Part B Insider (Multispecialty) Coding Alert

ELECTRONIC HEALTH RECORDS: Beware--Too Much Cutting And Pasting Could Wound You

Will your doctor's E/M notes stand up to EHR audit scrutiny?

Your electronic health records (EHRs) could soon need an upgrade.

RTI International (RTI) just released a draft version of anti-fraud standards for EHRs. The standards could put more pressure on your doctor to support evaluation & management levels in documentation. RTI convened a panel of experts to suggest ways that EHRs could guard against fraud and incorrect billing. The experts said EHRs should:

- Make sure cut-and-pasted documentation keeps the **original time-and-date** stamp from the records it was cut from. (But if the doctor cuts and pastes from one patient's record to another, the pasted documentation won't include the first patient's name or Medicare number.)

- Flag records where the doctor is **choosing an E/M** level the documentation doesn't support. Current standards from the **Certification Commission for Healthcare Information Technology** (CCHIT) say that EHRs should -prompt for data required to determine appropriate [E/M] codes if such data is not present in encounter data.-

The RTI experts said that it's appropriate for EHRs to calculate an E/M code based on the doctor's documentation. But it's not okay for EHRs to suggest that the doctor could raise the E/M level if he or she added certain additional documentation.

- Include **audit functions**, and allow auditors to access notes.
- Require the doctor to include the **correct national provider identifier** (NPI) to prevent confusion about who entered the documentation.
- Check the **credentials of each user** to make sure they-re qualified for the services they-re providing.
- Support **security measures** such as strong passwords or biometrics.
- Allow auditors to view **how each visit note was entered** (by voice, by keyboard, or by cut-and-paste).
- **Prevent unauthorized printing and viewing** of patient records by keeping track of all transfers.
- Allow **patients to access the EHR** and comment on it, so patients can help prevent fraud.
- Create a **link from the claim to the documentation** that supports it.

-There needs to be some point in the process of documenting an encounter when that documentation cannot be altered without retaining an audit trail of the original entry,- the draft standards say. In other words, the system should note if any changes were made after the doctor -signs- the note or the practice -closes- the encounter.

What's next: Once the standards are finalized, RTI will work with organizations that certify EHR software to incorporate them. The organizations- members will vote on the standards and may make some changes, says **Colleen McCue**, the RTI project director.