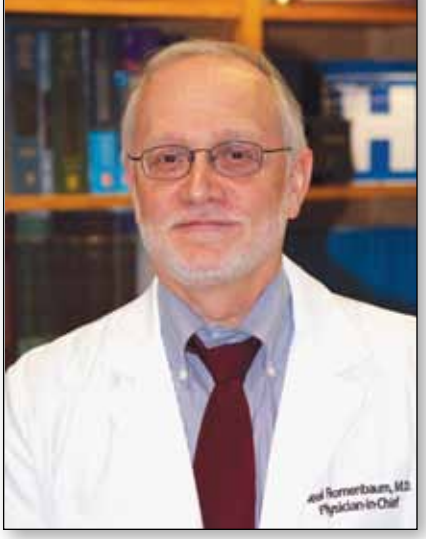
EDITORIAL

Neal Flomenbaum, MD
EDITOR-IN-CHIEF



WNL

Long before personal computers and electronic medical records appeared, physicians used abbreviations in their notes to save time. In many charts, the initials "WNL" appeared next to almost every organ system considered or examined. Although intended to mean "within normal limits," many of us soon came to interpret the abbreviation as "we never looked." I was reminded of this by a September 21 front-page article in the *New York Times* entitled "Medicare Bills Rise as Records Turn Electronic." According to the article, "Hospitals received $1 billion more in Medicare reimbursements in 2010 than they did five years earlier, at least in part by changing the billing codes they assign to patients in emergency rooms." The article went on to link the sharp rise in coding for the highest level of treatment with the hospitals' change to using electronic medical records (EMRs). It should come as no surprise that the rapid adoption of EMRs, driven by Federal incentives to hospitals and physicians, is currently a mixed blessing. That EMR problems should become evident in *ED records* early on is the latest painful reminder of EM's role as the medical "canary in the coal mine."

Many ED patients are clearly benefiting from such EMR features as safe and appropriate medication dosing, avoidance of dangerous drug interactions, medication reconciliation, printed discharge instructions, and elimination of illegible handwritten notes. At the same time, ED use of EMRs has probably been more problematic than anywhere else in the hospital. The different style, length, and content of ED physician notes, compared with those written on inpatient services, and inadequate hospital-wide "down-time procedures" for the short lengths of stay of ED patients, suggest that "one size [of EMRs] does not fit all," as I wrote in January 2011. Because the quantity and quality of physician notes also determine reimbursement under the present payment system, another serious and ugly concern arises.

A particular documentation issue results from the use of EMRs that contain nonspecific check boxes for "normal" histories or physical exams, but then generate detailed descriptions of organs that may or may not have been examined that thoroughly. From a patient care perspective, such boxes, along with the use of templates, and the copy-and-paste functions of software programs, can easily undermine the credibility of all medical records generated that way, while leading to higher reimbursement claims based on the number of different organ system exams "documented."

Like "WNL," templates for procedure notes and specific complaints or diagnoses predate the switch to EMRs and can facilitate appropriate evaluations and treatments while saving time for busy, multitasking physicians. But templates are acceptable only if patient-specific information must be inserted into the template for each new patient. Similarly, the ability to copy and paste relevant information obtained from other providers into a note can be helpful if the true source of that information is clear to everyone. An easy fix here is to ensure that all pasted notes appear in a different color than the rest of the record, eliminating any misunderstandings about originality and timeliness, or erroneous calculations of reimbursement rates.

Before EMRs, "ER" charts provided only very limited space for freestyle descriptions of complaints, histories, and exam findings; much billable information—especially negative or normal findings—were never recorded, coded, or billed. With limited time and competing needs of other patients, most EPs didn't bother including in their notes anything but the most important relevant information, although they had obtained the findings and factored them into their evaluations and treatments.

No one is seriously advocating a return to the "good old days" with their "good old problems." But the new problems are now evident, so we need to fix them *now*! **EM**