



Improving anesthesia documentation compliance through integration of alert systems and electronic health records

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Abstract:

The eligibility requirements to guarantee payor reimbursements for anesthesia services is becoming increasingly stringent. Institutions must comply with documentation standards set by the Center for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC). Such documentations often involve recordings of clinical events at specific times and attestations affirming that a particular assessment or procedure is performed. Alert systems have been implemented throughout numerous industries to reduce mistakes and enhance efficiency through improved quality control. In healthcare, alerts are sent by clinical decision support (CDS) systems integrated with electronic medical records (EMR) to assist healthcare providers, either by a passive alert system or an active system with real-time guidance. By analyzing clinical data and deviations from hospital standards in the EMR, CDS systems can potentially improve the quality of patient care, reimbursements, and compliance with regulatory requirements.

Biography:

A practicing physician in the field of healthcare in the state of Kerala in India for the last 30 years and very much interested in basic research. My interest is spread across the fever, inflammation and back pain. I am a writer. I already printed and published nine books in these sub-



jects. I wrote hundreds of articles in various magazines.

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