



CMS-ONC Listening Session on Coding and Billing

May 3rd, 2013

CMS Auditorium, Baltimore



Today's Agenda

9:00-9:30

Welcome & Overview

- Jonathan Blum, Deputy Administrator and Director for the Center of Medicare, **CMS**
- David Muntz, Principal Deputy National Coordinator, **ONC**

9:30-11:00

Impacts of EHRs and Coding Trends

- Benjamin K. Chu, MD, 2013 Chairman, **American Hospital Association**,
Regional President, Southern California, Kaiser Foundation Health Plan and Hospitals
- Bruce Siegel, MD, MPH, President and CEO,
National Association of Public Hospitals and Health Systems
- Steven J. Stack, MD, Chair of the Board, **American Medical Association**

11:00-12:00

Developing Standards for Coding with EHRs

- Sue Bowman, MJ, RHIA, CCS, FAHIMA, Senior Director, Coding Policy and Compliance,
American Health Information Management Association
- Mickey McGlynn, Siemens Medical Solutions, Healthcare Services Chair,
Electronic Health Records Association

Today's Agenda, cont.

12:00-1:00

Break

1:00-2:00

Invited Statements on Coding Challenges

- Jason Mitchell, MD, Director of the Center for Health Information Technology, **American Academy of Family Physicians**
- Ivy Baer, Senior Director and Regulatory Counsel, Regulatory and Policy Group, Health Care Affairs, **Association of American Medical Colleges**
- Jeff Micklos, Executive Vice President, Management, Compliance, & General Counsel, **Federation of American Hospitals**
- Steven A. Wartman, MD, PhD, MACP, President and CEO, **Association of Academic Health Centers**
- Lisa Gallagher, Vice President, Technology Solutions, **Healthcare Information and Management Systems Society**
- Tom Leary, Vice President, Government Relations, **Healthcare Information and Management Systems Society**

Materials Available



http://www.cms.gov/eHealth/codingsessions_may3.html



Jonathan Blum

Deputy Administrator and Director for the
Center for Medicare
Centers for Medicare & Medicaid Services



David Muntz

Principal Deputy National Coordinator
Office of the National Coordinator of Health IT

Jacob Reider, MD

Chief Medical Officer

Office of the National Coordinator of Health IT



CMS/ONC Summit: EHRs and Provider Payment

May 3, 2013



Benjamin K. Chu, MD

2013 Chairman, American Hospital Association
Regional President, Southern California,
Kaiser Foundation Health Plan and Hospitals



Physicians and hospitals use EHRs to improve care.

- Clear view of relevant patient information
- Decision support
- Patient education and engagement
- Quality improvement
- Population health management
- Documentation also used to support billing



Electronic tools supported Kaiser Permanente's Sepsis Improvement Program.

- Early recognition of sepsis in ED critical for best clinical outcome
- Focused effort to improve sepsis care using treatment algorithms, standardized order sets and flow charts, best practice alerts, etc.
- Better clinical data led to increased number of sepsis diagnoses
- Use of electronic tools and focused clinical efforts led to more early, goal-directed therapy and improved outcomes

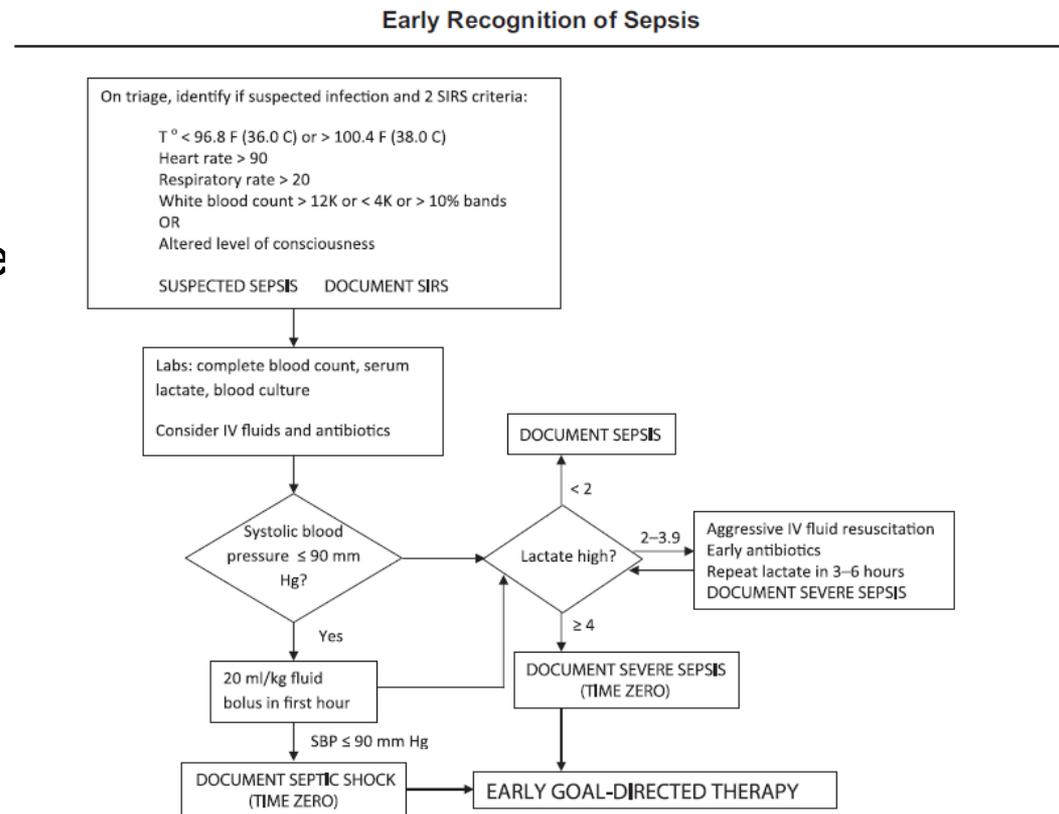
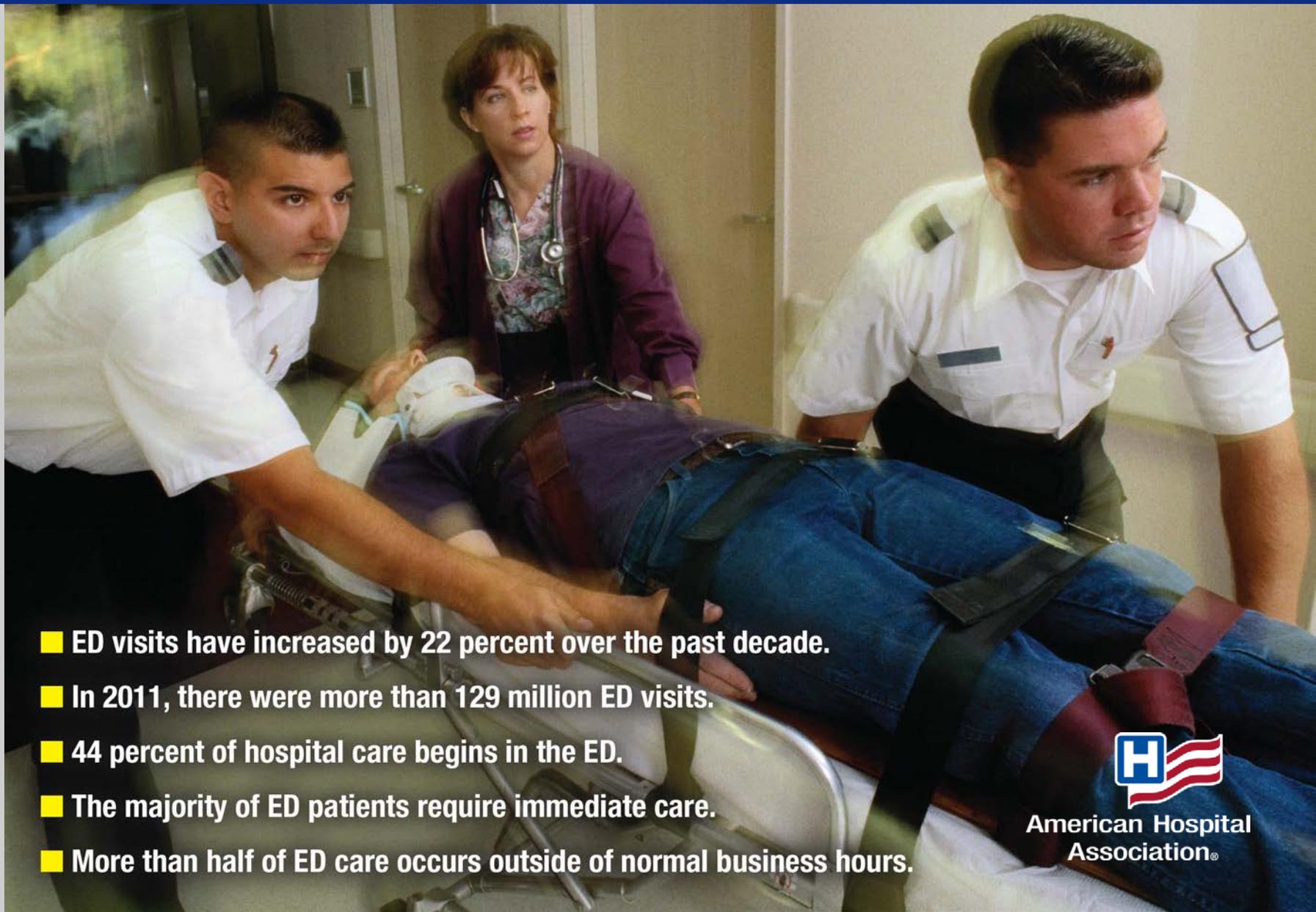


Figure 1. This tool facilitates the identification, documentation, and stratification of sepsis on admission. SIRS, systemic inflammatory response syndrome; T, temperature; IV, intravenous; SBP, systolic blood pressure.

Source: Whippy et al, Kaiser Permanente's Performance Improvement System, Part 3: Multisite Improvements in Care for Patients with Sepsis. *The Joint Commission Journal on Quality and Patient Safety*. November 2011.

Americans rely heavily on the 24-hour access to care provided by hospital emergency departments (EDs), and this need is growing.



- ED visits have increased by 22 percent over the past decade.
- In 2011, there were more than 129 million ED visits.
- 44 percent of hospital care begins in the ED.
- The majority of ED patients require immediate care.
- More than half of ED care occurs outside of normal business hours.



**American Hospital
Association®**

Sicker, More Complex Patients are Driving up Intensity of ED Care

Summary

Policy makers have noted an upward shift in the intensity of services provided to fee-for-service (FFS) Medicare beneficiaries in hospital emergency departments (EDs), as reflected in the level of evaluation and management (E/M) visits coded. This report examines a number of factors contributing to this trend including:

- Rising severity of illness among Medicare FFS patients receiving ED services;
- An increase in the number and frequency of ED visits by Medicare FFS beneficiaries;

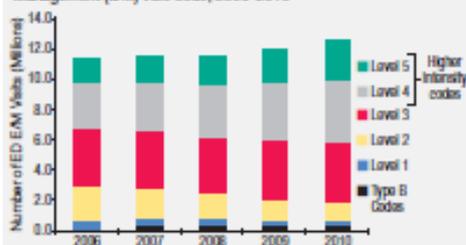
- Increasing numbers of ED visits that include observation services due to mounting pressure to shift care from the inpatient to the outpatient setting;
- Greater use of the ED by people dually eligible for Medicare and Medicaid (dual-eligibles), who tend to be sicker and have more chronic conditions; and
- Increasing use of the ED by Medicare FFS beneficiaries with behavioral health diagnoses who require a higher intensity of services.

Background

Recent data indicate that the volume of evaluation and management (E/M) services provided to Medicare beneficiaries in the ED is growing, and that the mix of services is shifting toward services that demand higher resources (Chart 1). Policy makers have raised concerns that these trends are leading to higher spending on ED care for Medicare FFS beneficiaries. The ED visit codes at issue are Current Procedural Terminology (CPT®) 99281-99285, which correspond to Level 1 through 5 ED visits, and G0380-G0384, which are similar codes used in Type B EDs.¹ The codes indicating a higher level of service intensity are the ones at the upper end of each range. This report, based on an analysis of Medicare claims data conducted by The Moran Company,² outlines a number of factors that are contributing to this trend.

Medicare FFS beneficiaries are receiving a greater volume and intensity of ED services.

Chart 1: Number of Medicare FFS ED Visits by Evaluation and Management (E/M) Visit Code, 2006-2010



Source: The Moran Company, Trends in the Provision of Emergency Department Evaluation and Management Services, January 2011.

Coding of ED Visits

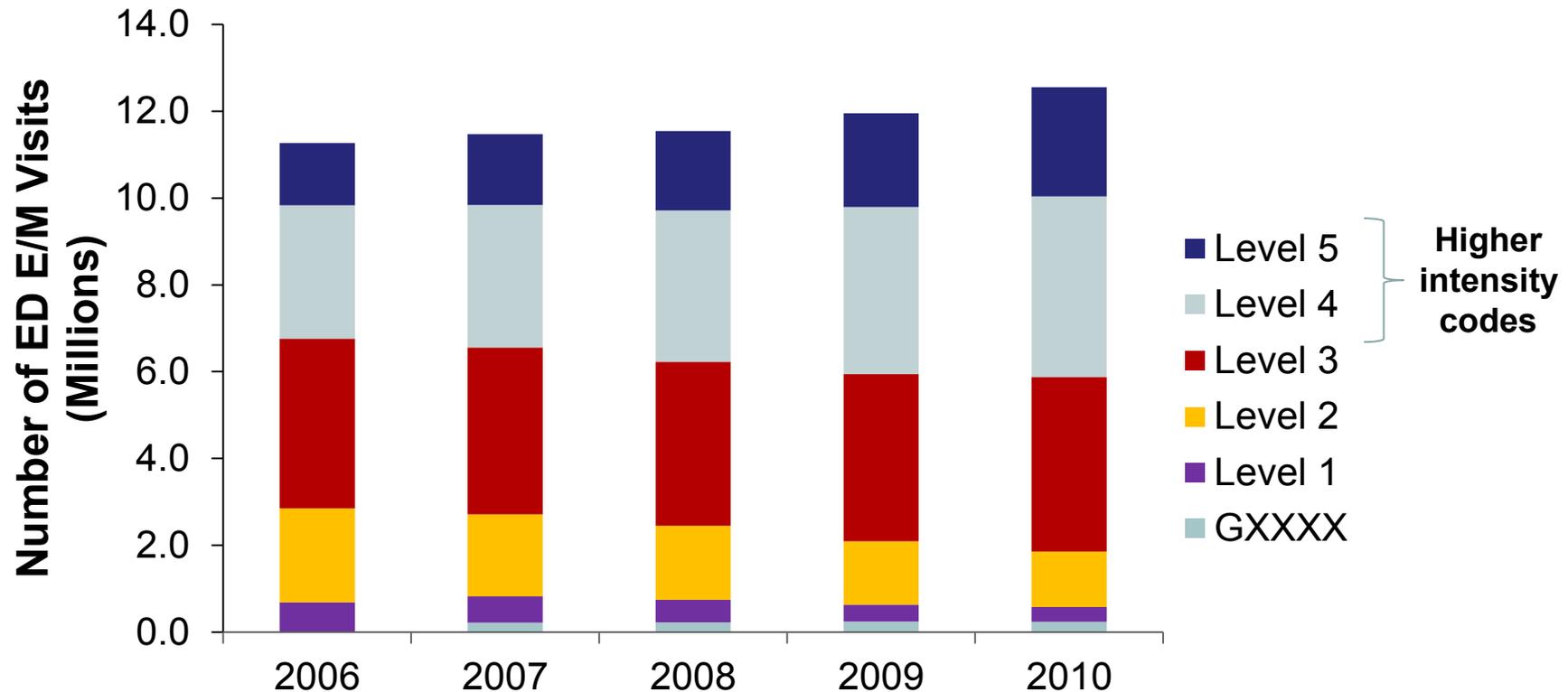
Hospitals have been using the CPT® E/M codes to report facility resources used to treat patients in the ED since April 2000. Facility resources include such things as time spent by nurses and other hospital staff in caring for patients and a variety of interventions performed by nursing or ancillary staff (e.g., administration of medication, wound cleaning, cardiac monitoring, catheter care, etc.) Recognizing that the E/M code descriptors, which were designed to reflect the activities of physicians, do not adequately describe the range and mix of services provided by hospitals, the Centers for Medicare & Medicaid Services (CMS) has instructed hospitals to develop internal hospital guidelines to determine the level of ED services provided. No national guidelines with clear and specific criteria exist.

¹Type B EDs are typically EDs that are open less than 24 hours a day, seven days a week.
 See: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientFFS/Downloads/OPPS_GandA.pdf
²The Moran Company (2013). Trends in the Provision of Emergency Department Evaluation and Management Services. Arlington, VA.



Medicare FFS beneficiaries are receiving a greater volume and intensity of ED services.

Number of Medicare FFS ED Visits by Evaluation and Management (E/M) Visit Code, 2006-2010

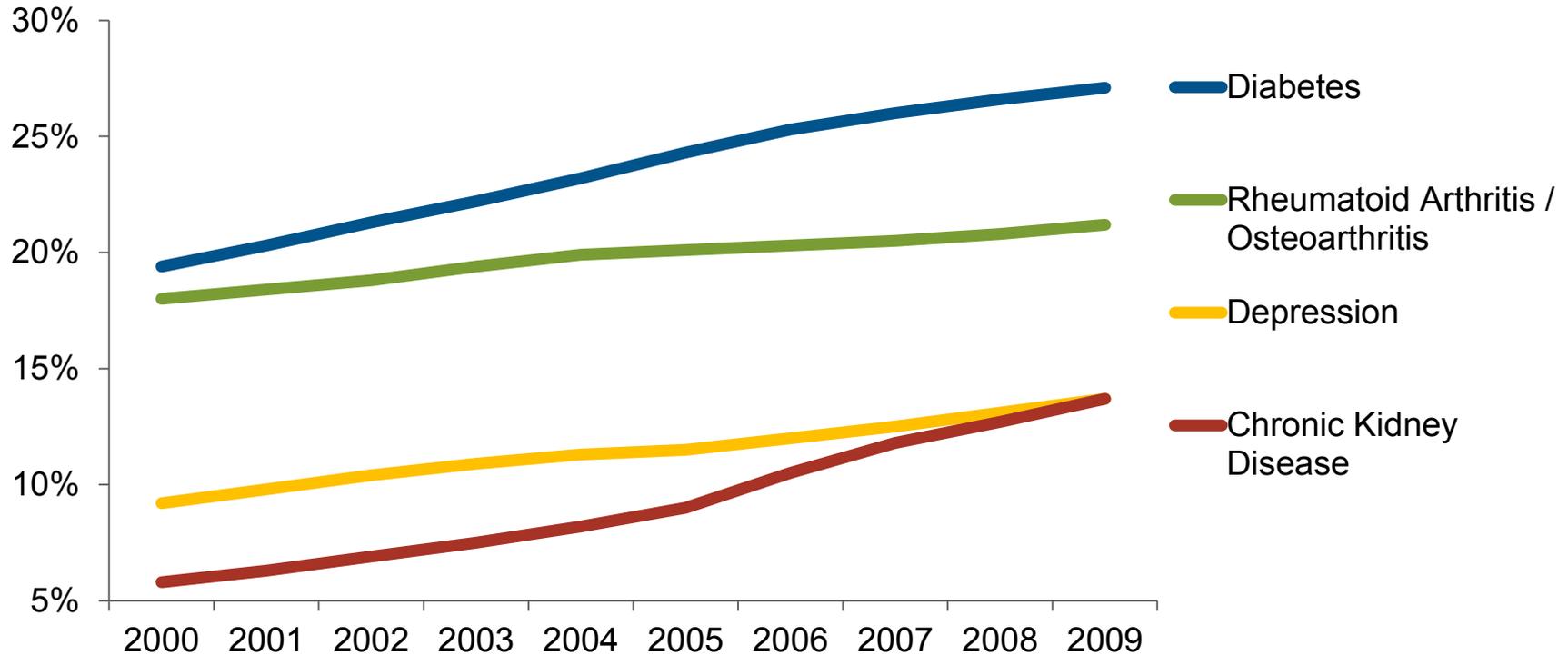


Source: The Moran Company, *Trends in the Provision of Emergency Department Evaluation and Management Services*, January 2013.



Chronic disease rates are rising in the Medicare population.

Rates of Chronic Conditions Among Medicare Beneficiaries,* 2000 – 2009



* Includes random 5% sample of Medicare beneficiaries.

Source: CMS Chronic Condition Data Warehouse Medicare 5% Sample. Medicare Beneficiary Prevalence for Chronic Conditions for 2000 Through 2009.

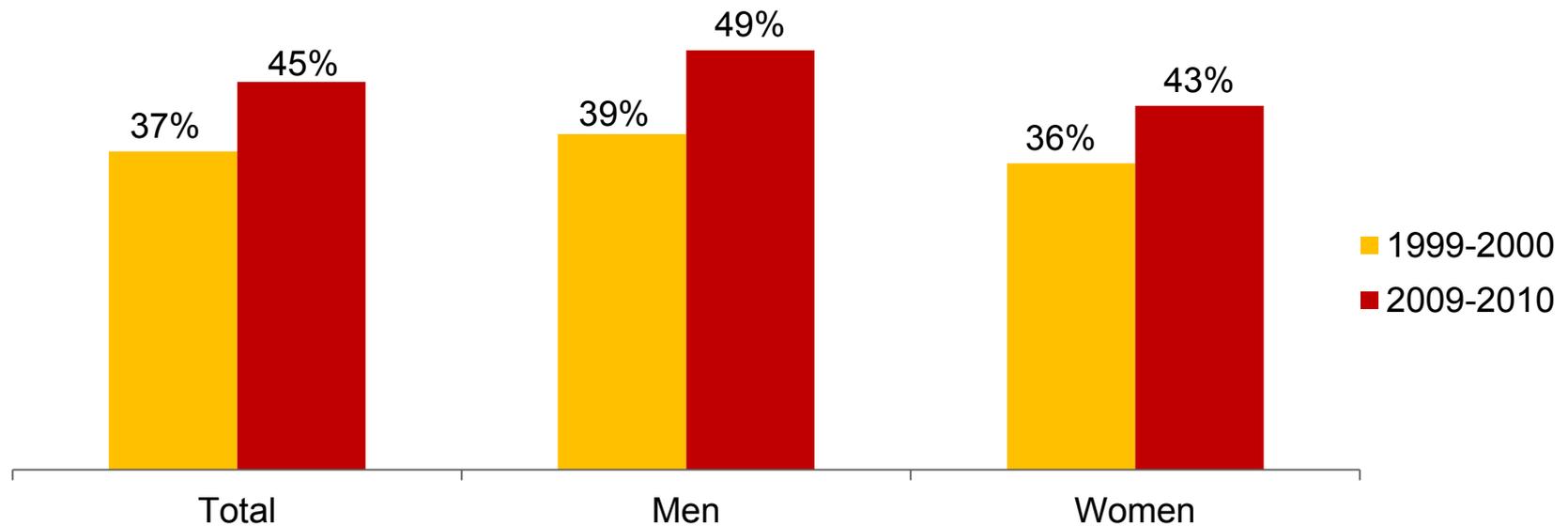
http://www.ccwdata.org/cs/groups/public/documents/document/wls_ucm1-000774.pdf



American Hospital
Association®

More seniors are living with two or more chronic conditions.

Percentage of Seniors* with Two or More Chronic Conditions, 1999 – 2000 and 2009 – 2010



* Seniors are defined as individuals age 65 and older.

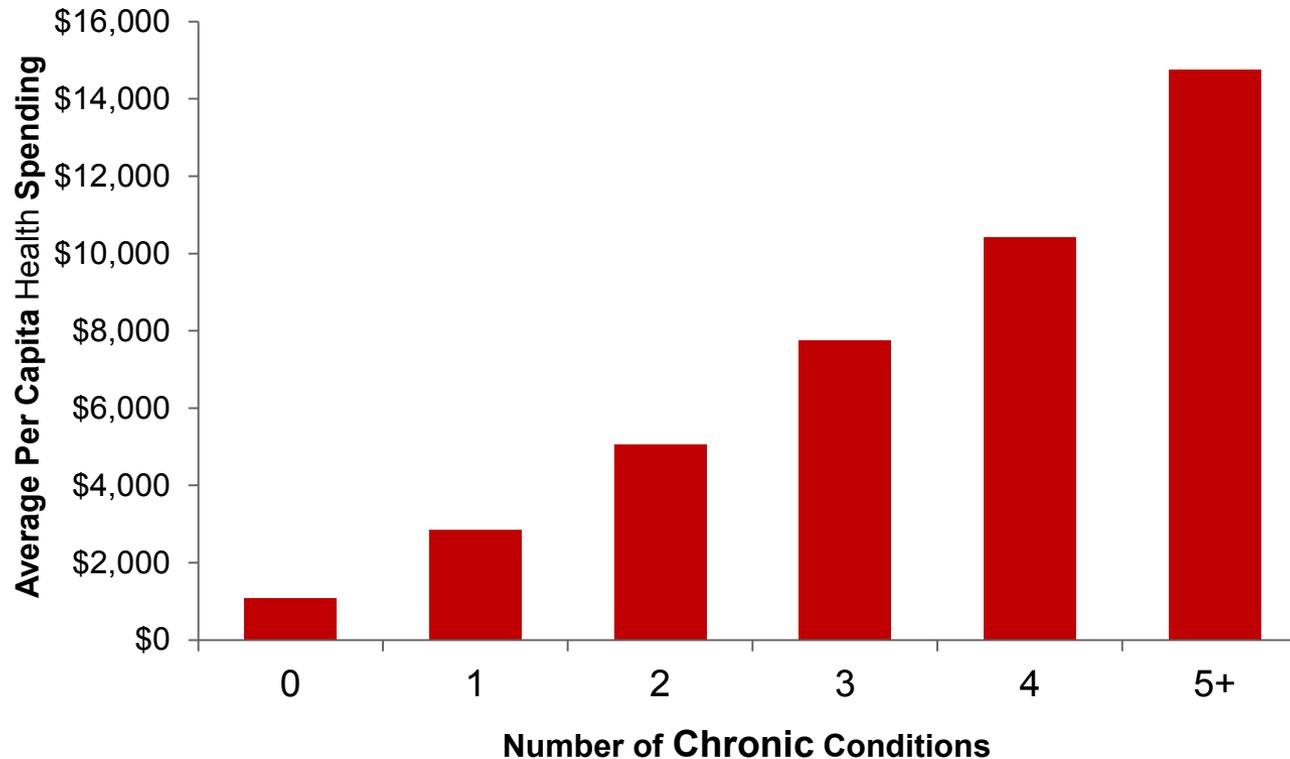
Source: Freid, V., et al. (July 2012). *Multiple Chronic Conditions Among Adults Aged 45 and Over: Trends Over the Past 10 Years.*



American Hospital Association®

People with multiple chronic conditions use more health care resources.

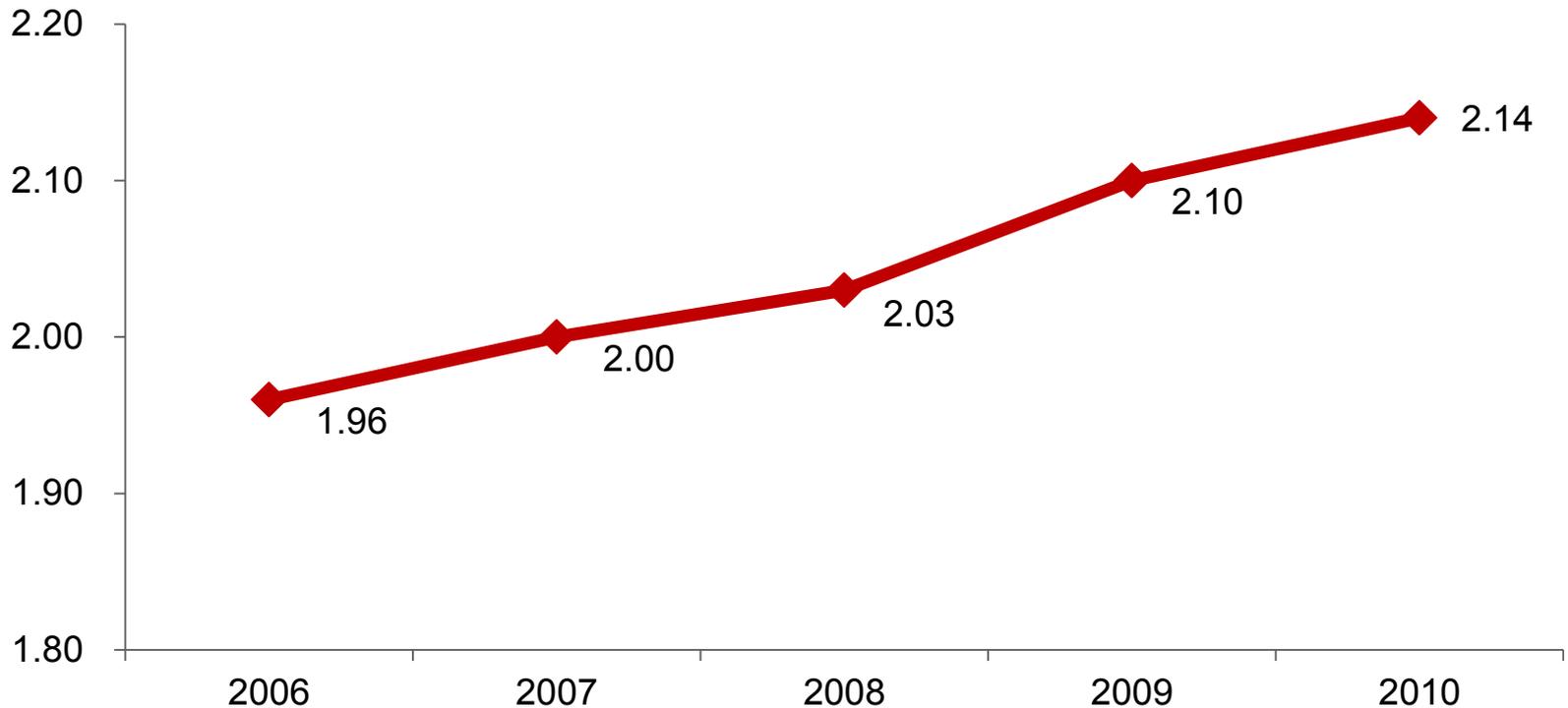
Average Yearly Per Capita Health Spending for Individuals with Chronic Conditions, 2006



Source: Anderson, G. (2010). *Chronic Care: Making the Case for Ongoing Care*. Johns Hopkins University and the Robert Wood Johnson Foundation.

Medicare ED patients are getting sicker.

Average HCC Scores for Medicare FFS Beneficiaries Visiting the ED, 2006-2010*



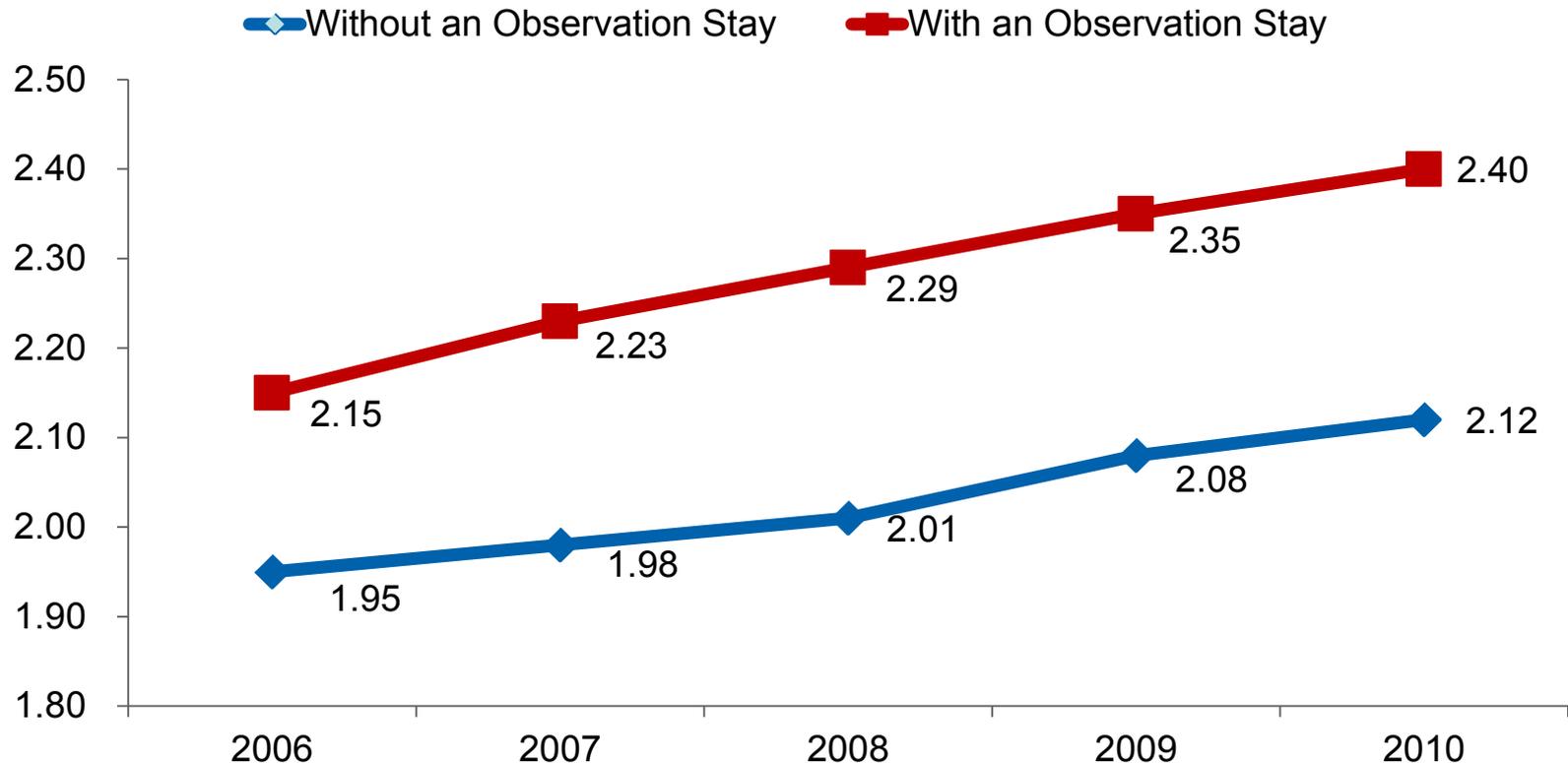
*These data are visit-weighted so that patient severity of illness is reflected for each visit.

Source: The Moran Company, *Trends in the Provision of Emergency Department Evaluation and Management Services*, January 2013.



Beneficiaries receiving observation care are sicker than other ED patients.

Average HCC Scores for Medicare FFS Beneficiaries Visiting the ED with and without an Observation Stay, 2006-2010*



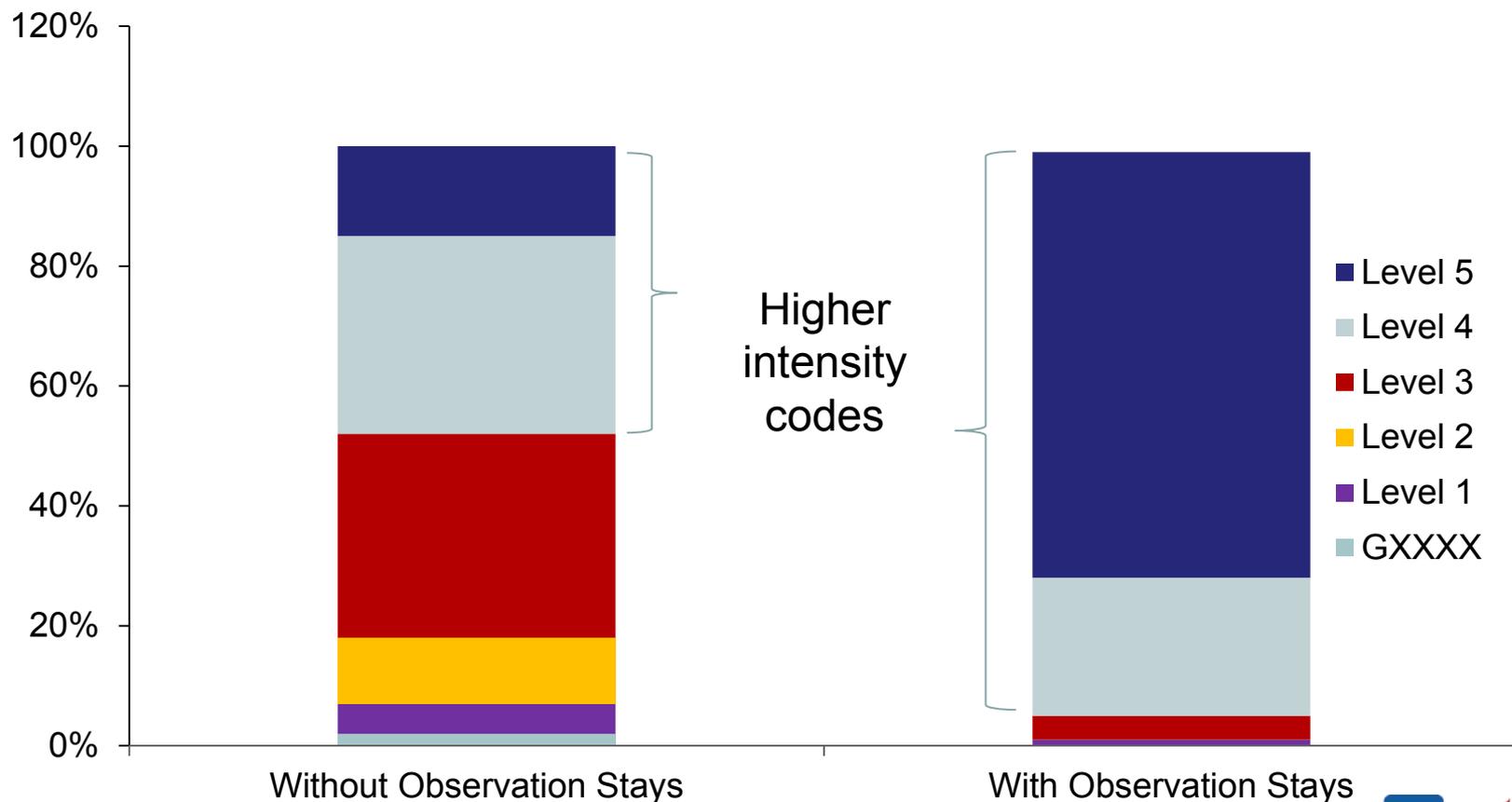
*These data are visit-weighted so that patient severity of illness is reflected for each visit.

Source: The Moran Company, *Trends in the Provision of Emergency Department Evaluation and Management Services*, January 2013.



Observation patients receive a markedly higher coded intensity of care...

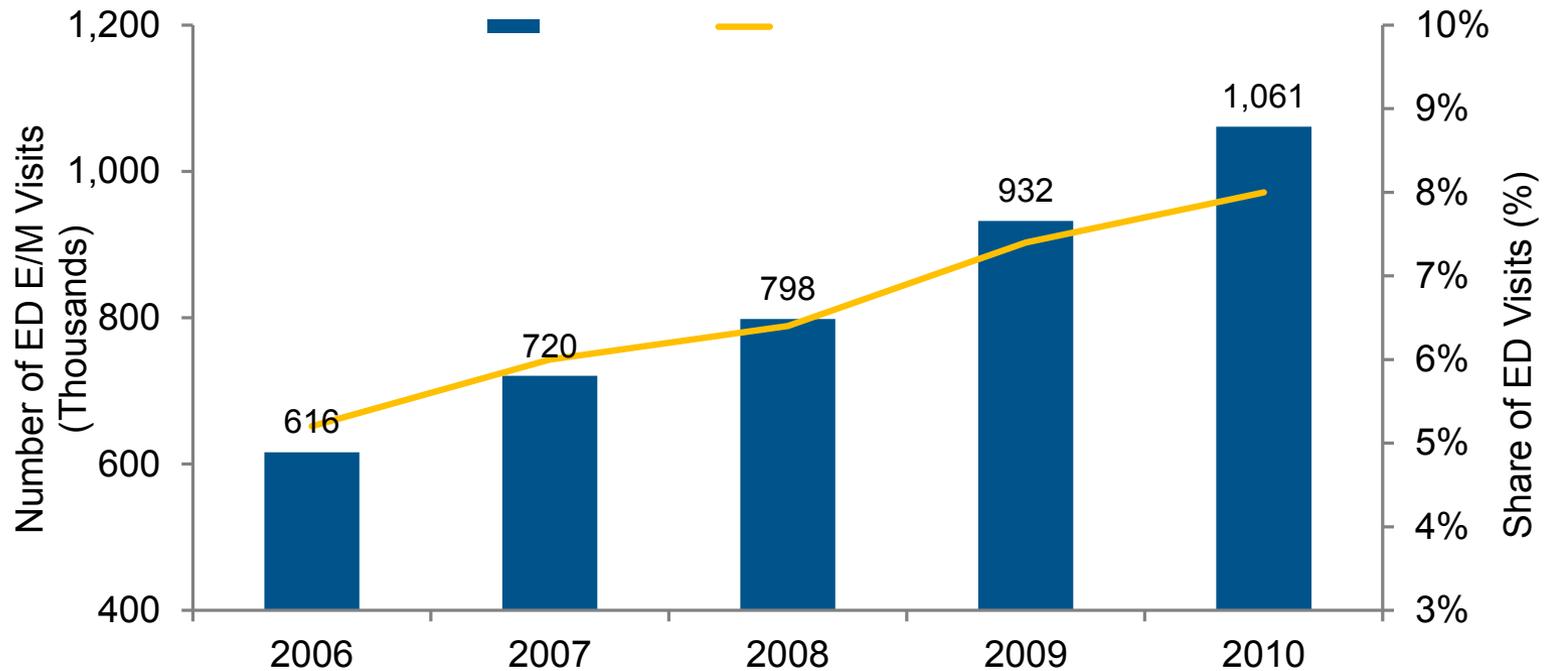
Distribution of ED Visits with and without Observation Stays by E/M Code, 2010



Source: The Moran Company, *Trends in the Provision of Emergency Department Evaluation and Management Services*, January 2013.

...and their numbers and share of ED visits are increasing.

Number and Share of Medicare FFS ED E/M Visits with an Associated Observation Stay, 2006-2010



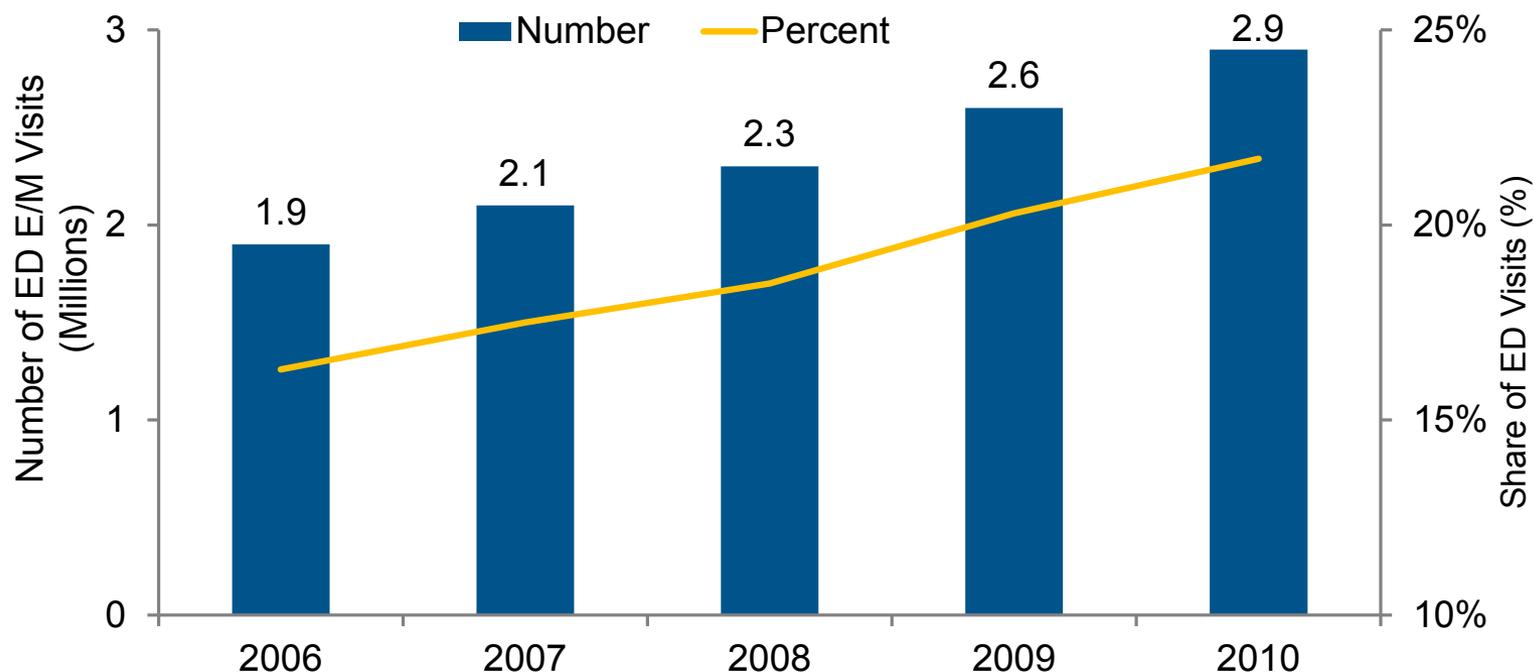
Source: The Moran Company, *Trends in the Provision of Emergency Department Evaluation and Management Services*, January 2013.



American Hospital Association®

ED visits for Medicare beneficiaries with a behavioral health diagnosis are increasing rapidly...

Number and Share of Medicare FFS ED E/M Visits for Patients with a Behavioral Health Diagnosis, 2006-2010



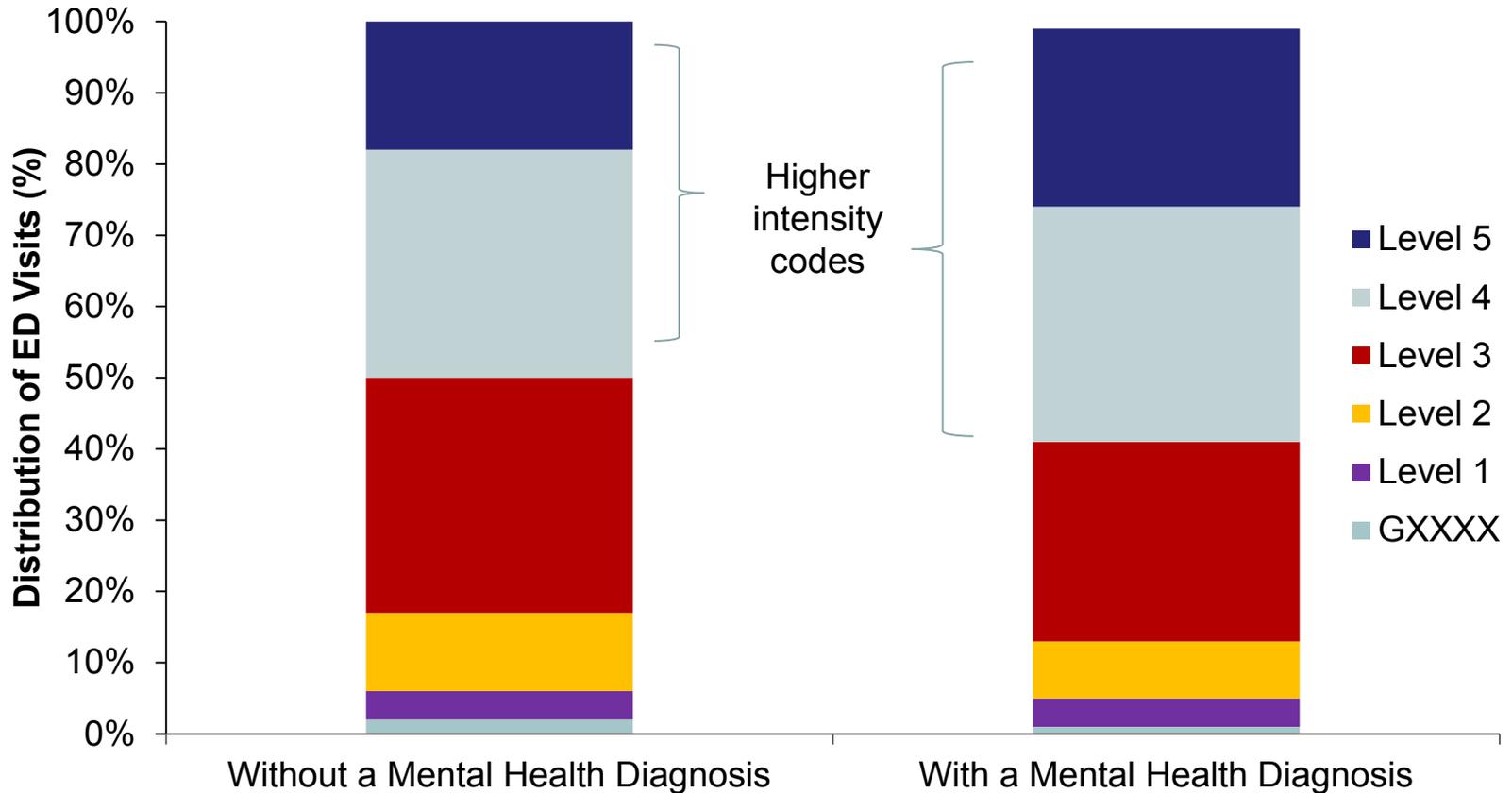
Source: The Moran Company, *Trends in the Provision of Emergency Department Evaluation and Management Services*, January 2013.



American Hospital Association®

...and these patients, on average, have a higher coded intensity of care.

Distribution by E/M Codes for ED Visits with and without a Mental Health Diagnosis, 2010



Source: The Moran Company, *Trends in the Provision of Emergency Department Evaluation and Management Services*, January 2013.



American Hospital Association®

Next steps

- Continue on path of EHR adoption to improve care
- Consider national hospital coding guidelines for the ED
- Make sure EHRs support good documentation and adherence to coding conventions and guidelines
- Education will be key





National
Association
of Public
Hospitals
and Health
Systems

Bruce Siegel, MD, MPH

President and CEO

National Association of Public
Hospitals and Health Systems





National
Association
of Public
Hospitals
and Health
Systems

Snapshot of Members



- 200+ major metro safety net hospitals and health systems
- Half of care goes to Medicaid, uninsured
- 2% of acute care hospitals, 20% of uncompensated care
- 58% patients racial, ethnic minorities; 100+ languages



National
Association
of Public
Hospitals
and Health
Systems

Essential Community Services



Trauma, burn
care, NICU,
emergency
psychiatric,
disaster
response



National
Association
of Public
Hospitals
and Health
Systems

Health Professionals Training





National
Association
of Public
Hospitals
and Health
Systems

The ED and the Safety Net

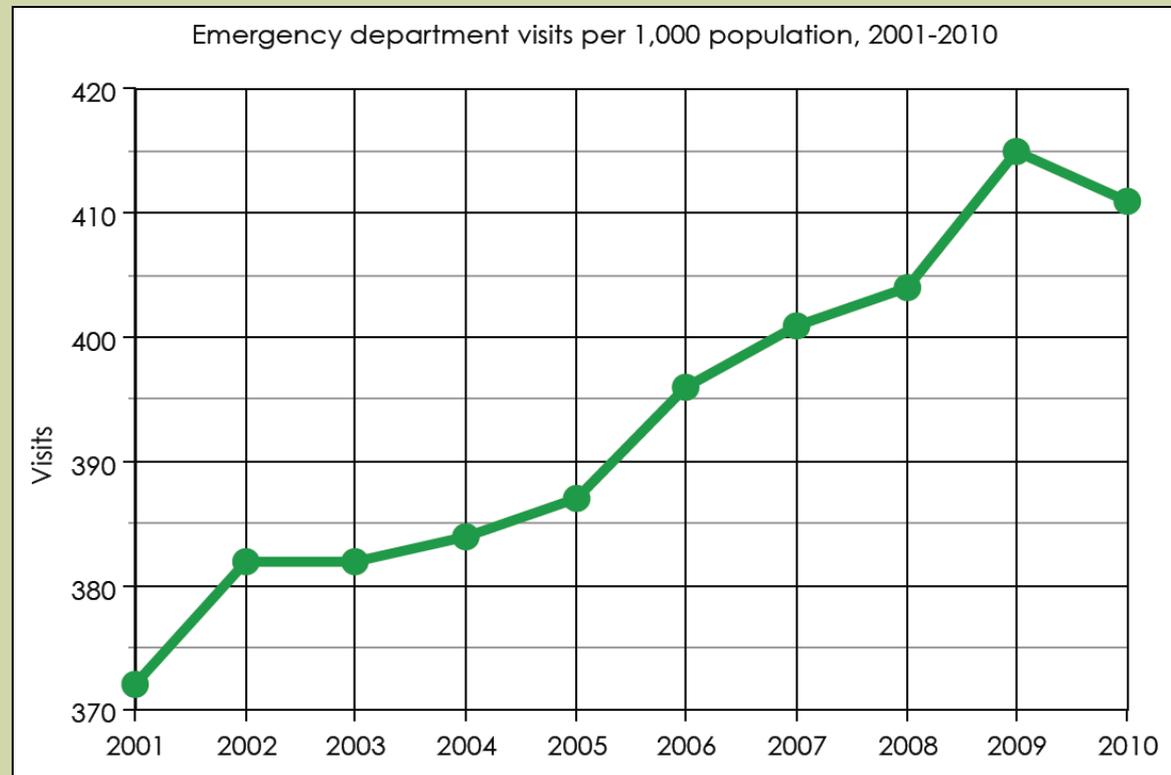


Often first
point of
contact with
health care
system for
vulnerable
patients



National
Association
of Public
Hospitals
and Health
Systems

ED Use Nationally



Source: statehealthfacts.org, Kaiser Family Foundation



ED Care Complex, Costly

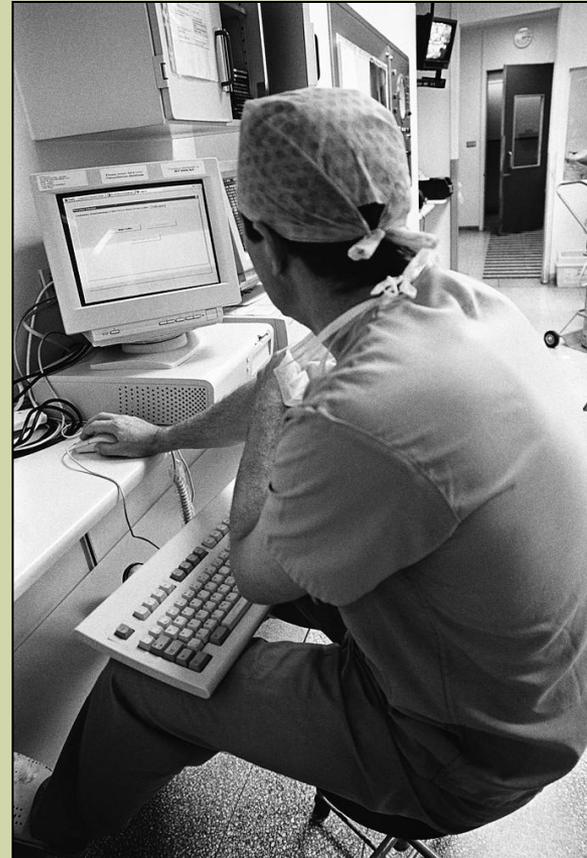
Procedure	2001	2008	% Increase
Any blood test	34.2	49.4	44%
Radiograph	37.2	44.0	18%
CT scan, MRI, or ultrasonography	9.0	21.6	140%
Intravenous fluids	19.5	32.9	69%
Any procedure	43.9	57.3	30%
3 or more diagnostic tests	40.6	46.4	14%
2 or more medications	49.3	64.6	31%

Pitts SR, Pines JM, Handrigan MT, Kellermann AL. National trends in emergency department occupancy, 2001 to 2008: effect of inpatient admissions versus emergency department practice intensity. *Ann Emerg Med* 2012;60:679-86.



National
Association
of Public
Hospitals
and Health
Systems

Intersection of ED and EHR





National
Association
of Public
Hospitals
and Health
Systems

NAPH Members and EHRs



- Some early adopters with EHRs in use for decades
- Members working diligently toward EHR meaningful use
- Results to date demonstrate innovation, better quality, savings



National
Association
of Public
Hospitals
and Health
Systems

Truman Medical Centers

- HIMSS level 6 certification
- A “Most Wired” hospital
- 2009: Project Q6 to improve clinical quality, outcomes through advanced technology





National
Association
of Public
Hospitals
and Health
Systems

UC San Diego Medical Center

- IMPACT-ED improves primary care, PCMH access through ED
- Electronically links ED with local clinics
- Working with Beacon Community Collaborative





National
Association
of Public
Hospitals
and Health
Systems

Wishard Health Services



- EHR pioneer: First system in place 40 years ago
- First in nation to put EHR in ambulance fleet
- GRACE Program



National
Association
of Public
Hospitals
and Health
Systems

Moving Forward



- EHRs a story of innovation, quality and savings for NAPH members
- Provider education and vendor support key
- Promise of EHRs: Reduced fragmentation, better care for our most vulnerable



National
Association
of Public
Hospitals
and Health
Systems

Thank You

Contact:

1301 Pennsylvania Ave. N.W.

Suite 950

Washington, DC 20004

www.naph.org

info@naph.org

Impacts of EHRs on Documentation, Coding and Billing – a Physician’s Perspective

Steven J. Stack, M.D., Chair, Board of Trustees
American Medical Association

May 3, 2013

Coding & Documentation Issues & Challenges in EHR Environment

Sue Bowman, MJ, RHIA, CCS, FAHIMA
Senior Director, Coding Policy and Compliance



AHIMA - Background

- Non-profit professional association
- More than 67,000 individual members who are educated and certified in health information management (HIM)
- Leader in assuring that health information is valid, accurate, complete, trustworthy, and timely
- Long history of working with DOJ, OIG, HHS to combat fraud and abuse

Coding Challenges

- Clinical complexity of patient encounters
- Inadequate, missing, or conflicting documentation
- Complexity and variety of payment policies and billing rules
- Coder shortage
- Tougher productivity requirements
- Transition to ICD-10-CM/PCS

Impact of EHRs on Documentation & Coding

- Improved documentation and coding resulting in higher reimbursement does not equate to fraud or abuse
- Extent to which EHRs have led to **improper** reimbursement is unclear
 - More study is needed on causes of higher levels of coding and reimbursement

EHRs Better

Documentation & Coding

- EHRs produce more complete and accurate documentation
- Better documentation leads to more complete and accurate coding
- Better coding ultimately impacts reimbursement

Computer-Assisted Coding Technology (CAC)

- Growth in use of computer-assisted coding technology also improves coding quality
- CAC: use of computer software that automatically generates a set of medical codes for review, validation, and use based on clinical documentation
- Benefits:
 - Improved coder productivity
 - Improved coding accuracy and consistency
 - Improved data integrity
 - Improved coding compliance

Basic Documentation & Coding Principles

- Complete, clear, and accurate health record documentation is the foundation for complete and accurate coding
- Health record documentation, whether electronic or paper-based, must be clear, accurate, complete, and timely
- Only codes clearly and consistently supported by authenticated clinical documentation in accordance with code set rules and guidelines should be reported

Current Standards for Proper Coding

- Adherence to conventions and rules contained in HIPAA code sets
- *ICD-9-CM Official Guidelines for Coding and Reporting* are required under HIPAA for ICD-9-CM code reporting to promote accuracy and consistency
- AHIMA's Code of Ethics and Standards of Ethical Coding set ethical expectations for HIM and coding professionals

Standards of Ethical Coding

- Assign and report only codes that are clearly and consistently supported by health record documentation in accordance with applicable code set and abstraction conventions, rules, and guidelines
- Refuse to participate in or support coding or documentation practices intended to inappropriately increase payment, qualify for insurance policy coverage, or skew data by means that do not comply with federal and state statutes, regulations, and official rules and guidelines
- Refuse to participate in or conceal unethical coding or abstraction practices or procedures

EHR Documentation Assist

Features - Benefits

- Proper documentation is facilitated through **effective** use of EHR documentation assist features
 - Time-Saver
 - Improves efficiency of data capture, allowing more time to be spent on patient care
 - Improves timeliness and legibility
 - Prompts clinicians for appropriate documentation
 - Supports capture of clinical content in a standardized and structured manner
 - Can improve consistency and completeness of documentation
 - Can reduce need for physician queries due to missing documentation

Risky EHR Documentation Features

- Copy/Paste (i.e., copy forward)
- Auto-creation of default documentation
- Single-click template notes
- Templates with limited options
- “Make me an author”
- Evaluation and management (E/M) code optimization alerts

Why Are These EHR Features Risky?

- Poor system design
 - Choice selection is too limited
 - Prompts or available choices guide clinicians to make clinically inappropriate choices
- Improper use
- Payment system structure creates incentives to produce documentation targeted toward reimbursement rather than clinical relevance

Risks of EHR Documentation Features

- Inaccurate, outdated, or misleading information
- Invalid auto-population of data fields
- Redundant information
- Duplicated or inapplicable information
- Inability to identify the author or intent of documentation

Risks of EHR Documentation

Features

- Inability to identify when the documentation was first created
- Inability to accurately support or defend E/M codes
- Propagation of erroneous information
- Internally inconsistent progress notes
- “Smart phrases” that pull in identical data elements (not specific to patient or encounter)

Achieving Documentation & Coding Compliance

- Industry-wide adherence to regulatory and documentation standards and requirements and applicable coding conventions, rules, and guidelines
 - *ICD-9-CM (and ICD-10-CM/PCS) Official Guidelines for Coding and Reporting*
 - ICD-9-CM (and ICD-10-CM/PCS) and CPT code set conventions and rules
- Adoption of, and adherence to, code of ethics (by both EHR vendors and users) to demonstrate commitment to development and use of compliant coding and documentation tools and practices

Achieving Documentation & Coding Compliance

- EHR documentation assist features should facilitate, not circumvent or replace, accurate and compliant coding processes
- Proper safeguards, education and oversight are needed
- Line between legitimate and inappropriate EHR documentation tools is not always clear

Achieving Documentation & Coding Compliance

- Guidelines should be developed for both EHR vendors and users regarding appropriate use of documentation techniques to ensure complete, accurate, and quality documentation
- EHR vendors should be expected to employ EHR system design and usability standards and implementation specifications that promote accurate, compliant documentation
- EHR vendors and healthcare providers should share accountability for ensuring compliant documentation and coding practices
 - Vendors should be held accountable for design of compliant documentation tools
 - Providers should be held accountable for compliant use of documentation tools

Achieving Documentation & Coding Compliance

- Organizational policies/procedures should be developed for proper use of EHR documentation assist features to assure compliance with governmental, regulatory, and industry standards, including compliant coding
 - Acceptable information capture methods
 - Limitations on use of certain features
 - Acceptable copy/paste practices
 - Acceptable uses, including limitations on use
 - Identification of origin and author of copied information
 - Provider responsibility
 - Error notification
 - Sanctions for violating copy/paste policies

Achieving Documentation & Coding Compliance

- All EHR users should receive comprehensive training/education on proper EHR use
 - Organizational policies/procedures on use of EHR documentation assist features
 - Proper use, features, and functions of EHR system
 - Individual responsibilities for maintaining information accuracy and integrity
 - Preventing erroneous entry of information
 - Sanctions
- Use of EHR documentation features should be monitored

Achieving Documentation & Coding Compliance

- CMS should adopt a national set of coding guidelines for hospital reporting of emergency department and clinic visits
 - AHIMA has advocated for national guidelines for more than 10 years
 - Use of hospital-specific internal coding guidelines is contrary to government and industry goals of data uniformity, consistency, and comparability

Conclusion

- EHR documentation tools can facilitate the efficient creation of high-quality documentation for coding and other purposes, but only when designed and used appropriately
- Organizations must have sound documentation integrity, auditing, and training practices
 - To properly use and manage EHR documentation features
 - To ensure compliant documentation and coding
- Real improvements in documentation and coding should be rewarded, whereas improper practices should be penalized
- Further research on fraud risks associated with EHRs and strategies for reducing these risks is needed
- AHIMA is committed to working with the federal government and healthcare industry to ensure US adoption and use of EHRs results in correct data and accurate trusted information

AHIMA Resources

www.ahima.org

- [AHIMA Standards of Ethical Coding](#)
- [AHIMA Ethical Standards for Clinical Documentation Improvement Professionals](#)
- ["Assessing and Improving EHR Data Quality" Practice Brief](#)
- [Defining the Core Clinical Documentation Set for Coding Compliance](#) (AHIMA Thought Leadership Series)
- “Integrity of the Healthcare Record: Best Practices for EHR Documentation” practice brief – available Summer 2013 (*update of 2007 practice brief titled “Guidelines for EHR Documentation to Prevent Fraud”*)
- Copy Functionality Toolkit
- Information Integrity in the Electronic Health Record Toolkit

Thank You

Sue Bowman, MJ, RHIA, CCS, FAHIMA

sue.bowman@ahima.org

(312) 233-1115

Listening Session: Billing and Coding with Electronic Health Records

Mickey McGlynn

Chair, EHR Association

Siemens Healthcare

May 3, 2013

- Established in 2004, the Electronic Health Record Association (EHRA) is comprised of more than 40 companies that supply the vast majority of operational EHRs to physicians' practices and hospitals across the US.
- We operate on the premise that the rapid, widespread adoption and use of EHRs will help improve the quality of patient care as well as the productivity and sustainability of the healthcare system.
- The EHRA and its members are committed to supporting safe healthcare delivery, fostering continued innovation, and operating with high integrity in the market for our users and their patients and families.
- Member companies work together to share knowledge and best practices on the development, implementation and use of EHRs to improve the safety, quality, and efficiency of patient care delivery.
- For more information, visit <http://www.himssehra.org>.

- Broad consensus that widespread adoption of electronic health records (EHRs) is a needed step in the evolution and transformation of healthcare.
- Recent concern raised that some providers may be using EHRs to obtain payments to which they are not entitled.
- Broad agreement that fraud and anything that contributes to fraud deserves serious focus and attention.

- Tools that can help providers facilitate care delivery, documentation, and payment for services provided
- When well-implemented and optimized, can assist providers to improve safety, quality, efficiency, and value
- Include decision support capabilities to assist in avoiding unnecessary tests
- Perform safety checks for drug-drug interactions, allergies, contraindications, etc., that could potentially lead to more expensive care
- Access medication formularies to reduce drug spending
- Identify gaps in care and recommend more preventive care, where appropriate
- Support providers in creating more accurate clinical documentation and coding
- Capture structured data accessible for use in decision support, population health management, interoperability, quality measurement, etc.

- To date, we are unaware of any confirmed data linking EHRs to inaccurate or fraudulent coding.
- Many providers find value in the use of the EHR tools for more accurate, complete documentation.
- Unfortunately, if a provider chooses to commit fraud, they can do so with or without an EHR.
- Significant concerns have been raised about the complexity of the coding requirements.
- As with other industries, the value of technology is the ability to automate complex processes.
 - Aggressive push to bring that automation to healthcare
- Increased billing could in fact be related to improvements in preventative care through improved clinical decision support and more accurate documentation of the care provided.
- EHR vendors have different approaches to providing various tools and capabilities.

- Software that assists in documentation and coding
- Copy/paste/forward capability
- Tools such as templates, drop-down boxes, and radio buttons
- “Note bloat”
- Usability, usefulness, and efficiency of EHRs as it relates to clinical documentation

- Adoption of EHRs needs to continue in order to achieve the expected improvements in care delivery for patients, providers, and the overall health system.
- Usability and usefulness will continue to be important for technology adoption to continue.
- Accurate capture of documentation as required for billing
- Accurate capture of documentation and structured data for care delivery, clinical decision support, quality measurement, communication, interoperability, etc.

- The move to incorporating clinical quality measure data capture into the clinical workflow (vs. manual chart abstraction) must be considered in this discussion of EHRs and documentation.
- Some clinical quality measures require negative charting and/or other explicit charting that a clinician would not otherwise do.
 - Adds to the volume of clinically insignificant documentation
- Meaningful Use Stage 2 will be the first implementation.
- Work has begun to harmonize various quality measurement requirements.
- Early work is under way to fully understand and consider the best approaches around new EHR-enabled quality measures.

- EHR Developer Principles
 - Incorporate user-centered design methodologies into design and development efforts
 - Support our customers’ needs to efficiently and accurately document care provided
 - “Open the black box”
 - Make information available to our customers about EHRs’ approaches to clinical documentation, coding, and quality measurement, for example:
 - Coding guidelines referenced
 - Conformity with applicable regulatory and documentation standards
 - The source of a quality measure

- Analysis is needed to evaluate whether there is any fraudulent activity.
- If it is determined there is fraudulent activity, an evaluation of the factors contributing to the fraudulent behavior should be identified.
- If it is determined that EHRs have a role in contributing to the fraudulent behavior - providers, EHR vendors, and CMS should collaborate to determine appropriate solutions.
- Before then, attempts at standards or certification criteria may not address real issues and could create significant unintended consequences.
- Consider the significant effort underway to transform quality measurement and measures to be “EHR-enabled” – evaluate as part of Stage 2 Meaningful Use.
- Fully consider the impacts to clinical documentation along with the topic of documentation for purposes of billing in light of the shifts to additional payment models and focus on quality improvements.
- Balance with a consideration of usability and usefulness, and impacts on adoption.

- Thank you for the opportunity to discuss this important issue.
- Contact info for EHR Association:
 - grawling@himss.org