

Documentation is King (or Queen)

This edition of the Coding Corner is deviating from the traditional fare of advice about how to justify coding for particular conditions or how to choose the proper diagnosis or procedure codes. A core value within all of those types of discussions is documentation. As the EyeCodeRight team unveiled the draft of our application at the AOA meeting in Las Vegas in June, one of the most common themes was the doctors interest in utilizing a recordkeeping system that improves their documentation.

Not that optometrists will ever directly admit that they need to better document their eye care services. We each commit to our patients to do the best possible job for them, and that includes taking good notes about their history and exam because that information tells us about what we can do for the patients now and also later. But in our heart of hearts, we all know that we have taken liberties with documentation that include shortcuts, justifications to writing less because it “makes sense to me,” and flat out establishing protocols that would not pass muster with an outside auditor.

The most likely reason that all health care providers started to create systems that only made sense to them was that no one else really needed to know what was in the patient chart. Sure, a patient might move and the record might be sent off to another doctor, but does anyone really care if they can read the entries? The health care systems started to care about what information was being kept in the medical record, either to justify payments on claims or to monitor outcomes in order to achieve national quality standards for accreditation. Perhaps the most important factor was finally becoming important: good records mean good patient care.

Documentation is king (or queen, whichever suits you.) With the federal government expecting the health care systems to adopt electronic health records in the next five years or slightly longer, a standard is being established in documentation of health care services. Adapting to this standard of excellence in documentation now is critical to being a good health care provider. The first step in adapting is admitting that you can do a better job, and that means putting your ego aside and admitting that you can change and you can learn to do things differently. When I have done chart reviews both as a consultant and more recently just as a friend, the critique that is delivered is often not easily accepted. If you have an open mind to your documentation, you will accept these three most common critiques of optometric recordkeeping.

1) If it wasn't recorded, it wasn't done. The historical OEP 21 point exam had an interesting built-in value: the doctor had to note a finding for each point of the exam, from keratometry to accommodation to ocular health. Today's optometrist might still use a part of that sequence, 7a for example, but there is not a standard that is easily put onto paper. As optometry entered the health care arena in addition to their vision care service, the patient visit entered a winding path of service that might have the same core categories as the 21 point exam, but the expectation is that the doctor has even more responsibility to the patient's overall wellness: history

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about vision, history about health, history about family, entrance tests, refractive testing, health testing. Doctors who want to make that process easier have been known to only record the findings of their exam that are significant, or “positive.”

For example, a patient comes in stating that she is visiting for a “routine” eye exam. The staff and doctor ask about any possible eye symptoms or signs, and the patient politely shakes off any of those issues. If these “pertinent negatives” are not noted, the documentation fails to show that the care was widely attentive to any possible patient concerns. Then during the exam, the biomicroscope findings are pretty much normal, but instead of recording each of the subcategories of the assessment as “clear,” “normal,” or “within normal limits,” the doctor just records “Slit Lamp OK OU.” Again, the documentation fails to fairly represent the depth of care that the doctor has provided. Finally, the exam turns out to be pretty much normal as she stated when she came into the office, and the final entry in the chart is “Check one year.” Failing to provide an assessment and attending plan, even if things are normal overall, means that only the doctor who performed the service can assuredly say that the patient underwent a very important health care service. The solution is to record everything that was done, because it can matter to the patient’s care at that time and certainly in the future.

2) If it isn’t legible, it wasn’t recorded, so it wasn’t done. Handwriting is a stereotypical weakpoint for many health care providers. Optometrists must remember that they will not have any problem if their records are a haven of excellent handwriting. When it comes to having the data recorded legibly, the adage is that what can be read is what counts. The qualifying statement to that one is that the handwriting must be legible to someone else, not just the doctor of record. Whether the recipient of the record is another health care provider, optometrist most likely, or a health insurance auditor, the notes must be able to fairly represent the visit’s content. Poor handwriting is the equivalent to not writing anything.

3) Each visit must stand for itself. As problem-oriented medical recordkeeping (POMR) became common in the 1980’s, charts were expected to be roadmaps of the care that was provided. It wasn’t enough to simply record the name and the result of the exam. The convention became that the health care services being delivered were to be focused to the problems of the patient. Recording positive findings was important, but recording pertinent negatives was the most important aspect of documentation. Today, it is expected that a visit is recorded from start to finish as its own story, even if the patient has been in the office five straight days. The Reason For Visit (otherwise known as Chief Complaint) is recorded as the patient’s own words PLUS any previous reasons that were noted in the doctor’s previous visit with the patient, and those must all be re-identified at the beginning of the subsequent visit. This is a weakpoint for many optometric charts because of the inaccurate assumption that the previous visit stands as some sort of record for today’s visit; it does not. While it is entirely to link the visits with a notation in the history section that says “See notes from visit on XX/XX/XXXX” it must be noted as such. Electronic health records of the future will do this task automatically for the doctor, streamlining care and improving service to the patient.