

Improve EHR Systems by Rethinking Medical Billing

By Daniel Essin, MA, MD | February 6, 2012

"If we screw it up, start over. Try something else."

- Lee Iacocca

Last week's post introduced the subject of the various reasons why people are motivated to [record healthcare-related information](#), what might be the appropriate place(s) to record it, and how long does it need to be retained.

I'm starting with billing because, whether one has an intrinsic interest in medical records or not, everyone wants to get paid and, for most physicians, that still involves a bill. These days, there are documentation requirements to get paid. Merely submitting a billing code is not sufficient thanks to our colleagues who have been unable to resist the urge to submit phony and inflated claims. The University of North Texas has summarized the minimum required documentation pretty well in their [Clinical Documentation and Compliance Manual](#). They include:

- The documentation of each patient encounter should include:
 - reason for the encounter and relevant history;
 - physical examination findings and prior diagnostic test results;
 - assessment, clinical impression, or diagnosis;
 - plan for care; and
 - date and legible identity of the observer.
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
- Appropriate health risk factors should be identified.
- The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
- The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

In a simple case, these items may correspond closely to what one might need to record to manage the patient but one can imagine more complex situations in which a chart entry could be much more extensive. Consider the advantages of sending this subset of information directly to the billing system at the time of the visit. The diagnosis and procedure codes that get assigned for billing have no place in the medical record. They are chosen with the specific aim of maximizing reimbursement and can be extremely misleading to anyone that assumed that they had any clinical relevance.

The second obvious advantage comes from easing HIPAA compliance. If the medical documentation for billing is stored in the billing system, there is no need for clerical staff to access the actual medical record and thus no possibility that they will discover and/or disclose something inappropriate.

Third, billing records only need to be retained for seven years; when they expire their disposal is simplified if they are not entangled in a large system designed to protect information from deletion.

The final, and perhaps most important, reason for reevaluating the way billing and billing-related processes are implemented is that big changes are in the wind. The current billing paradigm dates back to the creation Medicare in 1965. Since then, no purveyor of large-scale healthcare computer systems could be successful unless their product supported this approach to billing. In other words, it is now an integral part of the genome of every major EHR.

Under healthcare reform, the concept of the accountable care organization (ACO) presages a future in which payment is based on the number of patients seen, the nature and acuity of their problems, their co-morbidities, and the outcome. This is the new paradigm. While organizations will undoubtedly have an internal interest in knowing what resources are being consumed in providing care, the payers will (or should) lose interest in that information. The outcomes of patients that had documented (i.e. not fabricated) medical problems will be what counts. The information and data that will need to be collected by an ACO (and eventually by every practice) is entirely different from that which is now considered vital. Today's EHRs, for the most part, are not designed to gather the data required by the new paradigm rendering them obsolete. The certification criteria (patterned after those systems) are also obsolete but obsolete is now mandatory.

The value and the urgency of isolating the functions relating to the old billing paradigm in a separate module becomes clear. It will allow developers to concentrate on the clinician end of an EHR and the collection of the data that will be needed to quantitatively assess acuity and outcome. An isolated "old paradigm" billing module can be easily replaced with whatever is required by future payment schemes that have yet to be fully defined without destroying the entire EHR in the process.

This concept may be novel, but separating billing-related data from other clinical documentation and transmitting it to a billing system is not difficult. This is true regardless of whether the charting is done on paper, by dictation and transcription, or by using a computerized charting application.

Healthcare reform seeks new paradigms of care but will be difficult without a new paradigm of payment. Next week, the topic will be how to best address legal and regulatory concerns and requirements.

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