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Statement of

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Re: Billing and Coding with Electronic Health Records

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My name is Dr. Steven Wartman, and I am the President and CEO of the Association of Academic Health Centers (AAHC). Thank you for your invitation to speak today on the important issue of billing and coding with electronic health records. AAHC, representing nearly 100 academic health centers nationwide, is dedicated to improving the nation's health and well-being by mobilizing and enhancing the strengths and resources of the academic health center enterprise in health professions education, patient care, and research. Our members comprise all the health-related components of a university, including health professions schools (e.g., medicine, nursing, dentistry, public health, pharmacy, and others), biomedical and clinical research programs, and teaching hospitals and/or health systems.

Electronic health records have great potential to increase patient safety, quality of care, and efficiency. Those improvements are crucial for health professionals to be able to deliver the patient care of tomorrow. Changing demographics, increased coverage due to the Affordable Care Act, evolving payment models, and technological innovation, are all contributing to a time of great disruptive innovation in the way health care is delivered. To meet the needs of the population, health professionals will need to begin to work collaboratively in interdisciplinary and interprofessional teams, practice at the top of their scope, and work seamlessly with electronic health records and other technological tools.

AAHC and its member institutions acknowledge that while electronic health records offer great opportunity, they also pose potential problems. AAHC was one of a handful of organizations receiving a letter this past September from HHS Secretary Kathleen Sebelius and Attorney General Holder. The letter expressed concern about observed trends that might indicate that electronic health records are being used to perpetrate fraud. The trends mentioned in the letter were particularly related to the coding of evaluation and management (E/M) services, and indicated an intention to have CMS Recovery Audit Contractors (RACs) focus more heavily on E/M billing and coding.

The theory that electronic health record templates for clinical note documentation inherently lead to upcoding is thus far unproven. In fact, there is some evidence to the contrary. A December 2012 article in the *New England Journal of Medicine* argued that the trends in higher E/M codes in emergency rooms were actually linked to shifts in patient demographics and a changing care delivery environment. Templates serve as prompts and guides to remind health care providers to document information that may not previously have been written down or dictated into a note. One of the goals of increasing the use of EHRs was to increase the accuracy of documentation. The use of a template to encourage this increased accuracy does not deserve to automatically be flagged as fraud and trigger a RAC audit.

While we agree that some EHR features have the potential for misuse, academic health centers have and will continue to be diligent about encouraging a culture of compliance and imposing consequences whenever necessary. Over the past several years, our member institutions have worked diligently to develop robust compliance and auditing functions in order to prevent, and if necessary, respond to instances of fraud, waste, and abuse. Chief compliance officers from our member institutions participate in AAHC's Forum on Regulation where, for quite some time, they have worked together to share best practices. In the past few years, the group has expressed concern about the availability of clear and useful guidance on the coding of evaluation and management services, and in AAHC's response to the September letter from HHS and DOJ, we continued to express those concerns.

Fundamentally, AAHC believes the root of the problem lies in a system trying to move towards the future while still being rooted in the past. Current billing and coding regulations reflect a practice environment that is rapidly becoming extinct, an environment in which health care providers do their charts by hand, keep paper records, and have a younger patient population with fewer comorbidities. For example, current documentation and payment guidelines for E/M services require inclusion of certain data points (e.g., social history, past medical history, and family

history) in the note to justify a higher coding level. However, electronic health records are structured to allow for the storage of these data points without including them in the note itself. Omitting one or more of these data points from the note could lead to significant financial penalty, even though the information was appropriately obtained by the provider.

We strongly believe that billing and coding regulations need to be updated to reflect the changing demographics of the patient population and the rapidly evolving practice environment of the future, a future where multiple providers are collaborating with one another on a patient's care and increasing amounts of data on each patient are digital. EHRs are designed to enhance care coordination and communication by allowing multiple providers to document the care of a patient in a single note. This type of collaborative documentation can reduce duplication, decrease unnecessary errors, and streamline the process of caring for ailing patients and supporting their caregivers. The result not only increases efficiency but also improves the quality of care being provided. Unfortunately, in professional fee billing, a single note is required for each billing provider, and those single notes must include the same items collected (and stored) by other providers. This example highlights the disparity between the regulations and the way care needs to be delivered.

AAHC and its Forum on Regulation appreciate your willingness to explore and revise existing policies to better reflect the use of electronic health records. We would be pleased to work with CMS and ONC to improve the available guidance and increase clarity for our members and the healthcare delivery system as a whole. I thank you for the opportunity to speak today and look forward to working with you on this important issue in the future.