CHAPTER TWELVE
LESSON ONE

EHR Coding and Reimbursement
The EHR and Reimbursement

• If findings are not documented with sufficient detail in the chart, the auditor will assume that those portions of the encounter were never performed.

• Purpose of this chapter is to help you understand the guidelines used for calculating reimbursement by analyzing a patient encounter recorded in an EHR.
EHR Helps Meet Government Mandates

- U.S. government, Medicare, and insurance regulations financially affect all healthcare facilities.
- Three factors affected by an EHR:
  - Incentives and penalties
  - Proper coding of diagnoses
  - Factors of Evaluation and Management
Incentives and Penalties

• Providers that implement and have a meaningful use of a certified EHR before 2015 are eligible for incentives.

• Meaningful Use Requirements
  – Uses a certified EHR.
  – Submits most prescriptions electronically.
  – Reports clinical quality.
Incentives and Penalties

• Meaningful Use Requirements (cont.)
  – Has an EHR that interconnects electronically for healthcare delivery.
  – Reports billing codes indicating that patient encounters were recorded using an EHR.

• After 2015, Medicare will begin to administer financial penalties for physicians and hospitals that do not use an EHR.
Incentives and Penalties

- Penalties will involve incremental reduction of provider's payments by 1 percent per year cumulating in a 5 percent reduction by the fifth year.
- By 2020, provider still using paper charts will have payments reduced by 5 percent.
HIPAA-Required Code Sets

- HIPAA law regulates privacy and security of health records.
- It also standardized healthcare transactions and required use of ICD-9-CM, CPT-4, and HCPCS code sets.
Diagnoses Codes Justify Billing

- ICD-9-CM codes are used for mortality and morbidity studies and are required for insurance claims.
- Reimbursement for most inpatient hospitals is based on Diagnostic Related Group (DRG) determined from primary and secondary diagnoses assigned by attending physician.
Diagnoses Codes Justify Billing

• For both inpatient and outpatient facilities, use of correct ICD-9-CM code on a claim explains or justifies medical reason for services being billed.

• Outpatient billing requires one or more ICD-9-CM codes be assigned to every procedure.

• Diagnosis must correspond to procedure.
Diagnoses Codes Justify Billing

- ICD-9-CM codes are three to five digits long.
- First three digits (rubric) are followed by a decimal point and up to two numerals; they further specify or refine description of condition.
- Insurance billing rules require clinicians to code to most specific level.
Diagnoses Codes Justify Billing

- Offices without an EHR print a list of diagnosis codes on the paper encounter form.
- Clinician must be careful to use same terminology in dictation as ICD-9-CM description.
Diagnoses Codes Justify Billing

- Most EHR systems contain a “cross-walk” or internal reference table that can produce ICD-9-CM codes at fourth or fifth digit specificity automatically.
- Advantage of using an EHR with a codified nomenclature is that codes billed will always be in sync with note that is produced.
Diagnoses Codes Justify Billing

- EHR allows clinician to record nuances that are beyond the scope of ICD-9-CM.
- EHR software will automatically translate assessment to correct diagnosis code, which then may be used for billing.
Diagnoses Codes Justify Billing

Figure 12-1: ICD-9-CM codes displayed in Outline View tab.
CPT-4 and HCPCS Codes

- HIPAA requires use of CPT-4 and HCPCS codes for procedures.
- HCPCS stands for Healthcare Common Procedure Coding System.
- It was developed by the CMS to code for supplies, injectable medications, and blood products.
Evaluation and Management (E&M) Codes

- CPT-4 E&M codes are used to bill for nearly every kind of patient encounter: medical office visits, inpatient hospital exams, nursing home visits, consults, emergency room (ER) doctors, and other services.
- E&M guidelines determine the CPT-4 E&M code based almost exclusively on findings documented in encounter note.
Four Levels of E&M Codes

- There are four levels of E&M codes for each type of visit.
- Level important because provider's “allowed payment” amount is proportionate to the level of the exam.
- Each category of E&M codes has at least four codes representing the four levels of service.
How the Level of an E&M Code Is Determined

- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time
How the Level of an E&M Code Is Determined

• History, examination, and medical decision make the key components in determining the level of E&M services.
• The level of each key component is determined separately.
Undercoding

• If clinicians select a code that is at a higher level than dictated note supports, they can be fined.
• To avoid risk, many practices undercode or choose a code one level below what they believe to be correct.
• This is bad for the practice financially; they are losing payment for their work.
Accurate Coding

- EHR systems that use standardized nomenclatures have a codified record of the encounter.
- This enables the software to use data in encounter note to calculate correct E&M code for billing.
- EHR systems analyze amount and type of data and accurately determine correct E&M code at the correct level.