Codify
BY AAPC

Health Information Compliance Alert

Documentation Minefields: Don't Get Misled Into Documentation Errors

Your pay might be at stake if you miss these electronic health records quirks.

It's wise to be a little wary when relying on electronic health records (EHR) to document the care your practice provides. While EHR can be a time-saving and meticulous way of creating medical records, you put your practice at risk if you overlook items required to support your code choices.

Consider these three EHR myths to see exactly where your EHR system could be leading you astray.

Myth 1: Exam Documentation Will Carry Over for Follow-Up Visits

If your EHR is producing documentation that is robust in one section (such as History) and thin in another (such as Exam), you may be trusting the device to do too much.

One practice found that an auditor downcoded most of its E/M claims due to an empty "Physical Exam" section in the documentation. However, the practice argued, the EHR vendor had told them that patients being seen for established problems already had exam documentation on file, and that the EHR would carry it over from one visit to the next.

Reality: This may be true for some cases of past medical, family, and social history (PMFSH), but not for an exam.

E/M guidelines state that if a patient's PMFSH has not changed since a prior visit, your provider doesn't have to document the information again. He does, however, need to document that he reviewed the previous information to be sure it's up to date and also note in the present encounter's documentation the date and location of the initial earlier acquisition of the PMFSH. Some payers will give no PMFSH credit if you overlook one of these criteria. For instance, you can say, "I reviewed the past, family, social history with the patient taken from today's patient questionnaire and our previous visit of June 1, 2012. She reports that nothing has changed since that date."

However, there is no substitute for recording your physical exam information on each visit. For instance, suppose the patient presented with arthritis pain in the left knee in August and you documented a full exam on that day, prescribed medications, and told her to return if the pain returns. She comes back to your practice today because her left knee pain has flared up again, and you perform a full musculoskeletal examination. To get credit for a physical exam today, you will have to document the exam findings rather than trying to carry them over from the August visit. Even if you documented "left knee range of motion is 85 percent" in August and it is still at 85 percent, you should document it again today.

Myth 2: EHR's Calculation of Time Spent Qualifies You to Code Based on Time

One of the perks of electronic health records is that they typically record the date and time that you input information. In fact, many EHRs record a summary of the time spent on the record at the bottom of each visit's documentation and give a total, such as "Total time: 26 minutes, 15 seconds."

Practices have reported that they have used this time calculation to select an E/M code. For example, if the EHR says that the time spent is 25 minutes, these practices are automatically reporting 99214 for the visits, using the rationale that CPT® and Medicare guidelines allow you to code E/M services based on time.

Reality: The key to billing based on time is that counseling and/or coordination of care must dominate the visit. Therefore, you can only select an E/M code using time as the controlling factor if you meet the rules, and an EHR's notation of time spent in the record will not meet those guidelines. Instead, your documentation must contain the following three elements:

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- Notation of the total time spent on the encounter.
- Notation of the total time spent on counseling and/or coordination of care or the percentage of the visit spent on counseling/care coordination.
- The reason for/topic of the counseling/care coordination.

For example, the following statements would allow billing based on time alone: "25 minute office visit with 20 minutes spent on counseling about surgical options for recurrent tonsillitis" or "Total encounter: 55 minutes with more than 50 percent spent on coordination of care for patient's worsening Parkinson's Disease."

In an EHR, you may not know where to put such a statement, but most of these systems will have a radio button somewhere in the software that you can press to create a comment box. As long as you enter your statement about time as indicated above anywhere in the record, you can code based on time, but simply stating the total time you spent -- or letting the EHR calculate it for you -- is not adequate.

Myth 3: You Should Use the EHR's Code Selection in Every Case

Your electronic health record will most likely offer an E/M code suggestion at the end of each visit -- but that doesn't mean you can use that to justify all high-level codes.

Several practices have said that their physicians "thoroughly document" the History and Physical Exam elements for all conditions, leading to high-level codes, even if the medical decision-making (MDM) doesn't support 99214 or 99215. They justify this by pointing out that established patient office visits only require two out of three criteria (History, Exam, MDM).

Reality: CMS indicates in its Carriers Manual that "Medical necessity is the overarching criterion for payment in addition to the individual requirements of a CPT® code." In addition, the 1995 E/M Guidelines state, "The documentation of each patient encounter should include: reason for the encounter and relevant history, physical examination findings and prior diagnostic test results."

If your patient has a runny nose and you're documenting a complete neurological exam, Medicare would not consider that "relevant."

Therefore, you should use your EHR's code selection as a suggestion, but the final code choice should be up to the clinician, and should be based on medical necessity and the nature of the presenting problem.

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