The Reply

CrossMark

In his thoughtful letter, Keller extends the scope of my commentary (discussing current limitations in electronic health record documentation[1]) to cover the important issue of physician reimbursement. His arguments are germane and complement my position very well. Although I focused mainly on technologic and informatics considerations, Keller astutely notes that an important contributor to the current problem with electronic health record documentation is the external monetary pressure applied on physicians by payers.

I had alluded to the fact that electronic health record vendors seem to be more concerned with building systems that fulfill billing and regulatory requirements than with satisfying the end-user (mostly physicians). However, Keller further posits that these same billing requirements not only affect how electronic health systems are constructed but also negatively affect the way providers themselves actually use the electronic health record. As noted by Keller, payers use a team of "coders" to review documentation and then remunerate providers using Medicare guidelines as a framework for reimbursement. This creates a situation in which physicians may both (1) consciously or subconsciously inflate clinical notes with unnecessary clinical information to ensure appropriate compensation and (2) work within electronic environments that are specifically built to encourage and facilitate this suboptimal documentation behavior. This creates a perfect storm, generating a tsunami of unnecessary information in clinical notes that threatens to wipe out effective, succinct, clinical communication. This is a very real problem that deserves more attention.[2]

However, I would argue that physicians do have to share some accountability for their documentation. I expect Keller would agree. Although Medicare definitions often dictate the format of progress notes, I do not think they need to completely dictate the content. I still think the onus is on physicians to present a salient clinical narrative somewhere in the note with an easy to follow description of the treatment plan. I would suggest that perhaps the reams of data necessary to satisfy "coders" should be stored (quarantined perhaps) in a special section in the electronic note, one that can be collapsed and dismissed by subsequent readers. I do not agree with Keller's assertion that notes are "usually generated first and foremost to fulfill the requirements" of "coders." However, I would like to report an important disclosure: I am a fellow in training at an academic medical center and have not been subject to the financial pressure of real-world medicine.

In this context, I wholeheartedly agree with Keller that proactive steps are now needed to realign incentives regarding documentation. His suggestion that "coders" should be restricted from reviewing confidential medical notes for privacy reasons seems reasonable; however, I worry whether this is feasible (particularly in the current political environment). Nonetheless, erudite suggestions from providers such as Keller are exactly the type of conversation I hoped my commentary would generate. I am confident that providers will begin to proactively effect change in the electronic health record[3] and that vendors are taking notice.

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