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A Response to the Call to Action to Improve EHR Documentation

To the Editor:

In response to the "Call to Action to Improve EHR Documentation"[1]:

Physicians insert "boilerplate text" (which conveys no new medical information or insights) into their clinical notes mainly to satisfy documentation requirements imposed by the Medicare *Evaluation and Management* (E&M) *Services Guide*.[2] Medicare and nearly all private health insurers adhere to the E&M Guide to determine their payments to physicians. These E&M service definitions largely dictate the format and content of physicians' progress notes.

There is tension between physicians, who want to be paid in full for their efforts, and payers, who want to minimize payments to physicians. Payers enforce physician adherence to E&M documentation and billing regulations by hiring clerical employees called "coders" to audit patients' clinical charts for documentation deficiencies. To avoid fines and prosecution, physician notes are usually generated first and foremost to fulfill the requirements of these coder audits, rather than the needs of their fellow clinicians. Coders determine whether a progress note meets the billing requirements mainly by checking how many elements of defined data are present. Most physicians are not completely familiar with the complex, confusing, and arcane E&M requirements, so they load up their notes with as much computer-generated boilerplate as they can, hoping it will include an overlooked element of data needed to satisfy a coder's audit.

This whole system must be discarded, or there can never be any hope of having progress notes that communicate clearly and concisely between clinicians. A quick and sure way to end this "tyranny of the coders" is for Congress to terminate the exemption granted to payers by the patient privacy laws. This would eliminate inspection of the clinical chart by payers and their coders. Payers would no longer need battalions of coders, who could be relieved of their duties and retrained to perform more productive tasks.

Payers should not be allowed to read, inspect, or audit patients' clinical charts; this is a violation of patients' medical privacy. It harms patients by causing physicians to spend more of their limited time generating progress notes, leaving less time for interacting with patients. Payers must verify physician billings without violating the privacy of patient charts. Payments could be determined by the average amount of physician time required to treat the patient's illnesses and manage their chronic conditions, as determined from the submitted International Classification of Diseases, 10th Revision codes. Physicians could submit attestations for any required variations. In a world without E&M coding requirements, the clarity and efficiency of clinical documentation could be improved enormously, with more time for physicians to actually examine and treat patients.

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