

## Certification Adoption Workgroup

### Draft Transcript

December 19, 2011

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Hi, this is Mary Jo Deering and I am with the Office of the National Coordinator for Health IT. This is a meeting of the Health IT Policy Committee's Certification Adoption Workgroup. It is a public meeting. There will be an opportunity for public comments at the end and I will begin by taking roll. Joan Ash?

**Joan Ash – Ohio State University**

Here.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Rick Chapman?

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

Larry Wolf for Rick Chapman.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Adam Clark? Steve Downs? Carl Dvorak? Paul Ergerman?

**Paul Ergerman – Businessman/Entrepreneur**

Here.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

John Glaser? Joe Heyman?

**Joe Heyman – Whittier IPA**

Here.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

George Hripcsak?

**George Hripcsak – Columbia University NYC**

Here.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Charles Kennedy? Marc Probst?

**Marc Probst – Intermountain Healthcare**

Here.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Martin Rice?

**Martin Rice**

Here.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Donald Rucker? Latanya Sweeney? Paul Tang? Micky Tripathi? Have I missed anyone who is here, who is a member of the Workgroup? Okay, I think I'm turning it over to you Larry, is that correct?

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

That's fine. So I would like to welcome everybody to this call. This is mostly to bring this topic to the Workgroup. There have been some initial preliminary discussions with Marc Probst and myself and members of ONC, and a couple of other folks from HHS about this general topic. We felt it was worthy for our discussion and review, although our initial sense is that there is not a whole lot for us to do at this time given that several other federal agencies are looking to collect more information and maybe we should wait until they have something to tell us. So, maybe with that as context, Steve are you going to walk us through the slides?

**Steve Posnack – Office of the National Coordinator for Health Information Technology – Policy Analyst**

Sure, absolutely. I don't know if the operator can pull up the slides? All right awesome. Next slide please. That's the title. Okay, so for those of you that recall, Jodi Daniel presented at the Policy Committee maybe two Policy Committee meetings ago, about ONC's interest in pursuing additional recommendations from the HIT Policy Committee on this important area and we agreed to go off and help Marc and Larry at a staff level to try, and Paul as well, who I think was on our first call, to get more information and see where there were areas for the Workgroup's attention to focus, and if there wasn't, if there were other directions that the Workgroup would go in, in this area in general.

So, just to jog folks memory and I'm doing this presentation as the scribe so to speak in terms of the couple of calls that we had with different stakeholders. So, ONC has done work in this area previously as Jodi had mentioned under the...funds that we received from OIG to do analysis with respect to antifraud in EHRs and data quality and integrity over the years in 2005 and 2007 with those reports. We've also included, as part of our certification rules, certain capabilities related to security. There is a Standards and Interoperability Framework activity that CMS is part of, which is the electronic submission of medical documentation for claims review, EsMD, and then there is you all, which started roughly in September to take a look at what the state of affairs were. Next slide please.

Okay, so we had a first phone call with Dr. Don Simborg who is a respected expert in this area, lots of information that he's published articles about and discussed with us to give us the lay of the land, where things were as he saw them, etcetera, and we had a second call about relative to the federal agencies that have a role with respect to fraud, waste or abuse, and research in those areas as well. So, we had representatives from two different operating agencies within CMS, as well as folks from the OIG and colleagues from the Department of Justice who focused on, I believe it was Medicare fraud. So, we sought to get some of their feedback, what they had seen, what they are working on, what they're interested in, what keeps them up at night, and where further work from the Certification Adoption Workgroup could be helpful. Next slide please.

So, here's some of the observations and insights and I'm sure Larry and Marc, and Paul from their experiences on the calls could ad lib and provide some additional context for folks after I'm done with my talking head routine. There wasn't a kind of clear smoking gun relationship and evidence between EHR related or EHR attributed fraud. It's not to say that this might not be occurring. It didn't seem to be like a propensity, a large amount of research that had already been completed that pointed to it or a building trend, etcetera, there just wasn't this firm basis foundation to say that it's real, it's here, we need to deal with it in these x ways.

So, we had these discussions with the folks that we talked to relative to what their concerns were, what anecdotes people had heard, which could very well be perceived or miscommunication, and where there were potential areas where there could be potential, you know, putting the crystal ball out in front of folks

and saying, you know, where do you see some of the vulnerabilities and risks that exist with EHRs. And so some of them had to do with simple capabilities that are also built in to increase sufficiency, like particular templates, other types of functionality that may involve copy and paste or copy forward, or automated population of certain data from prior encounters, those all seem to stoke a little bit of concern in the minds of our colleagues relative to how they could be abused or misused.

And we talked with our OIG folks who I think, as Larry indicated there is some work underway and they have published a 2012 work plan which includes some things related to EHRs that I believe we could probably pull down and send to folks that don't have the specific initiatives memorized. And then we had a discussion relative to, broader than just, you know, black and white, is this fraud or not, areas where there are data integrity concerns, data quality concerns and making sure that the data is accurate in the EHR technology so that in the event that an investigator or an auditor come these things can be reviewed, the data is actually there for them to look at and other special technical means like digital signatures for tracking whose modified records. Next slide please.

So this is a public service announcement, current industry activities that are out there, HL7 has a Workgroup that is focused on records management and evidentiary support. We're also aware that there are programs out there in the private sector related to compliance officers that have issued guidance in some forays related to electronic health records and those are activities that are underway, so just people can keep in mind that it's not just the public sector here and the federal government aspect of things relative to these activities and I think the next slide would be my last.

And so this is for Workgroup discussion and turning it back over to the co-chairs as well. There could be a discussion about if there is additional work in this area that the Workgroup wants to pursue or for ONC staff to continue to plod along and figure out or you can turn your attention to other areas that we could find that is mutually beneficial to receive recommendations on, but there seemed like there was some general next kind of feedback steps and I think one of the reasons why we wanted to have this, I don't want to speak on behalf of the chairs, but you can correct me if I'm wrong, one of the reasons why we wanted to have this call was to update everyone on the activities that had occurred since you had last spoke and since Jodi had last presented and to kind of just nail down some talking points that if Marc and Larry were to present at the Policy Committee's next meeting they could convey the sense of the Workgroup in terms of what work could be done in this area. So, I will turn it over to you Larry, I guess.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

Okay. So, let me start with a question that Joan raised recently, which was why this Workgroup? And I think the reason for why we're having this discussion is as the certification gatekeeper, if you will, with ONC and the Policy Committee there was a thought that some of the attributes of electronic health records might affect their ability to either prevent or help detect fraud and certainly would relate to issues like authentication and...how data is handled in the record, the HL7 records management activities you mentioned. So, these might be areas that would fall broadly under our certification umbrella.

**Joe Heyman – Whittier IPA**

Larry, this is Joe Heyman.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

Yes.

**Joe Heyman – Whittier IPA**

I think there is a much bigger implementation reason for it coming before this Workgroup.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

Right.

**Joe Heyman – Whittier IPA**

We at the American Medical Association just passed a resolution at our last meeting in November about the issue of copying, templates, bringing information forward from a previous visit and all that stuff, we

really find it very disconcerting that some of the most important reasons for having an EHR, namely the efficiencies that you get from it, are now being looked at as fraudulent. We think that's an incredible barrier to implementation and I can tell you I use those things every day in my office and I don't do them to be fraudulent, I do them to increase efficiency, and if somebody is documenting something that isn't happening, of course that's fraudulent, but that can happen in a paper record and those people who use paper records and have been in practice for many years, if they look back over their notes they'll notice that they use the same language in every note, because they get to do that by habit.

So, I think the implications of starting, what I would consider a witch hunt for looking for people who are using the similar language because they use templates or because they copy a previous visit and just change the things that are different, or because they document a lot of information, I think that this has an incredible implication about people adopting this technology. If you want to scare people away this is a great way to do it.

#### **Paul Egerman – Businessman/Entrepreneur**

Yeah, this is Paul Egerman, and I just want to agree with what Joe just said. My previous company eScripton, one of the things we discovered is when physicians do dictation they say almost the exact same things over and over again. So, there is a huge amount of repetition in what physicians do. In fact, we based our company on detecting the repetition, you know, physicians think they're doing, seeing different patients and different situations, even somebody like a general surgeon just does the same stuff over and over again and they actually record pretty much the same material.

#### **Joe Heyman – Whittier IPA**

Actually, yeah, that's a great example, Paul. As a matter of fact in my hospital we dictate a standard note and then just modify it.

#### **Paul Egerman – Businessman/Entrepreneur**

Yeah, and what we found was that some people, some surgeons, even general surgeons would dictate the entire note and they didn't even realize that they were dictating major paragraphs pretty much the same each time, but I think it's because they were doing the same thing each time. I mean, they were doing the same procedure and they would just do that. And so the redundancy or repetition does not necessarily indicate fraud. It is also consistent with a lot of trends which is to standardize the practice, to have standard order sets, standard processes to treat patients and when you do that you end up with standard documentation.

#### **Martin Rice**

This is Marty Rice. My experience in the hospitals, it wasn't the templates that were in question, it was the actual assessments that were copied forward and that's what I think is in question with copy forward, the actual assessment data. Templates are, you know, they're pretty much the same.

#### **Joe Heyman – Whittier IPA**

Yes, but even an assessment, if you're seeing a patient relatively frequently your assessment of what their situation is doesn't change unless their situation actually changes.

#### **Martin Rice**

Well, that's my experiences with assessment data within a hospital, specifically within fast moving ones where you had to move it forward every 15 minutes and it was mostly nursing data.

#### **Marc Probst – Intermountain Healthcare**

Larry, this is Marc, I think this is a really interesting discussion as you relayed it back to what Dr. Heyman was saying, and I mean, clearly there's fraud out there and there are people that are using these capabilities inappropriately, they were doing it inappropriately with paper. But if it's becoming a barrier to adoption, because we haven't been clear enough or even provided some clarification maybe there's an opportunity to do that on a broader basis than, you know, and understand the situation better to not have it be a barrier to adoption.

**M**

Yeah, Marc, I think that's a really good question.

**Joan Ash – Ohio State University**

And this is Joan. And we were talking before the call really began about maybe the need for some research and I had brought up the notion that ICD-10 may make everything worse and make more things look like fraud that really aren't fraud. And it's just too soon to know what the unintended consequences of all of this might be. And I like the recommendation basically that we wait and see and study the situation.

**M**

Well, I also think it was sort of telling that in the discussions with the various investigative groups within HHS and DOJ that they didn't come to us saying we found these major problems with EHRs. And so I think it's really important that we get the message out that that is not what they're saying. They're not saying, you know, oh my God there's all this abuse.

**Joe Heyman – Whittier IPA**

Well, I would have to go back to this resolution, because I don't remember exactly what it was, it was from the State of Idaho originally. And I can tell you that there were signals from HSS that sort of, I'm not sure if it was from HHS or FDA, or IOG, I don't know where it was from, but there were signals, and I will find it and I will send you what the AMA passed. But, I can tell you that the whole purpose for having this was because of our concern that when we were finally getting to a tipping point somebody was going to introduce something to scare the crap out of everybody. So, I just want to put that on the table. They may not have said they had any evidence, but somebody was clearly signaling that they were looking for evidence.

**M**

Well, I think that is the concern.

**Joe Heyman – Whittier IPA**

So, I wouldn't object to saying that we want to wait and get some information first, but I would at least raise the opposite concern that this could be interference with adoption, interference with implementation, and even though it sort of came to us because of the certification side, I would say the other side is more important.

**Paul Egerman – Businessman/Entrepreneur**

This is Paul. I'm wondering if there is another way to approach this whole issue, if there's a way to approach the issue by trying to understand what we could do in EHR systems to help minimize the possibility of fraud. I mean, there's a lot of ways that fraud can occur, it can occur in a large organization where you've got some physician who just, you know, up codes, who somehow doesn't get the memo as it were, and does something inappropriate, which is frustrating for everybody, because, you know, you want to do things right, and it can occur when the billing activity is inconsistent with what's in the EHR, where, you know, you bill for a service that doesn't exist in the medical record, and perhaps there are some things that we can talk about that would help organizations with an EHR system feel that they're doing their best to be compliant with what's expected of them.

**Martin Rice**

This is Marty. I think that there is a difference between a mistake and fraud, and just because we're using an EHR doesn't mean it becomes fraudulent because you put the information in, it's just really electronic. And I'd really like to understand what the workflow is that could possibly cause these mistakes that might be interpreted as fraud down the road. So, there is an actual workflow that we have to understand before we start talking about copy forward or how information is moved throughout the EHR, and that's just my two cents.

**Joe Heyman – Whittier IPA**

I would agree with that, that's right, that's the reason that I raised the issue, because for example, in my office most people are coming for a routine exam. So, when I do a routine exam it isn't unusual if everything was normal on the previous exam and this one is exactly the same, it's not unusual for me to just take the previous exam copy it forward and it just automatically takes the new vital signs into it and changes the patient's age and that saves me a tremendous amount of work in my workflow and I haven't done anything different on it. I've done everything that I was supposed to do and I've documented it very carefully. And it just frustrates me when something as simple as that now is going to become a marker for fraud.

**M**

And you're signing that as being accurate.

**Joe Heyman – Whittier IPA**

Exactly and I'm attesting to it.

**M**

Right, so it's attributable back to your assessment, whether you documented it all today or from a previous documentation, it really doesn't matter that much, but you're saying that this is all correct and if you feel that you should be able to copy that forward.

**Joe Heyman – Whittier IPA**

Exactly, it was one of the biggest advantages.

**M**

I think copy forward is abused in certain situations, but I don't think it's on the provider level; I'm not so sure that same issue could be brought up. When you're documenting time after time, after time within an hour period, like every 5 minutes or every 15 minutes, and you just copy forward something, that's a different story, because you're doing those assessments for a reason that quickly.

**Joe Heyman – Whittier IPA**

Well, I would agree with that, but on the other hand I would say if nothing has changed because it's in a very short period of time, you know, it's very unlikely that over a one hour period in a stable patient something is going to change very dramatically, as long as, you know, it's obvious that you're not copying the same blood pressure and pulse, but if you're just copying forward your assessment I don't see that as a big deal, even if it says exactly the same thing every 10 minutes.

**M**

If you're signing it as being correct, you know, there is no difference if you wrote it or copied it forward.

**Joe Heyman – Whittier IPA**

Exactly, that's my point.

**M**

And I guess in defense of the nurses they have the same problems scope down to frequent documentations of smaller chunks of information.

**Joe Heyman – Whittier IPA**

Exactly.

**M**

Much of which isn't changing moment to moment. There monitoring should there be a change, but it doesn't happen in every moment that there is a change.

**Joe Heyman – Whittier IPA**

And the other point I would make about the nurses is, you know, everybody's always complaining that the nurses are treating computers instead of their patients, I mean if you're going to make them type it in

differently every single time just so that you can prove that they're not fraudulently bringing something forward, you know, you're not going to have any contact with patients.

**M**

Well you lose the value of the EHR.

**Joe Heyman – Whittier IPA**

Exactly.

**Paul Egerman – Businessman/Entrepreneur**

And, so this is Paul. So, I'd like to understand how fraud really does occur. So would fraud be that, you know, something is copied forward but the patient would just never be there, in other words they would bill for a visit when the patient never came or the patient came but they didn't really do a complete evaluation and they go ahead and do the copy forward anyway and bill as if it's a complete?

**Joe Heyman – Whittier IPA**

I think the implication, Paul, is that if it says the same thing you just copy it forward and you didn't really do it.

**Paul Egerman – Businessman/Entrepreneur**

Right, so do you understand what I'm asking Joe, is suppose you really were committing fraud, is that what you would do? You would copy things forward but you'd do it on a patient who just wasn't there. In other words there would be no visit and you'd go ahead and bill for a visit anyway.

**Joe Heyman – Whittier IPA**

Well, that I would certainly consider fraud.

**Paul Egerman – Businessman/Entrepreneur**

I'm just trying to understand what it would look like and that's what it would look like?

**Joe Heyman – Whittier IPA**

To be honest with you I don't know.

**M**

...

**M**

Fraud is intentional. Fraud is something intentional. The question of what's the act. If it's done intentionally to miscommunicate something then it's considered fraud. I mean, I'm not a lawyer, but, you know, what do you consider fraud if somebody does it on paper and they write down something wrong or they make a mistake, is that considered fraud? We shouldn't be treating something electronic that much differently than something electronic when it comes to legalese. So, if I am documenting on a patient and I document something that's wrong is that fraud or is it a mistake?

**Joe Heyman – Whittier IPA**

Well, I guess if you did it intentionally to defraud and to make extra money then it would be fraud. But if it's just because you made a mistake then you made a mistake.

**M**

So, if you copied something forward knowing that the information may not be correct at this time, is that considered fraud?

**Joe Heyman – Whittier IPA**

The implication I heard was that somehow, because there was a lot of information people are worried that people might be up coding. So, they're adding information that they didn't actually obtain in order to up code.

**M**

So, what I hear that we're doing is we're speculating in things that might happen in a case for someone who is looking to perpetuate fraud or where there's an abuse of coding relative to billing that's not supported by what actually was done and I think that that's sort of the problem that we're looking at here is that we don't have a lot of evidence of how systems are being used fraudulently and so there is speculation happening about what behavior might cause someone to suspect fraud, for example notes that look identical visit to visit, even though we know that there are lots of reasons they might look identical or nearly identical, even when detailed assessments are being done.

**Martin Rice**

But wouldn't it naturally make it easier for an EHR, since an EHR makes it easier to document it would make it naturally easier for somebody to document more information. I mean, somebody who is out to defraud they're going to do it whether we're doing paper or whether we're doing electronically just because it makes it easier electronically doesn't make it any different.

**M**

So the thing that you're saying Marty is that given it's a computer if it can document once it can document many times.

**Martin Rice**

Right and somebody who is going to do that was probably doing it in paper also. I mean, not everybody is out there, I mean I don't have the thought process that somebody is going to do something wrong just because it's easier to do.

**Joe Heyman – Whittier IPA**

Exactly, exactly right.

**Martin Rice**

I mean their doing it wrong because they are the type of person that would do it wrong to begin with. So, I don't know.

**Paul Egerman – Businessman/Entrepreneur**

I think there's somebody in the middle unfortunately who is not necessarily like super-evil but is just annoyed that they feel like they're getting under paid by Medicare or Medicaid and therefore feel that they are justified in charging a little bit more.

**Joe Heyman – Whittier IPA**

If they do that though they would have done that on paper too.

**Paul Egerman – Businessman/Entrepreneur**

That's probably right. In other words there's nothing about the computer system by itself that I think necessarily makes it easier to commit this type of fraud. In fact, if you think it's easier on a computer system it sort of flies in the face of some of the other things we've heard about how difficult these user interfaces are and people are complaining they say it's easier to do this stuff on paper than it is on the computer. And if that's the case one would think it would be harder to do fraud also on the computer and it would be easier to do it on paper. I don't know.

**Martin Rice**

Well the good thing about technology is that when you look at the whole process you can build these controls within the technology. So, we need to identify, if that's our purpose here to identify the type of situations that could cause fraud, intentional fraud or unintentional fraud maybe, and put that into a certification process to look at and build controls within the EHR. Because just to say you can't copy

forward is kind of like, the technology in my experience is not supposed to tell the business process what to do. We're supposed to make the business process easier.

**Joe Heyman – Whittier IPA**

Exactly. Exactly right.

**Martin Rice**

I said something right today so I'm going to shut up for the rest of the day.

**Paul Egerman – Businessman/Entrepreneur**

Well, yeah, I mean I agree with that, what you just said that technology should not determine the business process, but it is reasonable that the technology can be used to help avoid inappropriate activities. I mean, a simple example is it's certainly reasonable that technology is used to make sure that you have a valid diagnosis code, ICD-9 or ICD-10, before you submit the claim form and that's a reasonable thing to do, and that's just an observation. I think that if we can find ways that these systems can help minimize or identify fraud that would be a good thing for us to do. As I'm listening to this I'm not hearing any ideas yet, but it would be a good thing if we could figure out a way to do it.

**Joe Heyman – Whittier IPA**

Well even in the example you just gave a person could intentionally pick a different code.

**Paul Egerman – Businessman/Entrepreneur**

Well that's right.

**Joe Heyman – Whittier IPA**

And pick a code of something they didn't do.

**Paul Egerman – Businessman/Entrepreneur**

Well one type of fraud occurs when the claim form or the bill is not justified by what's in the electronic medical record or in the medical record, whether electronic or otherwise. I mean in the old days before computers I think that's how they did audits. They'd take the bills and they'd look at the record and see was the patient ever here and what was done for the patient and is what's in the record the same thing as what's on the claim form.

**M**

And those controls should be in place before the provider who is putting in information even leaves that document.

**Joe Heyman – Whittier IPA**

Yeah, that's true, but I just want to say, you know, just to give you an example of the kind of thing where even what you're describing, I have intentionally, I'm admitting to the whole country now, I have intentionally changed a diagnosis to something else out of frustration, when for example, I only treat women, there is a small percentage of women who have hydroceles, there's a black box at the insurance company level that says that women don't have hydroceles. So, I submit my bill with the honest example that I saw this woman for a lump in her groin and it turned out to be a hydrocele, I ended up doing nothing about it and frankly I charged only a 99212, which is a very low paying code. And then the insurance company denied it. So, I sent them the copy of the note and then they denied it again. And then they told me I had to do a special kind of clinical appeal and I said to myself this is ridiculous for a 99212 I'm already on my third time billing for this thing it's already cost me more to bill than it was that I was going to get paid. So, I changed it to a hernia and I got paid for my 99212. It wasn't completely dishonest but it wasn't exactly what the patient had.

**Paul Egerman – Businessman/Entrepreneur**

I think the example you gave Joe probably happens all the time in lots of different flavors, variations.

**Joe Heyman – Whittier IPA**

And, you know, I don't think I was committing fraud to be honest with you. I was just making it easier for both me and the insurance company.

**Paul Egerman – Businessman/Entrepreneur**

Yeah, so it's out of frustration with the way the system works.

**Joe Heyman – Whittier IPA**

Exactly.

**Paul Egerman – Businessman/Entrepreneur**

People bend it a little bit and it's hard to know though when you start bending it where's the line between what you're doing, which you're perhaps doing on an isolated case, and somebody who starts doing it more and more because they have a greater sense of frustration with the way the system works.

**M**

So, Joe could have done that on paper as well as with a computer.

**Joe Heyman – Whittier IPA**

Absolutely.

**M**

And our discussion is probably more around, I like going back to the adoption conversation you brought on early on, if there is something for us to do as a Certification Adoption Workgroup wouldn't it be to further explore that concept of clarification so that it isn't an adoption hurdle. I think you said it, Paul, there's a lot of things technology can do to help detect fraud once it's properly defined, you know, the computers can do a lot faster than paper can do it, but I think with our charter, certification adoption is there a step we can take around that adoption issue Joe brought up early on in our conversation? Is silence yes or no?

**Paul Egerman – Businessman/Entrepreneur**

It's a good question.

**M**

So, my take, Marc is that that is a direction we want to go in, but I don't think we have enough concrete specifics that you're getting immediate response from people about how we would do that.

**M**

Well maybe that's the subject of another call or something, but in that theory I don't know how we deal with the actual fraud and fraud detection. There are a lot of people working on that, but what we can deal with is how do we encourage or help encourage adoption, particularly, I was in a meeting with Farzad last week and, you know, he is kind of concerned about the smaller independent physicians and what they're doing and if this by any means is a hurdle I think there would be appreciation for us to help knock down that hurdle or clarify it anyway we could.

**M**

Just out of curiosity who would be detecting fraud for? What would the EHR be doing detecting fraud for, CMS, insurance companies? I'm kind of not understanding that.

**M**

Well clearly CMS because of the volume they get, but I would think anyone, the insurance companies would be interested if fraud were happening.

**M**

We're going to have to define exactly who is it that we're trying to build controls into the EHR with that would detect fraud and what fraud is to each.

**M**

A lot of, I mean OIG is doing that, CMS has got it seems to me multiple units doing that. I don't know what HHS is specifically doing about that, and that kind of goes to that last slide, there are a lot of people working on the detection of fraud and kind of why Larry and I landed on we're not sure what the next steps are because there are other agencies really specifically looking at it.

**Joan Ash – Ohio State University**

Well as the Adoption Workgroup isn't there some way we can let folks know that we fear that this may be a hurdle to adoption?

**M**

What detection of fraud? What's the hurdle? The discussion of fraud?

**Joan Ash – Ohio State University**

The discussion of fraud I think is what could be the hurdle.

**M**

Well and the distinction between fraud and normal operating or efficient operating procedures as we heard earlier.

**M**

So, I guess going back to paper versus electronic the question I would have is what would bother me so much about fraud in electronic going from paper to electronic? Is it that it can be detected more? I mean, I don't think documentation is that much different paper to electronic if you do it properly. So, just because something is electronic doesn't mean that, I mean I think we're bringing up fraud without really understanding how it would be detected in an EHR. So, I think it is a concern to providers because most providers don't really know what an EHR is and...

**Joe Heyman – Whittier IPA**

I guess the AMA's concern was that the discussion involved those things that were also mentioned in your discussions before...namely the bringing, I forget the whole list, but during the slide presentation there was a list presented of things that might be evidence of fraud and all of them are things that we use routinely to increase efficiency. There was not a thing on that list that wasn't something that we use all the time to increase efficiency and our point at the AMA was that not one of them is evidence of fraud, I mean we use them all the time, and the implication that somehow because they appear in an electronic medical record now they're evidence of fraud. They weren't written on the slide, but whoever was making the slide presentation listed a group of them.

**M**

I think to Joe's point and maybe to all of our points the specifics here are not that specific. We have people, like us, inventing things that we think might be interpreted as fraudulent. We don't have things coming from the investigative organizations telling us these are the examples that we have.

**M**

I mean, I think the best recommendation we can do is put in that controls should be made to avoid fraudulent billing or fraudulent reporting, or fraudulent documentation. I don't think we should be telling people how to do their business, which if they choose that they want to use copy forward that's their business in my opinion.

**Joe Heyman – Whittier IPA**

But I think we're worried that they're going to decide that they want the EMRs not to allow copy forward.

**M**

Well that's telling somebody how to do their business and that's not what technology is supposed to ultimately do. But we can say that we're going to be checking, there's going to be regular reports run that the patient doesn't have the same documentation results over a 5 day period, I don't know I'm making

that up. But, you know, reports can be written for that, to check. So those would be controls. I mean we had it when I worked for the Navy. I remember a lot of the docs would come up and they would say we need copy forward but it's not being used properly and we said well that's for you all to sort of police yourselves, it's not for us to tell you to take it off just because it's not being used properly.

**Joe Heyman – Whittier IPA**

Got it.

**M**

You know, it's something that a lot of things aren't used properly and it's not for us, you know, you don't build a process to say you can't do it anymore, that would take out the efficiency. But we certainly could write a report to find out how often it is being used and by whom. So, that's a control. That's the nurse's perspective, that's all.

**M**

So to sort of blow into more sort of techno paranoia but I can imagine that an organization looking to commit fraud would actually build those variances into to auto documentation they were using and that it's the folks who were just trying to be efficient and copy stuff forward and were making minor manual edits that were the ones that have the more consistent documentation encounter to encounter. I sort of feel like we're circling around the same set of comments again and again and I don't think we have particularly new information to be working from.

**Joe Heyman – Whittier IPA**

Well let me at least ask the AMA for whatever information they have and I'm going to send that forward to you guys. I don't what else we can do between now and some future date except to raise the concern, just raise the concern that we not get rid of the efficiencies in order to, you know, that there are plenty of people using these same exact processes and doing them honestly. But just because they use the processes doesn't mean they're committing fraud. And the worry that, you know, you're going to tell people that because they are using those processes they may be subject to a fraud investigation is a way of dissuading them from using an EMR.

**M**

I think we should probably really watch how we use the word fraud but make sure that people realize that they're responsible for their processes within their institution and policing their own processes and controls could be built into the EHR to monitor their processes.

**M**

So, I guess the question for the Workgroup is there was some draft thoughts on the last slide about where we are right now and what I'm hearing is, in addition to this, there's a concern about the threat of fraud becoming a disincentive for adoption.

**Joan Ash – Ohio State University**

I think the threat is being accused of fraud, wrongly accused of fraud.

**M**

Right.

**M**

Yes, sorry I misstated that.

**Joe Heyman – Whittier IPA**

To me it would be the implications of using the efficiency tools within an EMR as being an indication of fraud, because that's what they're doing, that's what the implication is and the folks who made that list is that those were things we routinely use and now because we routinely use them people think we can use them to commit fraud and therefore if you're using them it might be an indication that you're committing fraud. I don't know how to say it any better than that, I'm sorry.

**George Hripcsak – Columbia University NYC**

Hi, this is George, just to comment. One, thing, I think it's important for the committee to, in this question focus on what is or what isn't evidence of fraud and approach it that way rather than becoming say a defender of something like cut and paste or copy forward. We've done a lot of studies on that and I don't think we've figured out how to use a computer to document the history yet. I think under the paper chart, other than using copy paper, carbon paper, you didn't copy forward, you just rewrote your note and doctors were forced to write what was important in the note and although the paper chart seemed long, in fact it was pretty easy to get through to figure out what was going on with the patient. Now, our studies show that people are becoming frustrated with the computer chart because they can't figure out what's wrong with the patient because there's so little information because it's so redundant.

So, I think we're still figuring out as a field how do you encourage, through the user interface, how do you encourage people to document in such a way that it's efficient for them and also efficient for the reader who comes after and doesn't put in a lot of information. I mean, my favorite example is I showed, I have a paragraph that said 27-year-old man, 36-year-old woman taken from a real note that was in every note in that patient's chart after a certain time because it got copied forward and every doctor attested to the patient having 2 sexes and 2 ages, and all the ages were wrong anyway because the patient had gotten older and they'd never been updated.

**M**

Yeah, well that's terrible.

**George Hripcsak – Columbia University NYC**

But that's different than evidence of fraud and I think that's really what you're kind of getting to. As well there are problems with the user interface and how do we do this best to have an efficient data entry and we need to work on that and I don't know what the answer is, but probably something that minimizes the degree to which people feel the need to cut and paste is probably going in the right direction, but that's a different question than is it evidence of actual fraudulent activity. So, that's how I'd kind of frame it.

**M**

So, Larry we've got 5 minutes.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

Yes, we do.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

And there will be time for public comment at the end remember.

**Larry Wolf – Kindred Healthcare – Senior Consulting Architect**

Oh, so we have less than 5 minutes.

**M**

Right.

**M**

Right.

**Joe Heyman – Whittier IPA**

Because I know I have to leave right on the hour.

**M**

As do I.

**M**

Is there a next step here or do we just compile these recommendations for the next HIT Policy Committee based on this conversation?

**Joe Heyman – Whittier IPA**

I'm very happy to trust the two of you guys to figure out what to say on the basis of this conversation.

**M**

Well, I've heard a couple of things we might want to do to edit some of the slides to bring up this adoption concern and I think that seems to have been the major information in this call that we don't want efficiencies to become seen as fraudulent and therefore inhibit adoption. Beyond that, I think we're still in the same boat of we don't have good evidence of what is being used to create fraud and without that to speculate what would be helpful tools to prevent it or to detect it, it's just that, speculation.

**Joe Heyman – Whittier IPA**

That sounds good to me.

**Joan Ash – Ohio State University**

And me as well.

**M**

Okay, very good, so maybe we should open this up for public comment.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Okay, operator would you open the lines for public comment?

**Caitlin Collins – Altarum Institute**

Yes. If you are on the phone and would like to make a public comment please press \*1 at this time. If you are listening via your computer you may dial 1-877-705-2976 and press \*1 to be placed in the comment queue. We do have a comment from Carol Bickford.

**Carol Bickford – New York Nurses Association**

This is Carol Bickford from the American Nurses Association. Your conversation was focused on the physician and their copy forward capacity. I would like you to broaden your thinking to include other clinicians who have similar reporting burdens, there was referencing the nursing team about that, but don't forget that there are opportunities for other inappropriate actions in the reporting components and the collection of data to assure that when you count something it gets counted correctly and the formulas work correctly, and so that those aggregations are accruing appropriately. That's the end of my comment.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Thank you very much Carol. Operator any other comments?

**Caitlin Collins – Altarum Institute**

We have no more comments at this time.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Paul and Larry perhaps, I would just ask you based on this, would you be intending to call another meeting of the Workgroup?

**M**

So my sense is that we should update the slides, circulate them to the group and if that works for folks that we then present those summaries of that meeting at another call.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Thank you.

**Joe Heyman – Whittier IPA**

Sounds good to me.

**M**

Me too.

**M**

Okay.

**M**

Okay it sounds like we have a little bit of homework to do in advance of the New Year.

**M**

Thanks, a lot.

**M**

Okay, thank you guys, it was good having you on the call today.

**M**

Bye-bye.