Coding consultants explain where the risks are and how to avoid them.

By Ken Terry
TECHNOLOGY EDITOR

It's long been known that physicians tend to code higher for office visits after they get EHRs. But now Medicare and private payers are taking an active interest in this trend, and audits of computerized practices are becoming more frequent. So if you have an EHR, be very careful how you code, say coding consultants.

Joan Gilhooley, a consultant in Deer Park, IL, cites the case of an internist who was billing "a substantial number" of level 4 visits. A Medicare audit showed a pattern of nearly identical information in all of the records reviewed in his EHR. This physician appeared to be documenting a complete physical, a review of systems, and a family and social history in every encounter. He was potentially facing not only a civil charge of upcoding, but also the possibility of criminal fraud charges. Fortunately, his lawyer managed to establish that none of this was intentional: The physician's poorly trained staff had simply pulled in information from previous records for the doctor to consult when he saw each patient. So in this case, the government settled instead of going forward with the case.

Gilhooley tells this story to caution physicians against purchasing EHRs in order to increase their revenues. That may be a side benefit if they've been undercoding all along, as many doctors do. But that isn't why they should buy an EHR, she says. Vendors who promise that physicians will see a big return on investment from more appropriate coding, she maintains, just aren't paying attention to the Medicare coding rules.

Those rules, which set the standard for private payers, do not equate coding level with volume of documentation, she stresses. While EHRs help physicians document better, she says, "it still boils down to problem severity. If there's a mismatch between severity and the level of service, as calculat-
ed by the volume of documentation, they shouldn’t bill that higher level of service.”

Virginia Martin, a consultant in Waterville, OH, says she’s done internal audits of EHR-equipped practices that documented comprehensive exams and past histories when patients visited for minor problems. “The medical decision-making is really what determines the level of care; the history and the exam should be appropriate to the presenting problem,” she says.

Having staffers take most of the history is one reason why documentation goes awry, she adds. “Staff members can perform certain portions of the patient encounter, and they should not go beyond that.”

Over-documentation can also be related to how a physician uses an EHR, Martin points out. If a physician implements the system without customizing the EHR templates to his practice style, “the templates may contain more information than what he’s used to
documenting. So it appears that the history and the exam are more complex, but the medical decision-making level is low.

Martin and Gilhooly both advise physicians to spend time building their templates. "Be brutally honest with yourself."

"A revenue bump may be a benefit of using an EHR for doctors who have been undercoding, but it shouldn't be the reason they buy one."

Gilhooly adds. "Saying that you typically do an eight-organ system exam on every patient who walks in the door isn't being honest with yourself."

Pulling in past notes and charting by exception
You can often speed documentation, Martin points out, by copying part of an earlier visit note that deals with the problem at hand. "So if it's a routine hypertensive checkup after three months, it's not necessary to redocument; you just go back and edit what's different. The problem is that some doctors are so busy that they don't go back and edit appropriately. They're ordering labs or other tests, and there's no support in the documentation for the ordering of those tests. Or they bring the last visit over to the EHR, and now the patient has a new complaint that's never addressed in the note; for instance, chest pain or arthritic changes."

She also cautions physicians about a common practice known as "charting by exception." In this approach, the doctor sets up the EHR to record normal findings except where he indicates that they're abnormal. While this can facilitate documentation, it's essential to edit these documents carefully to make sure that you actually performed every item.

"It's no different than bringing forward notes from the last visit, when the doctor doesn't take time to edit that and make sure that it represents the patient's current problem," says Martin. "If you haven't done it, you shouldn't document it."

Gilhooly agrees that it's easy to make mistakes when charting by exception. But Kenneth R. Kubitschek, an internist in Asheville, NC, who has used an EHR for many years, says there's nothing wrong with charting this way if you do it right. "It all depends on how you utilize the tool. The key is, are you doing the work you're documenting or not. Because if you're doing the work and documenting it properly, whether you do it by exception or not, that's appropriate."

E&M coders can help, but not to justify codes
Many EHRs have a feature, known as an "E&M coder," that indicates which code level matches the documentation of a visit. (Conversely, if a physician enters a particular code, the E&M coder might tell him what's missing from his note to justify that code.) But the consultants strongly advise physicians not to rely on such devices to pick codes for them.

E&M coders count the elements of the documentation needed for a particular level, but they don't tell you whether it was medically necessary to do all that work, notes Martin. Gilhooly calls this "a huge risk" for doctors. "The level-of-service calculator function shouldn't be turned on for a physician until the physician has demonstrated competence in the selection of the correct E&M code," she says.

But Kubitschek, who rarely uses the E&M calculator in his EHR, says it can help educate novice physicians who are still learning how to code. It can also prompt doctors to be more thorough in documentation, notes Barbara Pappadakis, a coding expert and the director of network operations and government affairs for the Union Pacific Railroad Employees Health Systems. If that results in physicians coding higher because they fill in something they did that they left out, she says, more power to them. But if they're trying to cheat payers, she says, they'll get caught eventually.

How payers ferret out improper documentation
Health plans and self-insured companies like Union Pacific use a variety of methods to
catch cheaters. "One of the things they look for is a doctor claiming multiple diagnoses that don't exist in the patient's medical records at the insurance company," says Papadakis. "We know what the patients' diagnoses are. So does Medicare. And when you start popping up with a bunch of new diagnoses, there's a tip. So make sure your diagnoses are backed by clinical and lab findings.

"As long as the diagnoses support the level of service being billed, there should be no problem with any insurer. But you can't have the majority of your patients coming up with a level 4 or 5 visit. It doesn't make a lot of sense. And it's going to pop right out."

Another red flag waves, Gilhooley says, when a physician's notes all look the same. That kind of cookie-cutter documentation was what attracted auditors' attention in the case cited above. And, if a physician doesn't edit his notes properly, she notes, they'll have internal inconsistencies. "I've seen 'gait normal' recorded for patients whose history indicates they're a below-the-knee amputee. Another example: in a review of systems, the default is 'no shortness of breath' under respiratory.' However, in the HPI, the physician indicates that the patient was complaining of intermitent shortness of breath."

Even if you don't intend to cheat, the improper use of an EHR can lead to mismatches between medical necessity and documentation. Frank Cohen, a senior analyst with MIT Solutions in Clearwater, FL, recently studied coding patterns of seven practices before and after they implemented EHRs. He found an increase in their average level of coding, as well as in "medical necessity issues" that he attributed to over-documentation. Not coincidentally, five of the practices saw more of their claims denied or downcoded than previously.

The bottom line is that you have to document as scrupulously in EHRs as you do on paper. "You simply have to document what you do," says Kubitschek. "An EHR gives you the capacity to do that more efficiently. But if you didn't do it, don't document it, just because it's easy to do."

---

**Custom Reprints**

Custom reprint and ePrints of articles and features from Medical Economics create powerful marketing tools that serve as instantly credible endorsements. Use them to maximize your marketing initiatives and strengthen your brand's value.

Take full advantage of this marketing opportunity and publicize your accomplishments through a variety of customized reprint offerings.

**Utilize our various customized products for:**

- Sales Aids
- Web ePrints
- Tradeshow Handouts
- Media Kit Supplements
- Educational Programs
- Direct Mail Campaigns
- Recognition/Investor Confidence
- Presentation/Speaking Engagements

**ePrints**

Capture the attention of the online audience with a package including an electronic reprint (ePrint) of a feature for your website or e-mail distribution.

---

Contact FosteReprints for information regarding reprints and additional products specifically designed to meet your needs.

FosteReprints 800-344-8915 or
advanstarreprints@fostereprints.com