: 11%
- Post-Residency: 25%
- While in Practice: 35%
- Never: 11%

Environment for Training in ICD-10 Coding (Diagnosis Coding)

- Medical School/Internship: 13%
- Residency: 47%
- Post-Residency: 35%
- While in Practice: 21%
- Never: 10%
Statistics

Years in Practice

0-5 years: 6.7%
6-15 years: 26.4%
16-25 years: 27.6%
>25 years: 38.3%
Unknown/No Answer: 0.9%

Statistics

Environment for Training in Clinical Documentation (Writing Notes)

- Medical School/NP School: 19.6%
- Residency: 26.1%
- Post-Residency: 8.7%
- While in Practice: 43.5%
- Never: 2.2%
Statistics

Environment for training in CPT Coding (Visits and Procedures)

- Medical School/ NP School: 3.3%
- Residency: 5.7%
- Post-Residency: 13.3%
- While in Practice: 66.7%
- Never: 10.0%

Statistics

Environment for Training in ICD-10 Coding (Diagnosis Coding)

- Medical School/ NP School: 6.5%
- Residency: 3.2%
- Post-Residency: 12.9%
- While in Practice: 64.5%
- Never: 12.9%
The Coding Educator’s Perspective

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The “Golden Rule” (it’s not what you’re thinking)

- They who have the gold make the rules
- “Guidelines” are not suggestions, guidelines are requirements
- Perspective is Everything
Vignettes

• “Tell me about an interesting case you saw this week”
• Places the Provider in a Comfortable Environment
• Levels the Playing Field
• Keep it Specialty Specific
• Gestalt Coding
• Role Playing - Practice

Types of Education

• Large Group
• Smaller Groups
• One on One
• Champions Only Make it Better
When Dialogue Begins, Amazing Things Happen

• Getting it Right, Keeping it Simple
• Choose Your Battles Carefully
• No More Than Three Points at a Time
• For Small Groups Conversation is Better Than Lecture

Education at Every Level

• Medical School
• Internship
• Residency
• Fellowship
• In Practice
• In Practice
• In Practice…. (it never stops)
EMR’s and Other Things to Help You

• Let the EMR Work for You
• Own the EMR (or, at least, don’t let the EMR own you)
• Acronym Expansion or Macros
• Templates
• Scribes
• Ancillary Staff Support

The Doctor’s Perspective

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Put Mentation back into Documentation
Lost sight of why we document

Not for:
– Coders
– Payers
– Government
– Quality metrics
– Lawyers

Why we document

For clinical communication
Hhhmm, this is a really bad exacerbation of moderate persistent asthma, I think I would even go as far as calling it status asthmaticus. I’m worried about her.

Just another boring patient with asthma. I’ll check on her later.
Volume ≠ Good documentation

• If it is not documented, it has not been done.
• Clear and concise medical record documentation is critical to providing patients with quality care and is required to be paid.
• Payers may require reasonable documentation to ensure that a service is consistent with insurance coverage, site, medical necessity.
• The provider must ensure that documentation supports the level of service reported to a payer. You should not use the volume of documentation to determine which specific level of service to bill.

Motivation

https://commons.wikimedia.org/wiki/File:Origami_(made_from_an_American_1-dollar_bill)_of_an_elephant.jpg
Don't know what “compliance” is

HCCA:
Compliance is striving to meet the expectations of others, specifically those who grant us money, pay for our services, and regulate our industry. This means we must keep up-to-date with all the laws, rulings, and regulations governing the healthcare industry.

AAPC:
A general term describing the observance of conventions, guidelines, and state and federal laws.
Needs to be integrated

- Denials
- E&M
- CDI
- Diagnoses, specificity & linkage
- Clinical validation, specificity & linkage
- Correct DRGs, HCCs
- Core measures, HACs, PSI, mortality, metrics
- Quality
- Medical Necessity
- Status, meet NCD/LCD
- Internally consistent, accurate severity
- Attestations, follow rules and regulations
- Compliance
- Clinical Care
- Clinical communication

Needs to be part of curriculum

- Medical school
- Residency

- Curriculum
  1. General good and risky documentation practices
  2. Clinical documentation integrity and medical necessity
  3. Documentation for your dinner
Needs to be part of the culture

- “Documentation Excellence”
- Clinical communication improves patient care
- Good documentation should be a communal expectation (Karma-what goes around, comes around)

Dragon nonsense

yesterday morning. Patient to ask in the breakfast, and 80, and feel well. After taking at its. There are related off to know when he was sitting at the at the dinner table and his granddaughter was in his lab and he started feeling a lot of nausea, belching, Margaret abdominal pain, even to the bathroom 3 times yesterday. He was not work today, via he denies, fever, chills, sweating.
Disclaimer

Disclaimer:

Portions of the note may have been dictated by speech recognition. Please excuse any grammatical or typographical errors.

Revised disclaimer

Disclaimer:

Please feel free to notify my lawyer of the amount your plaintiff client is seeking, because I am obviously not interested in ensuring that my documentation is accurate, and you may well infer that I practice medicine the exact same way.
EHR should be helpful

- Standardized documentation (e.g., enterprise-wide macros, templates, “uneventful night”)
- Attestations (e.g., trainee, split/shared, critical care time, 2MN)
- Caveats (e.g., unable to obtain PFSH/ROS, speech recognition)

EHR should not be harmful

COPYING WITHOUT PERMISSION IS STEALING!

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THIEF!

https://commons.wikimedia.org/wiki/File:ME_109_Thief.png
HOPI:
- 60 yo male, hx chronic a/fb, htn, type 2 dm, copd, presents with
reports increased lower extremity edema; reports dyspnea on exertion with walking short distances;
reports no hx chf; pt seen in pulmonary office today and referred for direct admit.
Pt reports blood pressure routinely runs 200 or higher; took his losartan and metoprolol; states
recently taken off amlodipine dt edema; denies cp, cough, fever, m/v/d, abd pain, dysuria;
States had cardiac cath at

Hospital Course:
Acute on chronic diastolic CHF
- Continue the lasix 40 mg bid
- EF was 55%
- Stress test was negative.
Malignant HTN
- Continue the norvasc 10 mg
- Continue the losartan 100 mg daily
- Continue the metoprolol 75 mg bid
Chronic a/fb
- Continue eliquis
- Continue sotalol
COPD
- Stable
- On PO prednisone
Leukocytosis
- Monitor the WBC.
Type 2 DM
- Continue the ISS.
DVT prophylaxis.
- Patient was placed on Eliquis

Copy and paste

https://commons.wikimedia.org/wiki/File:Garlic.jpg
Copy and paste - recommendations

- Provide a mechanism to make C&P material easily identifiable
- Ensure that the provenance and chronology is available
- Ensure medical staff training and education regarding appropriate use of C&P (→ Mindful editing)
- Ensure regular monitoring

Audit and Feedback

- Providers should audit each other’s documentation (PA can use same tool during routine chart reviews)
- Create an audit tool
  - Focus (E&M, CDI, compliance, all facets?)
  - Different for various note types?
  - Make it easy to use and to interpret
- Perform at regular intervals
  - Within residency, service line, department
- Mechanism for dissemination of findings
Assessing Electronic Note Quality Using the Physician Documentation Quality Instrument (PDQI-9)
Stetson, PD, et. al.
Tell the Story

Tell the Truth
Questions?

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Put Mentation back into Documentation

Contact Information

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