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**TESTIMONY OF THE
ASSOCIATION OF AMERICAN MEDICAL COLLEGES
THE OFFICE of the NATIONAL COORDINATOR'S HEALTH INFORMATION TECHNOLOGY
CLINICAL DOCUMENTATION HEARING
FEBRUARY 13, 2013**

Panel 4: The Role of Clinical Documentation for Legal and Billing Purposes

My name is Ivy Baer. I am Senior Director, Regulatory and Policy Group at the Association of American Medical Colleges. The AAMC represents all 141 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans' Affairs medical centers; and nearly 90 academic and scientific societies. Through these institutions and organizations, the AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians.

I have been asked to address the role of clinical documentation for legal and billing purposes. What I know has been learned from the smartest people in the business—compliance officers who work at AAMC member institutions. You will not be surprised to hear that they echo their institutions' commitments to providing quality patient care, improving population health, and submitting accurate bills to all payers. Our members have robust compliance programs and are squarely facing the many challenges of moving from paper to electronic records.

In the latest 1990's, with the growing focus on compliance, the purpose of the medical record shifted from its original purpose-- a document that was necessary to ensure the best patient care-- to a document that had to support any service billed. In an academic medical center, the complexities are enormous, as the number of individuals who touch a medical record—whether it be paper or electronic—is large, both because care is more likely to be delivered by a team and because of the presence of learners—medical residents, medical students, and other health profession students.

In recognition of the environment in which our members are implementing electronic health records, the AAMC's Compliance Officers' Forum has undertaken a multi-year project that is aimed at developing advisories that set out best practices in compliance. The three Advisories produced to date address: medical student documentation; the use of information that is not generated during the encounter for which the claim is submitted: Copying/Importing/Scripts/Templates; and physicians combining documentation or using information documented by others when billing for a professional service.

Preparation of the advisories involved many hours of discussions that lead to the conclusion that there is no single way to achieve what one of the Advisories describes as "appropriate clinical documentation to support quality patient care, facilitate the optimal and efficient use of available documentation, and

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simultaneously provides controls to ensure compliant data usage in support of billing.” As a result, the advisories look at a myriad of strategies that combine the need for appropriate EHR design, adoption and implementation of institutional policies, provider education, and monitoring. One of the advisories states that “much of the mitigation of risk rests on policy and training directed at the judicious use of tools [that are available in the EHR].” For example, it may be easy to cut and paste a portion of a note written during another visit, but does the note represent what is done during this visit? Or, does it merely mean that the note will contain information that is not needed and that leads to “note bloat”?

With that as background, each of the panelists has been asked to respond to four questions.

- **What is the current role of clinical documentation (particularly the progress note) for payment purposes?**

Clinical documentation is the source that is used to substantiate a bill. In the 1990’s when the commitment to compliance emerged front and center in the health care field, every compliance officer’s mantra was “document, document, document.” Generally this was followed by the warning that if something is not documented in the medical record, then for billing purposes it didn’t happen. This underscores the point that the medical record was viewed as the source for billing, leading to a role that seemed to overshadow the role of the medical record as the source for good patient care.

The progress note summarizes the events of the day, supporting the resources ordered and used to address a patient’s signs, symptoms and conditions that require care. A well written progress note may well be the most important document in the entire medical record.

The EHR poses particular challenges to fulfilling this purpose. As one of the advisories cautions: Unlike a note written on paper, a note written in an EHR can be generated by using information that already has been recorded elsewhere, and can be imported from either within or outside the EHR. The result can be a note that appears to be new and contemporaneous, but actually is a combination of pre-existing material. Incorporating information that is not original to the author into a note has the potential to jeopardize patient care and expose providers and/or institutions to liability. Risks include: populating a note with outdated, conflicting, incomplete or inaccurate information; inability to identify the original author; notes that are repetitive, inconsistent or identical; and notes that are too long and contain irrelevant information. Education, auditing, and monitoring are essential to mitigating these risks.

- **Do you foresee a change in the role of documentation (for billing, accreditation) under reform, when payment will no longer focus on verifying that transactions have occurred?**

For patient care purposes, population management, and risk management, accurate documentation will always be a necessity. Yet, every indicator is that payment systems—both governmental and commercial—are moving from fee-for-service reimbursement to payment that is based on quality and other metrics. Identifying and developing appropriate metrics is a huge challenge that currently is in

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the early stages. Nonetheless, the role of documentation should change from supporting billing that is based on level of effort (the current evaluation and management system) to supporting the metrics on which payment is based. In turn, this should mean that the focus of audits will have to change as well.

- **What policies would you recommend to mitigate the risk of fraud or to avoid misrepresentation in clinical documentation?**

Any documentation of patient care needs to clearly establish that it pertains to the particular patient and condition for which the patient is being treated. From a clinical perspective, timeliness and complete documentation at the point of care assist in reducing the possibility that the note will lack specificity or include conditions no longer requiring care. An active documentation program that addresses audit issues, claims denials, and shares updates via feedback loops goes a long way to support clinical documentation, reducing facility risks. Timely communication to patient care providers is the key to accurate and complete documentation.

Recommendations for policies include:

- Limiting the use of the copy/paste functionality within EHRs. This should be combined with a feature that flags anything that is pasted, by making the text appear another color or another font.
- Educating providers to only document the services they provide that are pertinent to the patient's presenting problem(s).
- Close monitoring of provider documentation to correct errors and educate providers in a timely manner.
- Having the ability to identify the author of any note or portion of a note.

Again, I need to emphasize that technology alone cannot mitigate the risk of fraud and avoid misrepresentation. System transparency and ensuring that patients receive medically necessary care also are required. The waivers from the fraud and abuse statutes that the HHS Office of Inspector General will grant to participants in the Medicare Shared Savings Program provide an example of how these concepts can be realized in a new type of health care delivery system.

- **How has/can technology be used to improve the accuracy and efficiency of documentation?
How can technology be used to guard against misrepresentation?**

There is no question that technology can improve efficiency and accuracy of documentation. For example, template-driven clinical documentation can provide alerts and decision trees that support accurate and efficient care. However, a balance must be achieved so that providers are not frustrated by an overwhelming number of alerts and decision trees. Prompts should never ask leading questions. Their purpose is to provide decision support that guards against misrepresentation. Documentation requirements should be designed to support care and communication and should not layer more controls on top of a system that is based on fee-for-service payment.

But no matter how good the technology, there needs to be an equal contribution from institutional policies, education about how to use the technology, monitoring, and providers, all of whom want to do the right thing for their patients while being paid appropriately for their services.

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AAMC Compliance Officers' Forum EHR Compliance Advisories are available at:

<https://www.aamc.org/download/253810/data/medicalstudentdocumentationinanehr.pdf>

<https://www.aamc.org/download/253810/data/medicalstudentdocumentationinanehr.pdf>

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