Part B Insider (Multispecialty) Coding Alert

Electronic Medical Records: Beware "Canned Documentation," Coding By Numbers, With EMRs

EMR may cause problems with documenting services, proving necessity

If you're considering obtaining an electronic medical record solution, you should be aware of potential downsides with this miracle device. Some experts warn of compliance and malpractice implications with an electronic system. And no matter how much documentation you amass, don't bill for medically unnecessary services.
Whether the EMR will enable you to code better or gain more reimbursement depends on how you use it, says consultant **Robert Burleigh** with **Brandywine Healthcare Services** in Malvern, PA. "It's just a tool," he points out. In a practice with five physicians, there's no guarantee that all five will use it the same way.

"The EMR is only as good as you make it," says consultant **Barb Pierce** with **Professional Management Midwes**t in Omaha, NE. "You're still going to have to perform and document the required elements" of history, examination and medical decision making, she points out. "It makes some things more automatic," she adds. "It may be a good thing or a bad thing."

The biggest problem with an EMR is that items may be carried over from the previous record as if the physician has reviewed them again. "It's the physician's responsibility to prove that he really reviewed that stuff," Pierce notes. "When I do an audit, I have to assume that the documentation for that visit is actually what happened that day."

You can have the best documentation in the world, but it still won't justify a level four office visit for a mild headache. "You have to be very careful," warns Cobuzzi. "You have to make sure there is medical necessity for that level of service." An EMR makes it very easy to provide loads of documentation for anything, "whether you need it or not."

If you obtain a good EMR, you should make sure to bill based on both medical necessity and documentation, adds Cobuzzi. It's almost malpractice to provide excessive services that the patient doesn't need.

If a patient has a cold, that wouldn't appear to justify a level four or five office visit. But if a patient has a cold, plus a compromised immune system, that may justify a higher level visit. That's where the extra documentation comes in handy, says Cobuzzi.

Leaving aside the documentation and billing requirements, the medical liability implications of "carried forward" documentation could be staggering. If the documentation states that the patient had no chest pain and then the patient drops dead of a heart attack right after leaving the physician's office, that doctor is looking at a monster lawsuit. If the EMR makes it look as though the physician updated those symptoms, "then I surely hope he did," says Pierce. "I don't like to have a lot of cookie-cutter type medicine."

The EMR should be customized for each particular patient," adds Pierce. If the system contains prompts that "remind the physician that he needs to address this or that, that's great," says Pierce. "Prompts are okay, but canned documentation isn't."

Pierce isn't sure if she's ever seen a practice that was able to code higher after implementing an EMR. She'd be glad if an EMR were allowing the practice to document more appropriately what it had been doing all along. But wearing her auditor hat, she'd also want to look into why this was happening. "If you saw something like that in an audit, you'd want to address why is it happening, and make sure it's happening for a reason."