Mitigating Coding Risks in the EHR

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Concerns with electronic records and overcoding

The Center for Public Integrity – September 2012
“coding levels may be accelerating in part because of increased use of electronic health records....”

Balancing Medical Necessity and Meaningful Use

• Bringing forward medical history in an EMR is an important aspect of meaningful use

• Does this mean that you can count that comprehensive history toward the level of service for every office visit now and forevermore?
Sebelius-Holder Letter
September 24, 2012
To hospitals, but same principles apply –
“False documentation of patient care is not just bad patient care; it’s illegal. The indications include potential ‘cloning’ of records in order to inflate what providers get paid.”

Congressional Response
October 4, 2012 letter to HHS Secretary Sebelius
“...your EHR incentive program appears to be doing more harm than good.”
Request –
• Suspension of EHR bonus payments and delay penalties for providers who don’t use EHR
• Increase what’s expected of meaningful users
• Block business practices that prevent exchange of information

OIG Workplan for 2012
“We will assess the extent to which CMS made potentially inappropriate payments for E/M services and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service based upon the content of the service and have documentation to support the level of service reported.”
Results expected later this year.
What are the auditors looking for?

- Authentication – signatures, dates/times – who did what? (metadata?)
- Contradictions – between HPI and ROS, exam elements
- Wording or grammatical errors/anomalies
- Medically implausible documentation

Mitigating Coding Risks

Code Generators?
- Is the coding software programmed for the 1995 or 1997 Documentation Guidelines?
- Has the coding software been programmed to account for medical policies specific to the local Medicare contractor?
- How does the coding software manage dictated portions of the encounter such as History of Present Illness?
- How does the coding software distinguish between the levels of medical decision-making?

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Templates?
- Is the provider able to choose only part of a template or to personalize a template?
- Are there multiple templates, personalized for complaint or diagnosis?
- Are the various contributors to the encounter identified? Nursing staff, physician, etc.
Mitigating Coding Risks

Cloned Notes?
“Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.
First Coast Service Options, Medicare Part B newsletter 2006
(Definitions published by Medicare contractors as early as 1999.)

Mitigating Coding Risks

Diagnosis Coding?
• Have the physicians been educated in diagnosis coding?
• Has the diagnosis code listing been personalized for that practice and that physician?
As more payment mechanisms are based on severity of illness, correct and specific diagnosis coding becomes more important.

Mitigating Coding Risks

Final Code Selection?
• Is the physician able to override the code selected by the EHR?
• Can he/she override the code to a higher level or only to a lower level of service?
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