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Dr. Andrew Gettinger
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Dr. Kate Goodrich
Chief Medical Officer
Center for Clinical Standards and Quality
Centers for Medicare and Medicaid Services
7500 Security Boulevard
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Dear Drs. Gettinger and Goodrich:

Thank you for the opportunity to provide feedback on reducing documentation burden for clinicians. We appreciate ONC and CMS's efforts on this important topic.

As you know, the American Health Information Management Association (AHIMA) is the national non-profit association of health information management (HIM) professionals. Serving 52 affiliated component state associations including the District of Columbia and Puerto Rico, AHIMA represents over 103,000 health information management professionals dedicated to effective health information management, information governance, and applied informatics. AHIMA's credentialed and certified HIM members can be found in more than 40 different employer settings in 120 different job functions—consistently ensuring that health information is accurate, timely, complete, and available to patients and providers. AHIMA provides leadership through education and workforce development, as well as thought leadership in continuing HIM research and applied management for health information analytics.

AHIMA supports the intent of Section 4001(a) of the 21st Century Cures Act to reduce "regulatory or administrative burdens (such as documentation requirements) relating to the use of electronic health records."[1] We are committed to assisting ONC and CMS in reducing regulatory and/or administrative burdens that hamper the ability of clinicians to provide quality care to their patients while ensuring that health information contained in the electronic health record (EHR) is confidential, complete, accurate, reliable, timely and useful. Along these lines, we would like to offer below some general comments about reducing documentation burden for clinicians.

Evaluation and Management Coding

The Evaluation and Management (E/M) documentation guidelines are outdated and a major revision should be undertaken. Currently, E/M code levels are often driven by the volume of documentation rather than by

[1] P.L. 114-255.

clinical differences in patient complexity. AHIMA believes any set of E/M documentation guidelines should accurately reflect differences in patient complexity and be readily understandable and objective. Unnecessary or clinically irrelevant documentation should not be required. Additionally, AHIMA recommends that only one set of E/M guidelines be developed versus the two guidelines that are currently in use.

AHIMA believes that medical decision-making is a more significant factor than history and physical exam in distinguishing differences in E/M levels and perhaps should be weighted heaviest in determining the E/M level for a patient visit. We believe the current history and exam documentation requirements are administratively burdensome, not representative of the current practice of medicine or meaningful for patient care, are ill-designed for use in an electronic documentation environment, and are vulnerable to upcoding. However, we are concerned about eliminating history and physical exam documentation requirements altogether. History and exam components that are relevant to the patient encounter provide a more complete clinical picture than medical decision-making alone and are important for quality of care. While the history and exam components are in need of substantial revision, there may be value in retaining a modified and scaled-down version of these components in the E/M documentation guidelines, especially for new patients.

We recommend that CMS work with industry stakeholders to modify the E/M documentation guidelines and pilot test the updated version in physician practices of different sizes and specialties. The goal should be to produce a relatively simple set of documentation guidelines that are easy to understand and use, distinguish meaningful differences among E/M code levels, and do not require the capture of additional documentation that is unnecessary for patient care. We also recommend that CMS consider incorporation of diagnoses as an element of distinguishing differences in the complexity of medical decision-making. Comprehensive education on the updated documentation guidelines should also be provided to facilitate their proper and consistent application.

Usability Standards

AHIMA supports the development of usability standards, and we believe that increased ONC involvement in the development and adoption of such standards would be appropriate. Limits to EHR design can often lead to misuse of copy/paste, potentially resulting in redundant, erroneous, and/or incomprehensible documentation as well as degradation of quality clinical data.[2] In turn, this can have serious implications for the quality and safety of patient care, the medico-legal integrity of the health record, and vulnerability to fraud and abuse.[3]

For that reason, AHIMA supports the development and implementation of best practice standards that have been sufficiently piloted and tested to improve the usability of EHRs and reduce instances of misuse of copy/paste. That said, our members have noted that usability is often broadly defined and can have different meanings for clinicians and related stakeholders depending on their specialty. Along these lines, should ONC increasingly become involved in the development and promulgation of usability standards, we recommend that the agency should begin with clearly defining usability. Additionally, we suggest that ONC work closely with specialty societies to ensure that any standards that may be developed are appropriately suited to meet the needs of clinician(s) and reflect an understanding of workflow differences across specialties.

[2] Available at: https://www.ecri.org/Resources/HIT/HTAIS_Copy_Paste_Report.pdf.
[3] Available at: https://bok.ahima.org/PdfView?oid=300306.

Public Health and Quality Reporting Requirements

AHIMA is concerned that both public health and quality reporting are often burdensome, particularly for smaller clinician practices. In general, our members have expressed concern that they are often faced with reporting specific data sets to several authorities via multiple methodologies. For example, with respect to public health reporting, our members are often bound by a patchwork of local, state, and federal public health reporting requirements that require the same information to be reported but require different methods to report. For that reason, we recommend that ONC and CMS work with state and local public health authorities to align public health reporting requirements as to alleviate reporting burden for clinicians.

Similarly, our members have noted quality reporting can be burdensome because it is often the case that payers (including those contracted for Medicaid) have different requirements for reporting quality measures with respect to form and format even though the exact same information is being reported. Additionally, our members have noted that there are instances where quality measurement performance data requested by payers is not "pushed" or "pulled" electronically by or to the payer. For example, in managing HEDIS® requests, it is often the case that such requests are managed internally by the institution and reviewers do not have electronic access to the EHR data. Rather, such requests are fulfilled via mail or fax, or the charts are reviewed on site. Such instances have also arisen in working with smaller payers that serve as Medicaid contractors. Under such circumstances, nurses will review records that have been physically mailed by clinicians that have been extracted from individual paper charts, abstracted, and tallied. This is despite the fact that many of these clinicians have EHRs that can produce standard quality reports that are often used for the EHR Incentive Program or the Merit-based Incentive Payment System (MIPS).

While we recognize that in some of these instances clinicians may have conservative access control policies in place and are attempting to comply with the minimum necessary requirements under HIPAA, requiring paper records when a clinician has the capability to submit the same quality measures electronically seems incongruous and burdensome. Therefore, we recommend that ONC and CMS work with other payers to align and standardize quality reporting requirements that are both meaningful and useful to the clinician and the institution which in turn could help to reduce burdensome reporting requirements. More specifically, as CMS continues the important work of the "Patients Over Paperwork" Initiative, we recommend that the agency review its agreements with health plans contracted through CMS to ensure that health plans are capturing quality performance measures electronically when possible, to help alleviate reporting requirements.

We appreciate the opportunity to submit comments on reducing documentation burden for clinicians. We hope that ONC and CMS will continue to engage extensively with stakeholders on this critical issue, and we look forward to continued collaboration with both agencies to reduce burdensome documentation and administrative requirements. Should you or your staff have any additional questions or comments, please contact Lauren Riplinger, Senior Director, Federal Relations, at lauren.riplinger@ahima.org and (202) 839-1218.

Sincerely,

Wylecia Wiggs Harris

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Chief Executive Officer
AHIMA