Health Information Compliance Alert

Beware -- Too Much EHR Cutting and Pasting Could Wound You

Your electronic health records (EHRs) could soon need an upgrade. In March, RTI International (RTI) released a draft version of anti-fraud standards for EHRs. The standards could put more pressure on your physician to support evaluation and management levels in documentation.

Get to Know the Standards

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 OK for EHRs to suggest that the doctor could raise the E/M level if he added certain additional documentation.
- Have 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.
- 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
- llow 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.

Be ready: Don't wait until RTI finalizes its new standards before you assess your recoding practices, experts say. Start contacting your vendors to make sure they are aware of upcoming changes to the guidelines. You should also inform your staff of these new standards.

Good news: The standards shouldn't mean more work for your office, McCue says. They should make it easier to keep track of who did what, and may even improve how your office processes information. The main goal is to make information more reliable.