Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Physician Note: HHS Sternly Warns Hospital Organizations of EHR Upcoding Risks

Plus: Therapy caps leading some patients to cancel appointments.

Most coders have known for years that electronic health records (EHRs) can be incredibly useful tools--but that they can also lead to inappropriate coding habits. The Department of Health and Human Services (HHS) now appears to also accept the potential for EHR errors, and sent a stern letter to several hospital associations warning them of potential audits in this area.

"False documentation of care is not just bad patient care, it's illegal," said HHS Director **Kathleen Sebelius** and Attorney General **Eric Holder** in the letter, which went to the American Hospital Association and other organizations. "These indications include potential 'cloning' of medical records in order to inflate what providers get paid. There are also reports that some hospitals may be using electronic health records to facilitate 'upcoding' of intensity of care or severity of patients' conditions as a means to profit with no commensurate improvement in the quality of care."

As the Insider reported last year and in our E/M quiz in this issue, many cases of EHR coding are not deliberate. When the physician marks that he reviewed all of the review of systems and physical exam areas, the EHR typically returns with a higher code, even if medical necessity is not met for going over all of those body systems.

Therefore, if you can't justify a high-level code for the condition you're treating, don't bill it. Go by the documentation of the medically necessary exam, history, and medical decision-making that you performed rather than the EHR-chosen code.