TIPS FOR MAKING AN ASC'S MEDICAL RECORDS MORE COMPLIANT

Vanessa Sindell

Medical records are legal documents, and it is critically important they are consistently accurate, thorough, and organized. You only have to be deposed once to fully appreciate the importance of the medical record. Months or years after a procedure was performed, it is the only thing you have to rely upon to defend your position.

For most surgery centers, medical record documentation is a never-ending and ever-evolving challenge. The primary challenge is in the continuing mandates from regulatory bodies such as Medicare and accrediting bodies that dictate precisely how and what must be included in a medical record.

While the regulations surrounding medical record documentation are relatively easy to interpret, the hard part for ASC staff and management is capturing it all 100% of the time. This is especially true when it comes to physician documentation. An ASC is a unique entity in that it is required to include documents that originate from both the ASC and the physician office. In essence, the ASC must have policies and systems in place to manage its own medical record documentation and get what it needs from the physician offices.

PHYSICIAN DOCUMENTATION CHALLENGES

Here are the most common challenges in capturing physician documentation.

Signatures with correct dates and times. Physician signatures are required at specific times throughout a surgical encounter. For example, the surgeon is required to perform a pre-surgical assessment on the patient and document this assessment prior to the patient's transfer to the operating room (OR). While most surgeons do perform this assessment, the actual signature, date, and time are hard to obtain. If the chart is not open, available, and marked to indicate where the signature is required, it will most likely be missed.

Signature, date, and time are also required on the discharge order. If allowed, many physicians will sign the discharge order in the OR prior to transfer to the post-anesthesia care unit (PACU). However, the discharge order should be written in the PACU to ensure the patient is stable and that the time correlates with the patient's arrival in PACU and discharge from the facility.

The ASC must also capture the anesthesiologist's signature several times during a patient's stay. Anesthesiologists must assess the patient prior to surgery and sign a consent form after reviewing the risks of anesthesia with the patient. They must also write a discharge order postoperatively.

Complete, accurate history and physicals. CMS mandates that comprehensive medical histories and physical examinations (H&Ps) be performed and documented for every patient within 30 days of surgery. Most ASCs expect H&Ps from the physician office. (Some ophthalmologists send patients to their primary care physician [PCP] to conduct the H&P.)

It is clear why this can be challenging; many PCPs are unfamiliar with ASC documentation standards. Frequently, they send a document that states the patient is

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cleared for surgery. This does not meet the "comprehensive H&P" standard and is unacceptable. Having a standardized, easy-to-complete form for the patient to give to his or her PCP can help to ensure the ASC gets what it needs.

Operative reports that are accurate and signed in a timely manner. This is the most challenging documentation issue with operative reports. It is imperative to provide surgeons with a quiet space where they can review their op reports. Handing them their charts during cases or at the end of the day almost guarantees that they will not review them.

Physician orders that are complete and accurate. Physician orders must be completed and signed prior to implementing the order; no action can be taken on a patient without a physician order. For surgeons who frequently perform the same procedure, a pre-printed order form improves efficiency.

The pre-op orders must be authenticated (signed) and transmitted to the ASC from the physician office prior to patient arrival at the ASC. Failure to do so may delay surgery. Even when a nurse takes a verbal order, it must be documented and signed by the ordering physician. Everything a nurse does to a patient must have an order, even that extra drop of tetracaine given in the OR.

EMR CHALLENGES

Electronic medical record users don't have it any easier. Getting a surgeon to sign a piece of paper is hard enough; requiring him/her to log into a computer and sign and post the correct time can be nearly impossible. Often in electronic charting the time is auto-filled, meaning the surgeon can't sign the H&P after the surgery is done. Therefore, the ASC staff must consistently manage when and what the physicians are documenting to ensure all the times match and make sense.

EASIER PROCESS

How can the medical record documentation process be made easier? Start by making the process easier on the medical staff. Here's how:

- Create user-friendly forms.
- Educate the physician office staff on the forms and Medicare requirements surrounding H&Ps and other physician orders.
- Clearly mark where on the medical record the physician needs to sign.
- Provide a separate, quiet environment for surgeons to complete their op reports and other documentation. Having refreshments and snacks available won't hurt and might encourage them to read their op reports.
- Provide surgeons with pens and the tools needed to complete the records. I once embroidered a pen holder with the name of a doctor who frequently made the excuse, "I don't have a pen." After I gave it to him, he rarely missed a signature.
- Get a large white board to track who is (and who isn't) completing medical record documentation. Post it by the scrub sink or in the lounge. This can be a very effective tool; nobody wants to look bad. You can also make it a competition; the surgeon who has the most complete and accurate medical records for the month wins a gift card.

COMPLIANT DOCUMENTATION

One of the worst things an ASC can do is become complacent with its documentation; it is not something that can be overlooked. *AE*

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