# Part B Insider (Multispecialty) Coding Alert

## ELECTRONIC HEALTH RECORDS: Talk To Your Vendor Now About Improving Your EHR System

**Even the best documentation may not stand up in court**

Don't wait until **RTI International** finalizes its new standards for electronic health records (EHRs) before you assess your recoding practices, experts urge. Practices should start contacting their vendors to make sure they are aware of upcoming changes to the guidelines, urges **Catherine Brink**, president of **Healthcare Resource Management** in Spring Lake, NJ. You should also inform your physicians and staff of these new standards.

**Problem #1:** Most of the EHR systems out there right now don't meet Health Insurance Portability and Accountability Act (HIPAA) standards, notes **Pati Trites** with **Health Care Compliance Resources** in Augusta, MI, who has studied EHRs (See PBI, Vol. 7, No. 11). Plus, these records won't stand up in court as a medical record. They -may be seen as hearsay,- she adds.

**Problem #2:** Some systems will allow you to keep records -open- indefinitely, meaning that staff can keep making invisible changes to the visit notes for months or even years. Other systems will allow you to turn the audit trail on and off, so changes can happen off the radar. If a Medicare auditor asks to see the audit trail, you don't want him or her to see that documentation hasn't been completed for claims you submitted months ago, Trites adds.

**Tip:** Only those who -need to know- should be allowed to make changes in the medical record, stresses Brink. Otherwise, your EHR is out of compliance with HIPAA.

**Warning:** Your EHR may be encouraging your doctor to upcode E/M visits, Trites adds. Some EHR products will display a -stop- or -caution- light if your doctor hasn't included enough documentation to -earn- a high-level E/M code. Others will allow a doctor to click -established patient, level four- and they-ll fill in all the required documentation--even if the doctor didn't perform all of the examinations listed.

Your EHR shouldn't be suggesting things your doctor can add to achieve a higher level code, Trites stresses. You should also guard against winding up with four pages of detailed documentation for a patient who came in with a sore throat.

At the same time, you should make sure your EHR does warn your doctor that he/she may be upcoding based on the documentation entered, Brink says.

**Note:** One EHR product allows a doctor to press a button that says -make me the author,- and he-ll become the author of the documentation, even if someone else dictated it originally. The vendor charges practices $5,000 to remove that function, because it's a software change, Trites fumes.

**Teach your doctors:** Make sure everyone in your office understands what -cloned- or -pattern- documentation is Brink advises--documentation that your doctor has cut and pasted from a template or previous record. Organize an external audit of your E/M documentation to look for notes that don't look as if they apply to the patient in question, she adds.

**Bottom line:** The new standards shouldn't mean more work for your office, says **Colleen McCue**, project manager with RTI. They should make it easier to keep track of who did what, and they may even improve the way your office processes information. The main goal of the standards is to make information more reliable.