



Statement for

CMS-ONC Listening Session on Billing and Coding with EHRs

Good morning. I am Lisa Gallagher, VP Technology Solutions at HIMSS. I appreciate the opportunity to represent HIMSS at today's discussion on Billing and Coding and Health IT. HIMSS is a cause-based, not-for-profit organization exclusively focused on leading global endeavors that optimize health engagements and care outcomes through information technology. Founded 52 years ago, HIMSS and its related organizations are headquartered in Chicago with additional offices in the United States, Europe and Asia. HIMSS represents more than 50,000 individual members, of which more than two thirds work in healthcare provider, governmental and not-for-profit organizations. HIMSS also includes over 570 corporate members and more than 225 not-for-profit partner organizations that share our vision of better health through information technology

Today's conversation on Billing and Coding and EHRs provides us with an incredible opportunity to talk about the challenges and benefits inherent in health IT supporting healthcare transformation. We are all familiar with the September 2012 Wall Street Journal OpEd piece¹ and the NY Times story² relating to increasing Medicare billing rates attributed to the use of EHRs. And, last month, a report released by six Republican senators called out several challenges specific to billing and coding with EHRs³, including:

- "Code Creep"
- "Cloned" or Copied Records Can Increase Medical Errors

HIMSS recently gathered stakeholders in an "EHR Coding Integrity Work Group". The creation of this group is in response to public reports, released over the last many months, indicating that clinicians' (physicians, nurse practitioners, and physician assistants) use of Electronic Health Records (EHRs) has contributed to inappropriate over- or under-coding and over-billing, including in the area of Evaluation and Management Services (E&M). Our work group performed a critical review of the underlying causes of coding errors using EHRs. At the highest level, it is important to recognize that changes in reimbursements, practice patterns and technology *all* create opportunities for abuse. This work informed our statement today.

Prior to widespread use of EHRs in clinical practices, providers often were worried about claims of fraud and abuse. Many anecdotally report that their practice would *undercode* for the encounter if they were not absolutely sure about whether they met the complex guidelines that must be followed to select the correct codes – codes that are often also used by commercial payers.

¹ "A Major Glitch for Digitized Health-Care Record," <http://online.wsj.com/article/SB10000872396390443847404577627041964831020.html>, September 17, 2012.

² "Medicare Bills Rise as Records Turn Electronic," http://www.nytimes.com/2012/09/22/business/medicare-billing-rises-at-hospitals-with-electronic-records.html?_r=2&, September 21, 2012.

³ Thune, J., Alexander, L., Roberts, P., Burr, R., Coburn T., Enzi, M., "REBOOT: Re-examining the Strategies Needed to Successfully Adopt Health IT," April 16, 2103.



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Coincident with many other beneficial functions, today's EHR systems can facilitate better documentation as well as the direct selection of diagnosis and procedure codes by health care providers as well as a capability for computer-assisted coding. We make the following observations regarding the complex factors that impact of use of EHRs for coding:

- HIMSS members tell us that that they are able to code more accurately than in the past, perhaps increasing "health care costs" to the payer, but perhaps not to the overall system. That is, in the past, the provider absorbed the cost.
- Across the healthcare system, health IT enables earlier recognition of potential medical problems, so we are ordering more follow-ups and preventive/screening tests. While these efforts may increase costs in the short term, there exists a potential long term benefit of decreased costs as we aim for a healthier population, improve chronic disease management, and detect cancer and other conditions at an earlier stage.
- As we strive to increase quality and manage overall health, clinical and primary care are evolving, even in our current encounter-based system. For example, one approach, not invented by the EHR but made more achievable with EHR systems, is what is called a "shared agenda visit."⁴ As described by HIMSS Ambulatory Committee Chairman and Board Member-elect, Dr. Michael Zaroukian, "This means that although patients still come to the physician as needed for sick care, the physician uses the EHR to identify specific care opportunities and unmet goals. When appropriate and feasible, the provider then expands the acute care visit to include whatever preventive and chronic care needs are indicated and, when this is not practicable, recommends another visit in a timely manner. Depending on the number of chronic care conditions addressed and how they were managed, under the current coding guidelines, you would expect that shifting to an outcomes-focused shared agenda model will lead to short-term increased costs."
- With regard to EHR features that are designed to make the user experience easier, such as copy and paste, drop downs, radio buttons, etc., we must carefully consider their use in the clinical workflow. Such features must be considered for appropriateness in the clinical environment and the overall design and functionality should support patient and visit specificity. Bringing attention to this issue is important so that we can make better choices with regard to these features.
- Challenges exist today with use of EHRs for coding. While the provider is usually in the best position to know the clinical details of a patient encounter, they are often unfamiliar with the complex guidelines that must be followed to select the correct codes, in particular E&M codes. Still, because E&M is a codification of the diagnostic process in clinical medicine, we must facilitate functionality

⁴ Basch, P., Zaroukian, M., "Does EHR Use Lead to Lower or Higher Costs? An Overview," <http://doctorshelpingdoctorstransformhealthcare.org/2012/does-ehr-use-lead-to-lower-or-higher-costs-an-overview/>, September 30, 2013.



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and interfaces that incorporate E&M principles into optimal care principles. Our overall goal is that clinicians are able to easily incorporate the complex E&M guidelines to promote patient care excellence as one of the *benefits* of well-designed EHRs.

Finally, challenges with EHR workflows and/or clinician training may not optimally facilitate the capture of an adequate medical history, inhibiting a clinicians' ability to determine accurate and trustworthy differential diagnoses. In the absence of reliable clinical diagnoses, clinicians may sometimes resort to increased diagnostic testing (usually in order to discover a diagnosis, rather than only confirming or determining the extent of a clinically-diagnosed medical problem, as advised in optimal use of testing). With respect to these challenges, HIMSS recommends that the healthcare community:

1. Integrate E&M documentation training and oversight into medical school and residency curricula
2. Simplify CPT/E&M codes, *or*,
Provide more granularity/specificity in E&M guidance
3. Evaluate ways to specify functional requirements for EHR systems that would facilitate E&M compliance as well as better documentation and diagnostic workflows, where applicable.

As we look towards the future, we can anticipate new challenges:

- Clinical Quality Measures can lead to additional, non-clinically related documentation in the clinical work flow⁵
- Future payment models that are not fee-for-service may also drive additional documentation
- With new payment models, in order to incent uptake of Health Information Exchange capabilities, we may see adoption of new coding capabilities (e.g., higher E&M coding for "cognitive activities" using HIE, such as information reconciliation)⁶
- Finally, as we realize new payment models that pay for outcomes or are bundled, the phenomenon of coding errors related to care encounters may self-resolve

HIMSS notes that the IT market is already providing solutions. Third-party products can provide coding translation outside of the EHR as part of the billing cycle. For example, some new products that are aimed at easing the ICD-10 transition, could also possibly address the coding error challenge as well.

⁵ eMeasure Feasibility Assessment, *DRAFT TECHNICAL REPORT*, Report from the National Quality Forum, March 15, 2013, <http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=72933>.

⁶ Health IT Policy Committee, Information Exchange Work Group Recommendations on "CMS-ONC Request for Information: Advancing Interoperability and Health Information Exchange," http://www.healthit.gov/sites/default/files/iewg_recommendationscms.pdf, April 3, 2013.



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Companies that provide “clinical interface terminology” content provide clinician-friendly, yet clear and unambiguous, descriptions of diagnoses and procedures, along with mappings to standardized coding systems like ICD-9-CM, ICD-10-CM, CPT-4, and HCPCS that are done by certified professional coders. This allows for the best of both worlds: collecting structured data from the professional closest to the clinical reality, while ensuring that diagnosis and procedure codes used for billing are correct.

Conclusion

HIMSS and its members take coding errors, whether inadvertent or intentional billing fraud, very seriously, as evidenced by the convening of the EHR Coding Integrity Work Group and our other related efforts.

We appreciate the opportunity to participate in today’s conversation, and look forward to working with the federal government and healthcare community partners to ensure that we can leverage all opportunities to can maximize coding efficiency and accuracy and facilitate optimal use of EHRs in the clinical workflow.