Kudos to Dr. Powsner and Dr. Fochtmann for their eloquent discussion of the primary cause behind our problems with “copy and paste” and “note bloat.” The 1997 CMS E&M coding requirements, now in effect for 20 years without significant revision, create real conflicts and problems in the minds of practicing physicians every day. CMS and private insurers conduct both targeted and random audits where a clinical note’s bullet points are counted, often by personnel who lack sufficient training to do it accurately. If even a single section is short by one bullet point specified by the complex requirements, the auditor can judge that the documentation does not justify the level of care that was billed, downcode the visit, and demand that part of the charges be refunded to the payer. Once the auditor finds a note which is “deficient,” they will often ask to audit several more. If more than a few notes do not meet criteria, a pattern of “fraud” or “abuse” can be declared. In that case, CMS at least can require an audit of all the practitioner’s clinical documentation for the last three years, creating a risk that hundreds of notes will be judged deficient leading to demands that large sums be repaid to CMS or even to disbarment from the Medicare system. CMS even has a Fee for Service Recovery Audit Program (<https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/>) where it hires companies “to identify improper payments for claims paid under Medicare Part A and B” and compensates them, in part, based on the amount of money they recover for CMS. So far this program has clawed back over $9.5 billion since its inception in 2010 (<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/National-Program-Total-Corrections.pdf>). Of course, decisions under these programs can be appealed, but this process can take as long as two years to run its course, requiring many, many hours of provider time to defend.

Not surprisingly, fear that not adhering strictly to E&M guidelines can easily lead to drastic consequences has caused a pattern of “defensive documentation.” The American College of Physicians (ACP) summarized the situation perfectly in its Policy Position Paper on Clinical Documentation in the 21st Century (<https://www.acponline.org/system/files/documents/about_acp/chapters/mt/2015/ACP_EHR_Position.pdf>):

*However, not adhering to the E&M guidelines could lead to billing fraud, with the potential for fines, permanent restriction from the Medicare and Medicaid programs, and even criminal penalties. Therefore, it is understandable that the desire to be paid fairly for one's work and avoid civil and criminal penalties has become the primary driver for clinical documentation. Also, unlike in days past, what is now illogically considered to be the gold standard of a good note comes not from clinical professors and mentors but from professional coders and corporate compliance training. An imbalance of values has been created, with compliance, coding, and security trumping patient care, clinical well-being, and efficiency (12). A harshly negative “gotcha” mentality that saps the professionalism out of physicians has also appeared.*

Documenting with sufficient granularity to satisfy the E&M requirements while seeing enough patients to earn a living and not working 24 hours a day, 7 days a week essentially requires the use of copy and paste functionality, resulting in note bloat, poorly organized or even erroneous documentation, and the many other problems discussed in this thread. Also, the note structure arising out of the E&M requirements is not optimized for tracking multiple high complexity medical problems or maintaining continuity of medical decision making. Until these problems are addressed, the notes our clinicians use EHR systems to create are not likely to improve in a fundamental way.

I believe the members of this forum recognize it is extremely difficult to define the “quantity” and “quality” of clinical work, much less specify such a definition algorithmically. Our policy makers and payers have even less training and experience to address this issue than we do, but they do know how to count. The system of E&M coding criteria implicitly assumes that the amount of clinical care provided and the cognitive complexity of the medical decision making required for that care can be accurately measured by checking off a list of criteria designed to be used by staff with relatively little medical training and then counting the check marks. I think that the clear majority of practicing clinicians would agree that this assumption is **absolutely wrong** and that it is long past time for these cumbersome counterproductive regulations to be replaced by a new system designed to incentivize concise but history-rich notes that convey the subtle nuances of the patient’s story and the complex clinical reasoning that leads to diagnostic and treatment recommendations. The ACP paper on clinical documentation contains more detailed recommendations on how this can be accomplished, so I am attaching a copy for those who are interested.

Although often attributed to Albert Einstein, it was actually sociologist William Bruce Cameron who said “Not everything that counts can be counted, and not everything that can be counted counts.” I disagree with Dr. Fochtmann’s assertion that we don’t understand all the factors that led to the creation of the E&M codes, but the rest of her post is 100% spot on. At this point the codes do “simply waste valuable time that could be spent on patients and add sizeable amounts of health care costs due to administrative burdens.” AMIA as an organization should be advocating for the codes and bullet points to be retired so our software developers have the flexibility to develop the 21st century documentation tools we really need.