

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(I-11)

Introduced by: Idaho Delegation

Subject: CMS Audits of Electronic Health Records

Referred to: Reference Committee B
(Liana Puscas, MD, Chair)

1 Whereas, There is a federal push for medical practices to implement electronic health records
2 (EHR's) to improve quality of care, reduce errors, and create standard methods of
3 documentation; and
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5 Whereas, Incentive payments have been approved through the American Recovery and
6 Reinvestment Act of 2009 to assist in payment for physicians to adopt, implement, and upgrade
7 to EHR systems; and
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9 Whereas, The 2011 Office of Inspector General's (OIG) Work Plan includes direction to review
10 EMR/EHR systems due to concerns over system up-code selection, cloning of patient data on
11 subsequent visits, and auto population or "auto fill" features; and
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13 Whereas, The OIG expresses concern about the classic EHR physician documentation
14 shortcuts which OIG audits are identifying as exhibiting a documentation trend of cloning,
15 templating, and utilizing of "same language" macros; and
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17 Whereas, The OIG work plan specifically targets CPT Code 99214, *office or other outpatient*
18 *visit for the management of an established patient*, for increased scrutiny; and
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20 Whereas, An EHR's inherent systematic process is built upon technology which produces
21 redundant reproduction of the same information through the application of pull forward
22 technology, disease specific templates, and macro shortcuts; and
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24 Whereas, Physicians utilizing EHR systems to increase productivity and create a data system
25 that will correlate with a technologically based approach to track and improve quality of care
26 could inadvertently be exposed to increased scrutiny under the OIG's scrutiny for cloning, use of
27 templates, and macros; and
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29 Whereas, There is a significant disconnect between the OIG intent to scrutinize medical records
30 for cloning, use of templates, and macros, and the federal government's and the Centers for
31 Medicare and Medicaid Services' (CMS) actions to increase use of electronic health records to
32 reduce waste and increase quality of care; and
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34 Whereas, Idaho physicians who submit claims with CPT Code 99214 are currently being
35 audited by the Idaho Medicare carrier, Cigna Government Services; and
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37 Whereas, Medicare auditors are alleging that physicians are providing care that is found not to
38 be medically necessary at the level of CPT code billed; and

ADOPTED AS AMENDED

1 Whereas, Communication from the Idaho Medicare carrier does not specify the actual
2 determination found by the Medicare auditor for each of the three key elements of history,
3 exam, and medical decision making; and
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5 Whereas, CMS has failed to provide adequate communication to physicians regarding the
6 specific documentation criteria which are used by Medicare auditors to determine medical
7 necessity; therefore be it
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9 RESOLVED, That our American Medical Association lead an effort in concert with the Centers
10 for Medicare and Medicaid Services to establish specific guidance to be utilized by entities that
11 audit documentation generated by an electronic health record (Directive to Take Action); and be
12 it further
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14 RESOLVED, That such guidance provide specific protocols used by Medicare and Medicaid
15 auditors to allege a service is not reasonable and necessary based on the generation of an
16 electronic health record (Directive to Take Action); and be it further
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18 RESOLVED, That our AMA inform state and specialty societies about available AMA resources
19 to assist physicians with audits of electronic health records and prominently feature on their
20 website information about methods, resources, and technologies related to appeals of electronic
21 health record audits and Medicare and Medicaid overpayment recoveries as a members-only
22 benefit. (Directive to Take Action) and be it further
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24 RESOLVED, That the use of time-saving features, such as cloning, templates, macros, “pull
25 forward technology”, auto-population and identical language in EMRs, by itself is not an
26 indication of inaccurate documentation or incorrect coding (New HOD Policy); and be it further
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28 RESOLVED, That audit results that imply incorrect coding must specifically indicate which
29 portion of the chart language either does not accurately reflect the office visit or reflects
30 unnecessary care. (New HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000.

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RELEVANT AMA POLICY

D-175.985 The CMS Electronic Medical Records Initiative Should Not Be Used To Detect Alleged Fraud by Physicians - Our AMA will (1) communicate its concerns about the plan recently announced by the Centers for Medicare and Medicaid Services (CMS), in which CMS is to use data from the electronic medical record incentive program in the pursuit of fraud, waste and abuse; and (2) seek active involvement in the drafting of all program directives for CMS’s electronic medical record initiative, including all directives about potential data capture and subsequent audit processes. (Res. 212, A-10)

ADOPTED AS AMENDED