THE UNIVERSITY OF CHICAGO
Medical Center Compliance

Training Points March 2012

EHR/EPIC Documentation

Documentation Tips:

1. **Copy Functionality -** It is important to ensure that this functionality is used as part of a thoughtful process that assists with the accurate documentation of the specific services provided, supports medical necessity, and produces a note that enhances patient care.

   Inappropriate use of Copy functionality can lead to risks with:
   - Patient Care - Flawed medical record that results in poor patient care.
   - Billing and Reimbursement - Inappropriate use may suggest that services were provided when, in fact, they were not, resulting in the submission of an unsupported bill.

   Specific risks include the following:
   - Populating a note with outdated, conflicting, incomplete or inaccurate information.
   - Inability to identify the original author in the EHR.
   - The original date of note creation may not be evident or may be difficult to locate.
   - Notes that are repetitive, inconsistent or identical.
   - Notes that are too long and contain irrelevant information.
   - Work performed by others incorporated into your note can lead to false and misleading representation of the service(s) you performed.

   Entries carried forward from a previous visit(s) must be reviewed for accuracy and edited appropriately. Be sure system SmartPhrase text, SmartLinks and clinical data represent what happened in today's visit. It is never appropriate to copy information from one patient's chart to another patient's chart. The risk are numerous, chief among them are patient safety, patient privacy, and inaccurate billing.

2. **Note Authentication –** All patient medical record entries must be complete, dated, timed and authenticated by the person responsible for providing the service (billing provider) promptly/immediately following the service and prior to billing. This also includes dictated/transcribed documents that are uploaded/interfaced into EPIC. Dictated documents are not uploaded/interfaced into EPIC until they are signed rendering them unavailable for coordination of care, coding and billing.

3. **Results -** The attending physician is responsible to review/comment on any lab results and other studies imported into his/her note via any means (template/copy functionality). If results are reported elsewhere in the EHR, the attending physician is advised to summarize diagnostic findings rather than copying the complete report into the note.

4. **Teaching Physician Presence and Participation -** Teaching Physician (TP) Rules expects that the documentation of the resident be available at the time the TP documents his/her presence and participation in the service via an attestation statement. EPIC date and time auto recording illustrates the sequence of documentation events and is visible for assessment of compliance with this rule.

5. **Teaching Physician Attestation Statement** - The Office of Medical Center Compliance worked with the EPIC team in developing SmartPhrases for Teaching Physician Attestation statements that meet the minimum requirements for billing. Any variation from these approved statements must be vetted through the Office of Medical Center Compliance. Select the Teaching Physician Attestation that corresponds to the service that you provided.

   Statement SmartPhrases:

   .ATTESTNOTPRESENT
   .ATTESTPRESENT
   .ATTESTFULL

6. **Make Me The Author** – This is the EPIC Ambulatory workflow designed for scenarios when a resident/fellow working with a teaching physician creates a clinic progress note and the attending physician assumes the authorship of the note by clicking the "Make Me The Author" selection option when prompted. The system keeps track of each version of the note via an audit trail and hyperlinks to previous versions within the body of the note. The attending physician is responsible for reviewing the note, modifying it as necessary and personally documenting his/her teaching physician attestation statement.

7. **Medical record documentation must reflect all providers of service** - When an attending physician shares an evaluation and management service with an APN/PA, the attending physician's note must reflect that he/she independently treated the patient and personally documented their assessment and involvement in the care of the patient.

8. **Medical Student Documentation -** Do not copy/use any portion of a Medical Student's note other than Review of Systems and Past/Family/Social History**.** Federal regulations are clear that only the portion of a **note** originally authored by a medical student that can be used in support of a bill are the ROS and PFSH sections of history.

9. **HPI and ROS -** Ensure that the History of Present Illness and Review of Systems agree (especially when using macros, templates/SmartPhrases and checkboxes to generate review of system documentation.

10. **Date of Service -** Typically the date of documentation coincides with the date the patient was seen and examined. Each note type in EPIC contains a field labeled date of service which is defaulted to the date the note is initiated. On the rare occasion notes are generated subsequent to the date the patient was examined, the provider must override that field to make sure it reflects to correct date of service.

11. **Note Templates (Note Writer) -** Note Types and "NoteWriter" functionality are intended to help guide the provider in documenting for a particular service. Providers also have the option of documenting via free text, however by doing so they are running the risk of missing pertinent information. Although, EPIC allows adhoc creation of customized documentation templates it's important to seek guidance in development to ensure the template isn't designed to "lead" the provider in documenting to obtain a desired billing/ coding level or lack required data elements.

Privacy and Security Tips:

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1. Store passwords in secure areas – not accessible by others.
2. Do not share your computer user ID or passwords with anyone.
3. Do not access protected health information unless it is necessary to perform your job duties, including that of your family members (including spouse and children), friends, neighbors, colleagues, etc. University of Chicago Medicine has a zero tolerance policy on unauthorized access.