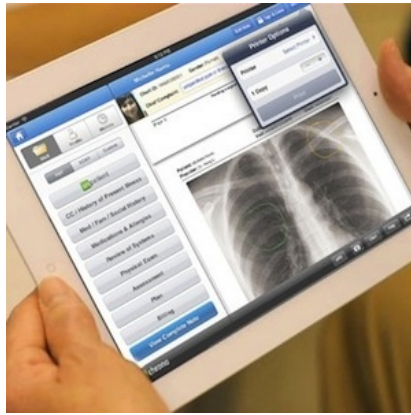




EHR Upcoding Compliance: Keep the Auditors Happy



While electronic health records (EHRs) have enabled the creation of detailed patient files there is a frustrating problem that this technology brings alongside convenience: [EHR upcoding](#).

The Centers for Medicare and Medicaid Services is very concerned about overcoding and the balancing act of combining medical necessity with meaningful use.

This is no surprise; on one side there are unscrupulous providers that upcode or game the EHR note system and on the side, conscientious clinicians who fall into the trap of documentation that can get them in hot legal water. Sometimes it is just that doctors are preoccupied or plain lazy and happy to offload the task of EHR charting to somebody else.

With EHR's approaching close to-universal adoption, it's time for hospitals to focus on data integrity, high-quality clinical documentation and ensuring doctors do not upcode improperly because it's less hassle. There's also the small issue of the audit!

See Also: [More Errors with EHR over Paper Records](#)

So what are auditors looking for when gauging medical necessity? The following may help:

Auditors want to see authentication like signatures, dates and times – in other words, metadata that tracks who did what and when;

They are keeping their eyes open for contradictions between history of present illness and review of systems;

Wording anomalies or grammatical errors stand out for auditors as they can hint at something other than above-board clinical notes;

Medically implausible documentation is also top on the list for auditors.

Key questions hospitals should be asking is about code generators and templates. For instance, has code-generating software been programmed to account for policies specific to the local Medicare contractor? Does the coding tool manage dictated portions of the encounter, like the HPI and how? How does it make a distinction between different levels of medical decision-making?

Can the provider select part of a template or personalise one? Do templates differ according to function?

Moving on to the matter of copy-and-paste, auditors can detect in an EHR where notes have been copied from another source by identifying inconsistencies in the style and content of the information.

Copy-and-paste is not necessarily wrong though

In 2014, the [American Health Information Management Association \(AHIMA\)](#) presented guidelines for correct use of copy-and-paste functionality. The aim was to promote EHR efficiency while maintaining accuracy and integrity.

AHIMA recommendations on copy-and-paste include providers, vendors, policymakers working together to devise standards for the monitoring of clinical documentation compliance.

Additionally, developers should ensure their EHRs are configurable so to enable accurate copy-and-paste.

Furthermore, AHIMA has suggested that the Office of the National Coordinator for Health IT and the National Institutes of Standards and Technology be more dynamic in the process of documentation.

Source: [Healthcare IT News](#)

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