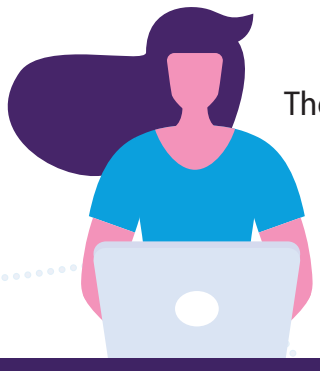
AMA | Credentialing Services



10 Regulatory Myths Debunked

The amount of information available today can be overwhelming to track. When it's not accurate, that information can be damaging. The AMA tracks and debunks regulatory myths to help clinicians focus on streamlining clinical workflow processes and improving patient outcomes. Here are 10 of the most common regulatory myths debunked:

MYTHS	FACTS
Hospitals must send ADT notifications to physicians' EHR inbox.	Hospitals are encouraged to deliver admission, discharge, and transfer notifications in a way that meets clinician preferences and prevents redundancy. **Learn more about patient event notifications.**
Physicians cannot openly discuss EHR issues.	Physicians and EHR users can openly discuss these topics as long as they don't jeopardize premarket testing and development. **Learn more about EHR gag clauses.**
HIPAA requires patient authorization to disclose PHI for treatment purposes.	Other than psychotherapy notes, HIPAA doesn't require patient authorization or consent to disclose PHI for treatment purposes. **Learn more about PHI disclosures.**
Licensing/credentialing bodies must probe into clinicians' past mental health.	Not only are they not required to ask about clinicians' past mental health, addiction or substance use history, doing so may deter physicians from seeking care. **Learn more about physician mental health inquiries.**
Physicians must sign every page of home health agency plan of care (POC) certifications/ recertifications.	CMS doesn't require physicians or allowed non-physician practitioners to sign every single page of home health POC certifications or recertifications and doing so adds unnecessary administrative work and time. **Learn more about home health agency POC certifications.**
Physicians must document time spent on each outpatient visit task.	Recent revisions to E/M codes give physicians the choice to bill office/outpatient encounters solely based on medical decision making or the total time spent face-to-face and non-face-to-face. **Learn more about documenting E/M during outpatient visits.**
Physicians are prohibited from responding to online patient reviews.	Physicians can respond, but they have to be very careful not to violate patient privacy protected by the Health Insurance Portability and Accountability Act (HIPAA) and applicable state laws. **Learn more about responding to online patient reviews.**
Physicians cannot bill for both preventive and E/M services in the same visit.	Physicians can bill for both preventive and evaluation and management (E/M) services in the same visit, but they must document all care performed and bill for what is documented. **Learn more about preventive and E/M services billing.**
Clinical support staff are required to log out of EHR between documentation.	While there is no official guidance, organizations are encouraged to document security and access policies and procedures to ensure that healthcare professionals use the EHR within the scope of their training and/or certification. **Learn more about EHR documentation requirements.**
There are strict regulatory prohibitions on the use of verbal orders.	CMS frowns upon verbal orders, however, there is no regulation prohibiting them. CMS does require that verbal orders be dated, timed, and authenticated promptly. **Learn more about verbal orders.**

See all regulatory myths debunked by the AMA:

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