Mitigating Coding Risks in the EHR: Physician Coders More Valuable With EHR Implementation

By Kim Huey, MJ, CPC, CCS-P, PCS

Though it may seem contrary to popular opinion, electronic health record (EHR) products will make providers' coders more necessary and valuable than ever. Physicians who trust only EHR and computer-assisted coding software to choose the codes they bill, without any training or oversight, are setting themselves up for audits, payer recoupments, and possibly fines and penalties.

In September 2012, the Center for Public Integrity released the results of a study on changes in coding by doctors and hospitals for the 10 year period from 2001 to 2010. The study found that thousands of providers moved to higher-paying codes, without evidence that patients' cases are more complex or that physicians are spending more time with each patient. The conclusions of the study are that at least some of the increase in coding is due to a more pervasive use of EHRs, which make it easier to create detailed documentation of each encounter.

Beware the Dangers of Cloning

As part of their 2013 Work Plan, the Office of Inspector General is conducting a study on the effects of electronic health records on documentation and coding:

> We will determine the extent to which CMS made potentially inappropriate payments for E/M services in 2010 and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service on the basis of the content of the service and have documentation to support the level of service reported.

For several years, Medicare contractors and other payers have warned providers against using the EHR to clone medical record documentation. In a 2006 Medicare Part B newsletter, First Coast Service Options, CMS' Medicare contractor for Puerto Rico, the US Virgin Islands, and Florida, defined cloning as:

> Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

However, many providers will argue that a normal examination is a normal examination, and will often be described in the same words-whether those words are clicked, selected from a template, or dictated.

For example, in a recent Zone Program Integrity Contractor audit in the southeastern region of the US, the reviewer refused to credit any examination elements that were documented the same from one visit to the next. For example, if the musculoskeletal system examination was documented with the same wording from one visit to the next, the reviewer assumed that this meant the system was not examined at all. This is not supported by coding regulations, and the physician is in the process of an appeal, but the costs of such a defense will be significant. In this situation, the physician simply had very limited understanding of coding and never overrode the code automatically chosen by the system.

Use of templated documentation without proper training and review may also create contradictions in the medical record. A Review of Systems run through a template may indicate "No abdominal pain," when the chief complaint is indeed abdominal

pain. Medically implausible documentation may occur, as seen in a recent audit that found the following included in the record of a six-month-old infant: "Normal gait and station. Intact recent and remote memory. Able to repeat key words and phrases."

Human Coders Assist with Meaningful Use

Another concern is that many elements documented for the Centers for Medicare and Medicaid Services' "meaningful use" EHR Incentive Program may not be medically necessary to treat the patient's complaint on the date of service. The code generator included in most EHR software would have no way to distinguish between medically necessary elements and extraneous elements that were documented for other reasons.

For example, meaningful use requires bringing a problem list forward from one visit to the next, but all previous problems may not have been addressed at the current visit. If the coding software is programmed to count all documented problems toward the complexity of the visit, then a higher level code may be generated. Documentation of three vital signs may be a requirement for meaningful use but it may not be necessary to treat an orthopaedic problem. The EHR code generator would not know whether it was appropriate to count it or not.

In an October 4, 2012 letter to Department of Health and Human Services Secretary Kathleen Sebelius, Congress responded to the findings of an investigation regarding upcoding and the use of EHRs: "Perhaps not surprisingly, your EHR incentive program appears to be doing more harm than good."

Coding Training Necessary, Even with EHRs

Many physicians have not been appropriately trained in diagnosis documentation and coding prior to implementation of the EHR. Many systems use search functions, or "drop-down boxes," for a physician to choose the diagnoses as part of the Assessment and Plan. However, if the physician is not aware of the correct wording of the ICD-9-CM code descriptions or the coding guidelines, incorrect codes are chosen. In one recent audit, a physician had consistently chosen the code 642.00, Benign essential hypertension complicating pregnancy, childbirth, and the puerperium for all his patients despite being a family practice physician that treated elderly male and female patients.

Practices with the most efficient use of the EHR will personalize the diagnosis code descriptions with wording that their physicians will actually recognize and use. It is also helpful to upload only the diagnoses the physician would use rather than the entire ICD-9-CM Coding Manual. A physician who never sees pregnant patients would not have to wade through the maternity codes; a physician who never sees children would not have to sort through the newborn codes.

In some EHRs, if a provider can't easily find the diagnosis in the search function or drop-down box, there may be no way to document it at all, thus leaving the medical record incomplete. And for procedure documentation, the EHR will sometimes input the CPT or HCPCS description word-for-word. Rather than "Arthrocentesis, aspiration and/or injection; major joint or bursa," medical necessity and professional liability would require more specific documentation, including technique, medications used, and which joint was injected.

EHR Coding Software Requires Vetting

The most compliant EHR systems have had both physician and coding input during their implementation. Expecting to take a product "off the shelf" and use the included documentation and coding tools without adequate physician training or personalization to the practice is unrealistic. Questions to consider when implementing an EHR in a physician practice include:

1. Is the code generator programmed for 1995 or 1997 CMS Documentation Guidelines? The examination portion of the 1995 Documentation Guidelines is very subjective, especially when choosing between an expanded problem-focused examination and a detailed examination. Some vendors have chosen to use the 1997 General Multi-system Guidelines for that reason. Doing so, however, unnecessarily limits physician coding choices-usually to a lower level of service.
2. Has the EHR code generator been programmed to account for medical policies specific to the local Medicare contractor? If the vendor is not familiar with the local Medicare contractor policies on evaluation and management, then the codes chosen may not be in compliance with those policies.
3. How does the code generator account for a dictated History of Present Illness? Many physicians are not happy with the appearance of a HPI in template form and choose instead to enter the information with free-text. If the physician

does not enter information into the template, the software will be unable to count it appropriately.

4. How does the code generator distinguish between the levels of medical decision-making? What will the physician have to enter, for example, for the software to recognize "New problem with additional workup" or "Established problem, worsening"?
5. Is the physician able to choose to use only part of a template or to personalize a template? Are there multiple templates, personalized for complaint or diagnosis? A comprehensive history and examination would not be medically necessary for a minor complaint in an otherwise healthy patient, regardless of the fact that it is easily documented with one click.
6. Have the physicians been educated in diagnosis coding? For example, do they know that correct diagnosis coding for diabetes with complications will require that they choose two codes for each complication-one for the diabetes code, and one for the specific manifestation? Has the diagnosis code listing in the EHR been personalized for that practice and that physician?
7. Is the physician able to override the code chosen by the EHR? Does he have sufficient understanding of the coding documentation guidelines to determine that the EHR has assigned an inappropriate code? Some systems may allow the physician to override only if he is choosing a lower-valued code, but in some cases, a higher code may be appropriate if the EHR code generator has not recognized some of the information entered.

Prepare Now to Prevent Future Risk

EHR systems have the potential to streamline documentation, to prevent overutilization caused by duplication of services, and to improve the quality of care. Without careful consideration of all the intricacies of information going both in and out of the system, however, providers will be subject to increased liability for incorrect coding and possible fraud and abuse investigations.

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Kim Huey (kim@kimthecoder.com) is president at KGG Coding and Reimbursement Consulting.

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