

## EHR REPORT

# Going Paperless

BY CHRISTOPHER NOTTE, M.D., AND NEIL SKOLNIK, M.D.

As medical practices grow, so does the number of charts occupying space on their shelves. Most physicians look forward to the day when they can dispense with paper charts completely and reclaim precious office space. Unfortunately, the goal of a paperless office is a very difficult one to achieve. It can take years to get there and, even with the best EHR software, the process of adding old data into the system can be arduous.

There are two basic methods to input old paper records. Historical information such as diagnoses, medication lists, and allergies can be manually entered by the physician or staff. More detailed information, such as reports of procedures or correspondence from other physicians, will need to be scanned into the record. Either way, it will take a significant amount of work to enter even a small number of charts. This can be both time consuming and costly. There are many pitfalls that may not be obvious initially, so it can be helpful to consider the following tips:

### Begin by Looking Forward

Typically, it is most beneficial to work forward from the point of installation and ensure that all new patient information is immediately entered into the EHR to avoid creating a paper chart entirely. One way to do this is to “scan forward”—that is, to scan documents received only after the EHR is in place. Such scanned documents can immediately be digitized and attached to the patient’s electronic chart. The original can then be shredded instead of adding it to the paper record. By doing so,

there will be a single date marking the end of information available on paper. After that date, all staff members will know to look in the EHR to find the data they need.

### Take It One Day at a Time

One way to feasibly address the problem of entering old information into the EHR is to do a limited but consistent amount every day. But where to start? Many practices select charts to scan by reviewing the following day’s patient schedule. By “preloading” charts, important data are available at the time of an appointment, and the charts of so-called “frequent flyer” patients are usually among the first to be entered. Once the chart has been inputted, it can be archived off-site or properly disposed of.

### To Scan or Not to Scan

Commonly, patient charts are filled with a tremendous amount of irrelevant information. Amidst the radiology reports, notes, and letters are likely to be dozens of sticky notes, blank pages, fax cover sheets, and antiquated data. For a couple of reasons, it behooves a practice to spend time prepping charts before scanning them.

First, every page that is scanned will need to be indexed for the EHR to properly file it. It would be extremely cumbersome, when searching for an old lab result, to have to wade through dozens of papers at random. Indexing allows all documents to be sorted by type and date, but this process is extremely time consuming. Each page scanned needs to be individually ad-

ressed. To minimize the amount of indexing, a practice may decide to only sort information of a certain age or type. Everything else can be then placed into a general, unsorted electronic file. In this way, the most important data are easy to find, yet even less valuable documents can be located with a bit of effort if necessary.

The second compelling reason is cost, both in staff hours and in storage. Many offices choose EHR solutions that are hosted off-site. All data exist on an external server and, depending on the nature of the storage agreement, every page scanned into the system may incur an additional charge. In most cases the rate is about a penny a page. One need not take a very long look at the chart rack to realize how quickly the price will add up. Choosing to electronically archive only the most important items can help minimize the economic impact and make the overall process much more efficient.

### When to Say Good-Bye to Paper

There are a few commonly cited reasons why practices hesitate to finally eliminate paper charts. First is the fear of unintentionally losing critical patient data. This is reasonable, and data security should be a primary consideration when designing an electronic storage solution. All EHR vendors have set specifications for storage focused on security and reliability. If the data are to be maintained on-site, one way to ensure safety is through continuous backup. Higher standards are typically maintained at off-site storage facilities with multiple levels of redundancy. A well-

chosen storage method should alleviate any fears of data loss.

The second reason practices hold on to paper records is concern about the need to produce the chart for possible malpractice proceedings. This represents a misunderstanding about the legality of electronic media. Regardless of where the chart is stored—on paper or in cyberspace—it is acceptable in a court of law. The length of time the data must be maintained varies from state to state, but is typically about 7 years for adults or 7 years after turning age 18 for minors. Fortunately, once all the charts are archived, they can be safely and securely maintained indefinitely without the ever-growing need for a bigger office to store them.



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## Changes in Physician Billing Could Save \$7 Billion Per Year

BY JANE ANDERSON

Implementing a single set of payment rules for multiple payers with a single universal claim form and standard set of rules potentially could save \$7 billion per year nationwide in fees for physician and clinical services, according to a study at one institution.

Those changes also could save 4 hours of professional time per physician and 5 hours of practice support staff time each week, according to Bonnie B. Blanchfield, a senior research scientist at Massachusetts General Hospital, Boston, and her coauthors (Health Affairs 2010 April 29 [doi:10.1377/hlthaff.2009.0075]). The savings in time and money could translate directly into improved, less expensive patient care, the authors concluded.

“The U.S. health care system

has generated byzantine systems of rules and regulations regarding payment for medical services. The result has been a growing and costly bureaucracy, which, in the end, pulls resources from direct patient care,” wrote Ms. Blanchfield and her coauthors, who included other researchers and financial officers from Massachusetts General Hospital and Massachusetts General Physicians Organization in Boston.

The study authors analyzed what they called the “excessive administrative complexity burden” imposed on a large, urban-based, academic teaching hospital’s physician organization that contracts with multiple payers, each with different payment requirements.

For 2006, the study found that the cost of excessive administrative complexity, including expenses and lost revenue, was

nearly \$45 million for this organization, or nearly 12% of net patient revenue. This represented \$50,250 per physician.

Out of the total estimated administrative complexity burden, almost three-fourths was attributed to the time costs incurred by practicing physicians and their office staff in preparing paperwork and contacting payers about prescriptions, diagnoses, treatment plans, and referrals. “Many of the subspecialty practices within the physician organization even have full-time staff members dedicated to referral processing,” they wrote.

On the revenue side, the study found that nearly 13% of billed charges for non-Medicare claims were denied on initial submission, and that 81% of these eventually are paid after appeals.

Non-Medicare payers ultimately deny more claims than Medicare does, usually because

the physician’s office has missed the filing limit date because of the initial rejection, the study found. If these legitimate claims had been paid, they would have been worth \$6 million for the physician organization studied.

In addition, 29% of current professional billing staff effort is spent on processing and appealing claim denials that eventually are paid, the authors said.

The federal health reform legislation approved in March directs health plans to implement uniform standards for electronic health information exchange by 2013, but “will not address the larger problems of excessive, different, and changing requirements imposed on the exchange of all health information, including billing information.

“Thus, administrative complexity is likely to remain high and is likely to be a high-value ‘target’ for finding savings in

ongoing incremental reforms.”

The savings from reducing administrative complexity by implementing a single set of rules and a single claim form could translate into decreased health care costs in general, Ms. Blanchfield and her colleagues noted.

“An incremental move to one set of payment rules would yield significant dollar savings as well as work-life and productivity opportunities,” the researchers said. “Administrative simplification could still leave room for a diversity of insurance products and could promote innovation without relying on blunt and opaque administrative processes as a tool.”

**Disclosures:** Support for the study was provided by the Robert Wood Johnson Foundation and the Commonwealth Fund. The authors reported no financial conflicts of interest.