The Importance of Physician Documentation

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Importance of Physician/NPP Documentation to Patient Care

- Allows the coordination of services among medical professionals, including clarifying goals of care (with **POLST** when appropriate)
- Tells other healthcare providers what services to furnish
- Indicates compliance with any regulations or questions regarding the standard of care
- Supports claims billed to government and private insurers
- Reduces the likelihood of improper payments and liability exposure

General Principles of Documentation

- The Patient's Record should be clean and legible:
  - Written so that it can be read by anyone
  - Written in ink (or typed)
  - Written in clear language and free of value-laden terms
  - Written without alterations
  - Dated (and timed)
    - Late entries (if absolutely needed) should be documented as such

General Principles of Documentation

"Picture your progress note (H&P, orders, etc.) being blown up on a huge screen in front of a jury"

Documenting Patient Encounters

- A physician should document each patient encounter, which should include:
  - The reason for the encounter and relevant history, any physical examination findings, prior diagnostic results, prognosis/rehab potential
    - Routine regulatory visits should be identified as such
    - When appropriate, the amount of time spent should be documented
  - An assessment, clinical impression, or diagnosis (including differential dx or "rule-outs" if definitive dx is not clear)
  - The medical plan of care and reasonable expectations/goals
  - The identity of any observer present during exam

Documenting Patient Encounters

- When the care process includes discussion with other clinicians, family members, institutions or agencies, these discussions should also be documented
- Telephone conversations with family members (or the resident) may be appropriate to document, even if not on-site and even though they are not compensated through most insurers
- It is the attending physician's responsibility to determine whether resident has decisional capacity—not always a simple yes/no
- Physician (prescriber) must obtain informed consent for psychotropics

What should be documented?

- The rationale for ordering diagnostic and other ancillary services
- Past and present diagnoses (ensure appropriate indication for all Rx's)
- Health risk factors (including falls, skin breakdown, weight loss)
- Patient progress, treatment changes, and response to treatment
  - Looks bad if a resident fell the day before and not mentioned in note
  - Actual physical examination, including wounds on occasion, vitals, wts., BG
- Diagnoses and treatment codes reported on the health insurance claim or billing statement

Medical Director Responsibilities

- Ensuring appropriate care is being provided by other clinicians, including timely initial and subsequent visits
- Chart audits (random and for-cause) should be part of every month's activities for Medical Director
- Discuss care and documentation issues with clinicians when concerns arise, and document these discussions
- Ensure facility policies & procedures are up to date and appropriate

Electronic Health Records

- Medical Records v. Electronic Health Records

Medico-Legal Benefits of EHRs:

- EHRs provide protections in the malpractice context:
  - Improved access to legible patient records
  - Standardized documentation
  - Improved efficiency of information transfer between referring and consulting physicians
  - Pop-ups in the EHR recommending courses of action

Potential Medico-Legal EHR Pitfalls:

- Patient confidentiality
- Juxtaposition errors
- Assumptions (i.e., a prescriber assumes an ordered medication has actually been ordered)
- Missing functionality of EHR systems
- Technical Issues
- E-Mail Communications w/ Patients
- E-Discovery & Metadata

Best Practices for Electronic Health Records

- Avoid "cloning," autofill, or key word features
- Document the patient's description (subjective), using direct quotes when appropriate
- Include clinical notes for each visit
- Update patient history and life events
- Check spelling and acronym usage

Best Practices for Electronic Health Records

- Clearly separate individual notes with punctuation, spacing, or paragraph returns
- Discharge summaries should include the patient outcome after hospitalization to assist those discharged to SNFs with documenting for PDPM
- Which leads to the next topic…

Transition from Prospective Payment System (PPS)/RUGs

- Under PPS, the facilities complete a Minimum Data Set (MDS) assessment at admission, which is used to calculate a Resource Utilization Group (RUG) score.
- The RUG score corresponds to different case-mix indexes, which (ultimately) determines the facility's per diem reimbursement rate.
- Under PPS, the MDS assessments were performed around days 5, 14, 30, 60, and 90

Patient-Driven Payment Model (PDPM)

- Beginning October 2019, Medicare patients at SNFs will no longer be reimbursed under the current Prospective Payment System (PPS).
- Largest change in 20 years.
- Per diem for post-acute (Medicare A) residents determined by six factors, with medical diagnoses playing heavily in the mix
  - Accurate and comprehensive documentation of all relevant diagnoses will be critical to reimbursement
  - Physician/NPP and Medical Director roles will be important

PDPM: Ways to Optimize Documentation

- Ensure full data base received from hospital
  - Coding summary contains diagnoses
  - Discharge summary, H&P, consult notes contain valuable information
  - Ensure correct use of specific ICD-10 codes
- Educate all attending physicians/NPPs on importance of including all relevant and active diagnoses in their documentation
  - Must be done within 5 days of admission
  - If not included in H&P, need to get practitioner documentation elsewhere
  - Consider specific info sheets containing diagnoses with NTA "points" listed
- Designate a champion in facility to capture codes (e.g., HIM/Med.Records)
- Consider obtaining information from community PCP and specialists to capture other diagnoses (e.g., diabetic retinopathy)

Opioids, Medical Records, the MBC, and Patient Privacy

- ***Grafilo v. Cohanshohet*** (Cal. Ct. App. 2/21/19)
  - Medical Board received anonymous complaint that physician prescribing excessive narcotics.
    - Potentially affected patients refused to release medical records.
    - Physician refused to comply with subpoena to turn over records.
  - MBC sought order compelling production of the records; trial court granted
  - Court of Appeals reversed, finding that MBC failed to show good cause to compel production of medical records in light of patients' significant privacy interests.

Opioids, Medical Records, the MBC, and Patient Privacy

- ***Grafilo v. Wolfsohn*** (Cal. Ct. App. 4/2/19)
  - Similar facts to *Cohanshohet*
  - Court of Appeals found no good cause to compel production of medical records
    - "The defects in the evidence supporting the subpoenas in *Cohanshohet* are present here and there are no additional facts that add substantial weight in favor of the subpoena."
    - The Medical Board "offered no evidence as to how many patients Wolfsohn treats, the percentage of his patients the five patients comprised, how often similarly-situated pain management specialists might prescribe the drugs Wolfsohn prescribed, or the likelihood Wolfsohn properly issued the prescriptions."

Medical Board Subpoenas

- Potentially applicable privacy laws:
  - ►**HIPAA**
    - ►45 C.F.R. Parts 160, 164
  - ►**Confidentiality of Medical Information ("CMIA")**
    - ►Cal. Civ. Code § 56.10
  - ►**Substance Abuse Confidentiality Laws**
    - ►42 C.F.R. Part 2 (Health & Safety Code § 11845.5)
  - ►**Lanterman-Petris-Short ("LPS") Act**
    - ►Cal. Welfare & Institutions Code § 5000, *et seq.*

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What does this mean?

- Proper medical documentation can protect you if treatment is ever questioned by the medical board or in other legal situations.
- If you prescribe opioids, there may be additional scrutiny, so always follow best practices and obey state and federal laws/regulations.
  - ►Documenting informed consent of risks/benefits is advisable
  - ►Naloxone can be ordered prn if appropriate, it is on e-kits in most facilities
    - ► Especially if resident on opioid/benzo combination
    - ► Do not order naloxone in the setting of terminal/hospice comfort care
- Consult with an attorney if you receive a medical board subpoena because there are steps one can take to protect their disclosure.

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Any Questions?

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