Federation of American Hospitals

Written Statement
Listening Session on Billing and Coding with Electronic Health Records
Centers for Medicare & Medicaid Services
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The Federation of American Hospitals ("FAH") is the national representative of investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching hospitals in urban and rural America, including inpatient rehabilitation, long-term acute care, cancer, and psychiatric hospitals.

The FAH has been, and continues to be, a strong supporter of the HITECH law. We have been a committed partner to the Department of Health & Human Services ("HHS") in the implementation of the Electronic Health Record ("EHR") Incentive Programs and believe strongly that interoperable Certified EHR Technology ("CEHRT") is a critical enabler for the health system to achieve the "triple aim" of better care, better population health and lower costs. The majority of our member hospitals are already "meaningful users" of CEHRT, and the remaining member hospitals are actively working toward that goal.

It is clear that access to objective medical information about a patient is critical to physician and provider decision-making at the point of care. Our member hospitals recognize that health information technology ("HIT"), specifically EHRs, can be a conduit for making the right information available at the right point during a patient's episode of care, whether in the Emergency Department or upon admission to a post-acute facility, resulting in better care for patients. CEHRT also can facilitate greater access to critical information for non-clinicians, empowering patients (and their caregivers) to assume a more active role in their healthcare.

Public policy has appropriately been used to drive adoption of EHR technology that meets established functional standards. Due to their very nature, EHRs have the ability to seek and capture more information than is accessible in paper records today. An electronic format allows for a more uniform way to capture data and eliminates existing challenges that create patient safety concerns, such as illegibility of medication orders and other health information. EHRs also create efficiencies for providers who in the paper world spent a great deal of time deciphering handwriting, searching thick paper records and waiting for patient charts to be

delivered to the floor to obtain information required to make appropriate treatment decisions. As technology matures and vendors continue to innovate, assistive technologies (such as voice recognition) will only lead to improvements in documenting care which, in the end, will result in improved care for patients.

The move from a paper-based to an automated environment marks a significant change and step forward for all parts of the healthcare system, both in terms of patient care and hospital operations. We understand the need to monitor this change closely and identify and mitigate any unintended consequences. However, the fact that improved documentation leads to more accurate and scientific coding should not be surprising and is not, in our opinion, an unintended consequence. It is a direct result of policies that are actively driving the goal of more robust documentation. CMS payment systems now seek greater specificity and more granularities (*e.g.,* MS-DRGs). These payment systems will be driven by even more detailed data in the future with the implementation of ICD-10. Both the payment systems and their underlying data sets incentivize better data capture and coding. Further, the Meaningful Use program, by its very nature, is designed to drive better documentation of the care being received by patients. Improved coding is a desirable and inevitable byproduct of this improved documentation.

The use of technology in healthcare has brought about great advances in treatment and outcomes for patients. EHRs increase the ability to capture meaningful data about each patient encounter. Hospitals are committed to using CEHRT to improve quality at the point of care and to improve our ability to measure quality and track progress overtime. Better structured documentation across the care continuum will result in a healthier population through a more coordinated care delivery system.

CEHRT is allowing hospitals to do a better job of documenting the patient's story. And, as providers get better at telling those stories, they will have better data with which to understand trends and complications in order to design improvement strategies based on sound data. For example, computerized provider order entry ("CPOE"), a critical function in Stage 1 and Stage 2 of Meaningful Use, is enabling providers to implement evidence-based order sets. This allows data capture on what clinicians are ordering and why they are ordering it. CPOE based on order sets built on best evidence, has the potential to lower costs and achieve better patient outcomes.

We believe that fraudulent use of EHRs by providers is the exception and not the rule. We take very seriously the integrity of each patient's individual record as an accurate reflection of the care that patient received while in the hospital. We understand concerns about the potential for "cloning" of patient records to facilitate erroneous billings due to inappropriate coding. Our member hospitals are committed to a culture of compliance in which payers are billed only for services actually furnished to patients using codes that properly represent the type and level of care furnished. And, improved coding should not be viewed as "upcoding."

Hospitals operate robust audit and compliance programs. EHRs as a tool to document the care received by patients, are being built into current hospital compliance structures. Hospitals see the value in backend, manual protections in a developing electronic environment. Our understanding is that hospital-owned physician practices function under a compliance framework that mirrors the hospital's rigorous methods.

Providers are beholden to the functionality of the EHR products they purchase from vendors. We see the obligation to build in safeguards to detect and prevent fraudulent use of EHR systems as a shared objective for both providers and vendors. In the hospital environment, coding is still largely a human function. Our member hospitals view this as a critical check and balance to ensure appropriate use of EHRs by the clinicians who input data during the care process. In the electronic hospital word, coders start from a better place, from a place that provides them with timely, legible, and searchable data.

We are confident that with innovations in technology, there are opportunities to build standard safeguards into EHR systems. We would like to partner with the vendor community and the ONC to identify technological safeguards that could be built into the EHR to aid providers attempting to identify fraudulent activity. Protections again misuse need to be incorporated in the underlying EHR infrastructure. For example, a reasonable safeguard would be that any "copy and paste" activity in a record would be permanently tagged in a different color, with no override capability for the clinician. This is already a common function in many vendor systems, but not standard across the industry. In our view, the level of resources necessary to document care should not hinder the ability to furnish care.

As HHS looks to address concerns about fraudulent use of EHRs, we encourage use of a balanced approach. Any policy aimed at combatting inappropriate use of EHRs, particularly any new certification requirements, should preserve the benefits of these systems for clinicians in the diagnosis and treatment of patients. Use of templates and pre-population of certain data fields, as well as edit capabilities, are critical enablers to ensure timeliness and accuracy of data and to facilitate an effective care delivery system. Data capture as a byproduct of the care process is a critical benefit of EHR technology.

It is important to recognize that there are many instances in which information is brought forward in the record to provide the clinician with complete details and the opportunity to update elements of the record. This functionality has important uses in the delivery of care and does not constitute a misrepresentation of the care delivered to a patient in order to achieve a higher reimbursement rate. In fact, many systems tag any information that is "brought forward" in a patient's record. Those tags then become part of the permanent record and can be easily identified by coders. Our hospitals view tagging as a critical function in EHRs in order to identify the origin of the data for a variety of purposes, including the incorporation of data from outside systems and as a safeguard against inappropriate use of the EHR.

The FAH is confident that the investment in EHRs by providers, and by the Federal Government in the form of EHR Incentive Payments to certain hospitals and clinicians, will result in real benefits for patients and the healthcare system as a whole. Hospitals are building robust analytics capabilities to take the data collected in EHRs, understand trends and what drives good outcomes and translate that data into improved care processes. EHRs have the potential to drive the discovery and adoption of evidence-based practice in a way unimaginable in the paper world.

We welcome the opportunity to work with HHS and other stakeholders to ensure technological advances in EHR technology are used to create operational and cost efficiencies in healthcare delivery and to improve outcomes for patients resulting in a healthier population.