‘Show Me the Money’ Revisited

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In the immortal words of Ronald Reagan, “There you go again.” Something that can be explained simply is twisted to look infinitely complicated with plots and subplots that would make J.K Rowling proud. The recent controversy over the use of electronic medical records (EMRs) to increase reimbursements to providers suggests intrigue, fraud, and bad intent. In contrast, if you learn how the money flows, you will better understand the true reasons for the outcomes seen in organizations using EMRs.

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A *New York Times* report published in September 2012 documented an increase of $1 billion in Medicare reimbursements in 2010 over the amount paid 5 years earlier. The report partly attributed this payment increase to changes in billing codes assigned to patients in emergency rooms.

For example, claims for the emergency room at Faxton St. Luke’s Healthcare in Utica, New York, rose 43% in 2009, the same year the hospital began using an EMR system. Baptist Hospital in Nashville saw its claims rise 82% in 2010, also the same year it began using an EMR. In response, both hospitals claimed their billing was now more representative of the services provided and therefore more accurate.

Methodist Hospital Center of Illinois in Peoria saw its emergency room coding shift from 50% of patients receiving the highest acuity code (higher reimbursement) in 2006 to more than 80% in 2010, making the hospital one of the country’s most frequent users of high-paying evaluation codes. We can easily guess when Methodist rolled out its emergency room EMR—2006.

In addition, 1,700 physicians of the more than 440,000 doctors in the country accounted for more than $100 million in additional reimbursement in 2010 alone. The majority of these physicians specialized in family practice, internal medicine, and emergency care. The role of EMR adoption in this is unclear.

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EMR Value Questioned

Such stories send shivers through the EMR community. To date, hospitals, EMR vendors, and the government struggle to demonstrate the value of EMRs in enhancing patient care and delivering cost savings. With billions of federal dollars earmarked to payment incentives for the use of EMRs, government officials anticipate some kind of return on this investment. Government EMR advocates did not expect to see an increase in reimbursements by public and private payors to providers through “enhanced” billing practices (code optimization [legal] or code maximization/up-coding [illegal]) activities.

To level set our understanding of our reimbursement system, let us take a look at how payments are determined. The amount of work associated with a particular type of care delivery drives the level of reimbursement. As observation of each patient encounter is an impractical way of documenting care and determining reimbursement, provider organizations utilize clinician notes

in patient medical records to assign and substantiate a level of work that is then tied to a set reimbursement amount.

Fast and Slow

Compared to paper records, EMRs allow for more rapid and complete documentation. In addition, EMRs slow the documentation process. Wait, how can EMRs both speed up and slow down documentation? It all depends upon deployment of the EMR and the constructed documentation workflows. EMRs with robust documentation templates and checklists facilitate documentation by allowing clinicians to leverage a single mouse click into a completely documented review of systems. If a clinician completes a partial review of systems—eyes, ears nose, throat, heart, and abdomen—but declines to examine extremities, skin or other areas, a clinician using an EMR must individually choose each system and document it appropriately. Clearly, checking one box to indicate completion of a comprehensive review of systems, with further effort made to document the problem area, is easier to do and takes less time than searching for and choosing each system individually within the EMR.

The limited consequences associated with not completely accurate documentation (e.g., organ system review appears normal even though each item was not reviewed in depth) incentivizes clinicians to utilize the easiest documentation workflow, which in many cases is checking a single box in an EMR. Most clinicians do not purposely falsify documentation to enhance reimbursement, but it is reasonable to believe that the documentation workflow facilitated by EMRs encourages more "robust" documentation simply because it is easier to do. We can postulate that as EMRs encourage full review of systems—or at least its documentation—those who fail to "check the box" may position themselves for future medical liability as complete review of systems becomes the norm rather than the exception. Of course, documenting a normal organ without reviewing it also exposes the clinician to malpractice claims if an abnormality is missed, but checking the complete-review-of-systems box may become the norm for those using EMRs.

Only a very small number of clinicians and provider organizations "game" the system to maximize their reimbursement. It is the economic incentives baked into our reimbursement system that generate the higher payments observed in organizations using EMRs.

Two Masters

Unfortunately, EMRs focus on two important objectives at the same time– 1) facilitate clinical documentation to deliver patient care, and 2) facilitate clinical documentation to optimize coding for reimbursement. Documenting for patient care does not closely parallel documenting for reimbursement. Some details required to optimize coding for reimbursement have little if any impact on care delivery, while other details needed for proper patient care do not impact reimbursement. This dual purpose of EMRs creates a situation of great complexity that prevents documentation from being an efficient process. Therefore, it is not unexpected that users design workaround workflows to increase usability of their EMR systems. This activity generates templates that encourage documentation of activities that in some cases exceed what was actually done.

As long as reimbursement is tied to documentation, EMR documentation workflow will suffer from inefficient documentation workflows, inaccurate documentation of care from global templates, and accidental (or deliberate) upcoding for reimbursement.

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Documentation for patient care must be decoupled from documentation for reimbursement. Rather than use EMRs to drive reimbursement, they should be refocused on assisting clinicians with patient care. Organizations under prospective payment models (e.g., capitation, ACO) are free to develop EMR documentation workflows focused on patient care, which should differ greatly from workflows developed by organizations motivated by other reimbursement models. Only by changing financial incentives will clinicians effectively utilize EMRs to enhance patient care. Until then, rather than blame EMRs for increased reimbursement trends, watch how the money flows.

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