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Ms. Safian is certified as a CCS-P by AHIMA and a CPC-H by the (AAPC). She also holds a National Certified Insurance Coding Specialist (NCICS) designation, as well as that of Certified HIPAA Administrator (CHA).

Shelley completed her Graduate Certificate in Health Care Management in June 2005 at Keller Graduate School of Management. The University of Phoenix awarded her Master of Arts/Organizational Management degree in 2002.

The Florida Association of Post-secondary Schools and Colleges (FAPSC) named Ms. Safian Faculty Member of the Year 2006 – 2007. Herzing College, Winter Park honored Shelley by naming her 2007 Teacher of the Year, and she was awarded the Faculty Scholarship Award - First Runner Up for the Herzing College System for 2006.

Ms. Safian is a volunteer AHIMA Mentor, working with health information management students from all across the country, and sits on the AHIMA Classification Practice Council. She attends local chapter meetings of the Central Florida Health Information Management Association (CFHIMA) whenever her schedule permits, and encourages her students to join her at the Florida Health Information Management Association (FHIAMA) Annual Convention every year.

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Objectives

- Discuss differences between coding from a paper-based record and an electronic health record (EHR)
- Review successful technology and coding resources used in EHR coding

Objectives

- Review internal EHR coding practices and policies
- Discuss how facilities implement EHR coding practices
“By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care.”
- President George W. Bush, State of the Union Address, January 20, 2004

- President Bush outlined a plan to ensure that most Americans have electronic health records by 2014.

In July 2004, the Department of Health and Human Services (HHS) unveiled a 10-year plan to create a new national health information infrastructure, including an EHR for every American and a new network to link health records nationwide.
Polling Question #1

What does your facility currently use to code claims?

* 1 All paper-based
* 2 Hybrid (some paper-based documents, some EHR documents)
* 3 All EHR

Coding from Paper

- Assure complete documentation:
  - Physician notes
  - Lab reports
  - Radiology reports
- Identify key terms/ phrases regarding diagnoses and procedures/ services provided
**Coding from Hybrid**

- Assure complete documentation:
  - Physician notes
  - Lab reports
  - Radiology reports
- Identify key terms/ phrases regarding diagnoses and procedures/services provided

**Coding from EHR**

- Assure complete documentation:
  - Physician notes
  - Lab reports
  - Radiology reports
- Identify key terms/ phrases regarding diagnoses and procedures/services provided
Coding from EHR

- All of the *same guidelines* for ICD-9-CM and CPT coding apply
- *Source materials differ*
- Drop down menus can force use of *consistent terms*
- *Time saved* not having to read illegible handwriting

Coding from EHR

- Human errors still affect quality
  (Excerpts from actual hospital charts)
  1. “The patient refused autopsy.”
  2. “On the 2nd day, the knee was better and on the 3rd day it disappeared.”
  3. “Discharge status: Alive but without permission.”
Coding from EHR

- Glitches and data transfer inconsistencies

Challenges to Coders

- Collection of documentation:
  - Physician dictation/transcription
  - Reports not filed or misfiled
  - Answers to queries
EHR Benefits

- No delay waiting for dictation or transcription
- Electronic filing *generally* more accurate
- Electronic queries can provide written response more quickly
- Security protections are better

EHR Benefits

- Better completion
- Faster completion
- Single entry/ multiple use
- Error reduction
- Easier to retrieve files
- More than one user at a time
Polling Question #2

What is the biggest challenge to your coding process?

* 1 Incomplete documentation
* 2 Poor or non-existent query process
* 3 Lack of coordination between departments
* 4 All of the above

EHR Records

- Accurate, complete, and fast clinical documentation is key to patient care, as well as reimbursement processes.
EHR Record Content Concerns

- Accuracy
- Compatibility
- Authenticity
- Patient identification

Accuracy Concerns in EHR

- Duplication of inaccurate data
- Pre-completed templates
- Checklists without complete details needed for coding
- Continuity from paper to EHR
**Accuracy Concerns in EHR**

- **Auto-fill coding can be a problem**
  
  *Example:*
  
  - Hypertension 401.9 is really hypertension unspecified
  - **Better:** Screen commands to get physician to specify malignant 401.0 or benign 401.1

**Accuracy Concerns in EHR**

- **Auto-fill coding can be a problem**
  
  *Example:*
  
  - Laparoscopic hysterectomy 58550 is really Uterus 250g or less
  - **Better:** Screen commands to get specific weight of removed organ – *More than* 250g 58553
Compatibility Concerns of EHR

- Laboratories/ Imaging centers
- Other healthcare facilities
- Accounting/ claims processing software

Authenticity Concerns of EHR

- Access - Use - Control
- Data input
  - Data entry
  - Modification of entries
- Confirmation of merged data accuracy
Authenticity of EHR

- Verification of user
  - Confirm *attending* physician’s NPI
- Tracking of users
  - Who has permission to enter data
  - Who has permission to read only
- Stewardship of records

Patient Identification in EHR

- Identifiers visible
  - Prevent incorrect data for patients with same/similar names
  - Who can see what data - HIPAA
- Accuracy of default data
- Update referential integrity
  - Single entry - multiple entry
Records Portability in EHR

- Chart duplication for patients
- Transfer to another physician
- Printing capability
- Audit trails
  - Electronic
  - Team

Best Practices in EHR

- Implementing E-signatures
- Core data set protection
  - Limit auto-fill coding
- Provider/ patient e-mail correspondence
- Automate tracking
- Automate back-up systems
**Resource List**

- **Useful Web Sites:**
  - HIMSS www.himss.org
  - HHS www.hhs.gov/healthit/ahic/healthrecords/

- **Other resources:**
  - “Guidelines for EHR Documentation to Prevent Fraud” Journal of AIMA, January 2007
  - AIMA e-HIM resources web page at: http://www.ahima.org/e-him/

**Resource List continued**

- **Data Content for EHR Documentation**
Audio Seminar Discussion

Following today’s live seminar
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Effective Coding Under MS-DRGs
Faculty:
James S. Kennedy, MD, CCS, and
Sharalyn Milliken, RN, JD, CPC-H
February 14, 2008

Present on Admission Reporting
Faculty:
Gail S. Garrett, RHIT and
Susan Von Kirchoff, MEd, RHIA, CCS, CCS-P
February 21, 2008
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