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Internal Medicine Coding Alert

EHR Mythbuster: Get The Ground-Reality On 3 EHR Myths That Could Cost Your Practice Heavily

Warning: Blindly relying on your electronic system could mean payer audits.

If you are using an electronic health records (EHR) system or contemplating adding it for your family practice, you also need to know the pitfalls of the system, such as inadequate documentation or unnecessary documentation, and how you can overcome them to get your hands on deserved reimbursement.

Consider these three EHR myths to determine exactly where your EHR system could be leading you astray.

Myth 1: Exam Documentation Will Carry Over for Follow-Up Visits

If your EHR is producing documentation that is robust in one section (such as History) and thin in another (such as the Physical Examination), you may trust the device to do too much.

A coder recently told Family Practice Coding Alert that an auditor down-coded most of her E/M claims due to an empty "Physical Exam" section in the documentation. However, the practice argued that the EHR vendor had told them that patients being seen for established problems already have a physical examination documentation on file, and that the EHR will carry it over from one visit to the next.

Reality: This may be true for past medical, family, and social history (PFSH), but not for a physical examination.

E/M guidelines state that if a patient's PFSH has not changed since a prior visit, your provider does not need to document the information again, says **Elizabeth Hollingshead, CPC, CUC, CMC, CMSCS,** corporate billing/coding manager of Northwest Columbus Urology Inc. in Marysville, Ohio. He does, however, need to document that he reviewed the previous information to be sure it's up to date and also note in the present encounter's documentation the date of acquisition and location of the earlier PFSH. Some payers will give no PFSH credit if you overlook one of these two criteria.

Good documentation: For instance, you can say, "I reviewed the past, family, social history with the patient taken from today's patient questionnaire and our previous visit of June 1, 2013. She reports that nothing has changed since that date."

However, there is no substitute for recording your physical exam information on each visit, Hollingshead warns. For instance, suppose the patient presented with arthritis pain in the left knee in August and you documented a full exam on that day, prescribed medications, and told her to return if the pain returns. She comes back to your practice today because that left knee pain has flared up again, and you perform a full musculoskeletal examination. To receive credit for a physical exam today, you will have to document the exam findings rather than trying to carry them over from the August visit. Even if you documented "left knee range of motion is 85 percent" in August and it is still at 85 percent, your provider should document it again today.

Myth 2: EHR's Calculation of Time Spent Qualifies You to Code Based on Time

One of the perks of electronic health records is that they typically record the date and time that you input information. In fact, many EHRs record a summary of the time spent on the record at the bottom of each visit's documentation and give a total, such as "Total time: 26 minutes, 15 seconds."

Several coders have told Family Practice Coding Alert that they have used this time calculation to select an E/M code based on time alone. For example, if the EHR says that the time spent is 25 minutes, these practices are automatically reporting 99214 for the visits, using the rationale that CPT® and Medicare guidelines allow you to code E/M services based on time alone.

Reality: The key to billing based on time is that counseling and/or coordination of care must dominate the visit, says **Barbara J. Cobuzzi, MBA, CPC, CENTC, CPCH, CPC-P, CPC-I, CHCC,** president of CRN Healthcare Solutions, a consulting firm in Tinton Falls, N.J. Therefore, you can only select an E/M code using time as the controlling factor if you meet the rules, and an EHR's notation of time spent in the record will not meet those guidelines. Instead, to bill on time alone, your provider's documentation must contain the following three elements:

- Notation of the total time spent on the encounter**,**
- Notation of the total time spent on counseling and/or coordination of care or the percentage of the visit spent on counseling/care coordination
- A description of the counseling/care coordination

For example, the following statements would allow billing based on time alone: "25 minute total office visit with 20 minutes spent on counseling about surgical options for skin cancer" or "Total encounter: 55 minutes with more than 50 percent spent on coordination of care and discussion in detail concerning this patient's worsening migraines."

In an EHR, you may not know where to put such a statement, but most of these systems will have a radio button somewhere in the software that you can press to create a comment box. As long as you enter your statement about time as indicated above anywhere in the record for the encounter, you can code based on time alone, but simply stating the total time you spent or letting the EHR calculate it for you is not adequate.

Myth 3: You Should Use the EHR's Code Selection in Every Case

Your electronic health record will most likely offer an E/M code suggestion at the end of each visit but that doesn't mean you should use that to justify all high-level codes.

Several practices have told Family Practice Coding Alert that their providers "thoroughly document" the History and Physical Exam elements for all conditions whether the nature of the presenting problem requires such detailed documentation. This leads to the ability to report high-level codes, even if the medical decision making (MDM) and medical necessity of the encounter do not support 99214 or 99215. They justify this by pointing out that established patient office visits only require two out of three key components (History, Exam, MDM). "However, keep in mind that the method of calculating MDM is not always consistent with medical necessity," Cobuzzi warns.

Reality: CMS indicates in section 30.6.1 of chapter 12 of its Medicare Claims Processing Manual that "Medical necessity is the overarching criterion for payment in addition to the individual requirements of a CPT® code." In addition, the 1995 and 1997 E/M Documentation Guidelines state, "The documentation of each patient encounter should include: reason for the encounter and **relevant** history, physical examination findings and prior diagnostic test results."

If your patient has a urinary tract infection and you're documenting a complete neurological exam, Medicare (and most other payers) would not consider that "relevant," Cobuzzi explains.

Therefore, you should use your EHR's code selection only as a suggestion, but the final code choice should be up to the clinician, and should be based on medical necessity and the nature of the presenting problem as well as the other key components of the service.