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Correspondence

CPT Coding

Your editorial regarding the function and responsibility of CPT coding[1] highlights the complexity of disentangling the triangulation between payers, patients, and physicians, and returning to the simpler, bidirectional, "direct" financial relationships between doctors and patients.

Ten years ago when we were setting up our practice, we recognized an opportunity to re-create such a simpler relationship. Since then we have been regularly reminded of its importance by stories such as Dr. Brown's.

We needed to establish some boundaries while recognizing the realities of the system that exists. With the assistance and support of AAPS, we opted out of all insurance plans and Medicare, but in an effort to ease reimbursement for our patient visits, actually considered filing the appropriate claims forms on their behalf.

Instead, like Dr. Brown, we wanted to take what was then the bold position that insurance filing falls under the patients' responsibility with their insurers. But we did produce superbills, replete with all necessary filing information (in our case, including the CPT code) that the patient could then submit for out-of-network reimbursement. As a gesture of our sensitivity to this burden that we were appropriately putting back on the patient, and also a reminder of the boundary we defined, we supplied our patients with stamped envelopes and a mailbox to "facilitate" claims filing.

Not everyone agrees with our position. Some patients are upset. We collect comments from those who don't approve. Our favorite, coming from a Medicare patient upon learning that we've opted out of Medicare, is "Why do you hate old people?" Insurers may be confused. Many reimbursement checks have been sent to the practice instead of the patient and have had to be returned. Some fellow physicians refer to our practice as a "healthcare spa," a "business," and once even an "experiment." Despite this occasional negative feedback, we have stood strong on our position, which is simply that we only work for patients.

That said, there is very little we won't do (within the boundaries of a professional practice of medicine) to create value for those patients, who in most circumstances pay us more in exchange for that added value—24/7 access, free in-house medications, accompaniment to specialists' appointments, closer coordination of care, etc. We do this to distinguish ourselves, as did Dr. Brown, from practices that take third-party payment.

To your point on CPT coding, anyone would agree that this is undoubtedly an insurance function, one in which traditional doctors participate (among too many other contortions to list) in order to obtain third-party payment. Once stepping out of that world, as Dr. Brown and I have, coding is no longer mandatory. Your question of whether CPT coding is a component of standard-of-care documentation related to a physician's licensure is indeed an interesting one, but from your article, it did not appear that her license was in jeopardy, only her patient's potential reimbursement.

Regardless, the point, in my world, is moot. In our practice, we continue to code (and generate reimbursement-ready superbills, which we give to our patients upon request) because it brings value to the patient, and not because we see it as an obligation to insurers or licensure board. Our electronic medical record, by the way, attaches the CPT code to the diagnosis automatically.

David L. Albenberg, M.D.
Charleston, S.C.

Dr. Huntoon raises concerns about medical societies backing up the insurance companies in requiring ICD and CPT codes,[1] even for private transactions. Dr. Brown's experience with the Oregon Medical Association, unfortunately, is not

unique. I submitted a Resolution in support of dignity and freedom of individual physicians and their patients to the Massachusetts Medical Society. It fell on deaf ears. I could not even gain the support of my colleagues (with one exception) in my own district (Essex North and South). Sometimes I wonder why I continue to be a delegate.

Bernhard Heersink, M.D.
Newburyport, Mass.

1 Huntoon LR. CPT coding: practice of medicine or insurance function? *J Am Phys Surg* 2012;17:34-36.

Electronic Medical Records (EMRs)

The clinic in which I work has recently implemented electronic medical records to comply with healthcare reform's mandates.

I am not a Luddite, and can safely say that, for my age group at least, I am rather a geek. Until recently I built my own computers.

I knew EMRs would be problematic, but even my wildest vision did not prepare me for the devastating effect this system has had on my practice. After more than 100 hours writing templates adapting the program designed for family practitioners to my orthopaedic practice, I still cannot help producing a mediocre document of my patients' visits.

The real world of patients is analog, and no digital input can ever make up for the infinite variety of clinical histories and examinations. No cookie-cutter, punch-button assessment can equal a thoughtful dictated analysis by a dedicated, observant physician. The idea that a computer puts your medical information at the doctor's fingertips is laughable. Whereas in the old paper chart I had patients' past medical histories at my fingertips with one quick flick to the "Ortho" tab, now, as I enter the exam room, the only information available to me is the one-line summary written on a blank clipboard by my staff. An ENT colleague with EMRs told me he just hopes his patient will say something that reminds him who the patient is. It is like practicing medicine with Alzheimer's.

The upshot of all this is: I don't bother reading the referring doctor's note because it is the same drivel that my notes have become. I don't bother reading the emergency department referral because a malleolar fracture may be called a tibial fracture in the limited lexicon of available digital diagnoses. I needn't bother reading the notes from the specialist to whom I referred the patient because I no longer get a better understanding of my patient's problems from his analysis—there is no analysis, just a list of diagnoses with ICD-9 codes. I find myself giving up and just skipping documentation of oddities because it is just too hard to keep modifying the templates to fit the exceptions.

EMRs mean forced mediocrity. They should, however, save Medicare a lot of money. Since it takes me at least twice as long to produce the EMR, I can only see half as many patients.

Lee D. Hieb, M.D.
Lake City, Iowa

Watching a high school football game, one where we were hopelessly outmatched, the parents of our players became very quiet as the visiting team scored time after time. When the silence had become almost too much to bear, one of the parents yelled, "Cheaters!" This defiance to the end, discounting the opponents' victory, struck me as funny. But the real cheaters we encounter in medicine are not a laughing matter.

One of the purposes of EMR systems in hospitals is to maximize revenue. Certain tests or consultations (nutrition consultations, for instance) bring revenue far in excess of the resources needed to provide this service and are therefore extremely profitable. One of the ways these systems can be used to pad the profits of these "not for profit" hospitals is enabling a "level 4" exam. In some large hospital systems, a hospitalist checks all of the necessary boxes on the EMR form to indicate that a complete history and physical exam (level 4) has been performed on every patient in the hospital, every day. In enabling fraudulent billing, they are just following orders, like good little hospital soldiers.

Imagine what the cheater would have to spend a solid hour doing every day to generate the record honestly. He would have to ask the patient: "Do you have a family history of diabetes since yesterday?" "Are you a heavy drinker or a social drinker since yesterday?" "Are you still a widow since yesterday?" "Have you ever had asthma or a heart attack since yesterday?" The insanity of this conversation is obvious, yet that is the interview the cheater claims to have done. Then he'd have to do the physical exam: "Now I am going to check all of your cranial nerves and your entire circulatory system. I'll check your entire body for lymph nodes or masses, and you'll get your daily rectal exam, too."

The truth is that the cheaters are spending about two minutes with each patient, the rest of their time being spent on a computer at the nurse's station, cutting and pasting information to fabricate an EMR, the primary purpose of which is to generate the maximum revenue for their hospital boss.

One of the purported benefits of EMRs is that the patients' records are portable. But because of cheaters hired by some hospitals, all of these records look virtually the same. Pertinent, potentially life-saving information, if present at all, is camouflaged by meaningless cut-and-paste drivel, most of which exists to pad the hospital bill. EMRs, utterly devoid of meaningful clinical information, supposedly represent improved quality care. However, in the vernacular of central planners, they are meaningfully useless.

I believe the results will be complications and deaths for hospitalized patients like never before. Numerous patient disaster stories will not bring an end to this insanity, but rather will result in more government oversight, such as mandated jobs for Medical Record Safety Management and Compliance Specialists. Some ambitious nurse bureaucrat will salivate at the prospect of getting the MRSMCS initials after her name. Watch for more government-funded "studies" showing the cost savings and enhanced patient safety from hospital EMR systems. Just as the EMR provides camouflage for the patient's true condition, these "studies" will attempt to hide the human death and suffering resulting from their use.

Recently, a surgeon told me a cheater referred a patient to him for an abscess in the throat. The physical exam section of the EMR included a "normal" check for "throat exam."

G. Keith Smith, M.D.
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