EMRs' Many Benefits Are Well Worth the Cost

BY GREG MUIRHEAD
Contributing Writer

MAUI, HAWAII — Rheumatologists and physicians in other specialties are needlessly resisting the inevitability of electronic medical records, said Dr. Martin J. Bergman.

As of 2005, about 23% of office-based physicians used electronic medical records (EMRs), said Dr. Bergman, citing statistics from the Centers for Disease Control and Prevention's National Center for Health Statistics that were reported in 2006. In contrast, almost 80% of office-based physicians used billing software, he added.

Reasons for resistance include complaints that EMRs are difficult to complete, interrupt the office flow, and take too much time to administer and review, said Dr. Bergman, chief of rheumatology at Taylor Hospital, Ridley Park, Pa.

"The first obstacle is cost," he noted. The cost of getting EMR software can range from $5,000 to more than $30,000, although the better software doesn't necessarily cost more. Once EMRs are established in the practice, rheumatologists can expect significant savings associated with their use. The practice will save on transcription fees, and dictation will no longer be needed. "My example is 12 years ago, when I went into electronic records, I was paying just under $20,000 a year for transcriptions," he recalled. "I no longer use a transcriptionist. Over 12 years, I've saved close to $250,000 on transcription fees alone."

As for time difficulties, there is a "steep learning curve" in getting used to using EMRs. "Those first 3 months are ugly," he said. "After that, your productivity doubles."

Dr. Bergman pointed out that rheumatologists can use EMRs to track metrics—measures of patients' progress—which is difficult to do with paper files. Metrics can quickly help gauge the success of the practice, and the news is not always good. "Until you start doing metrics, you think you are doing better than you are," he said. "The majority of us are not using any form of metric."

Other benefits of EMRs include:

► **An increase in productivity.** Dr. Bergman observed that, now, paper records slow him down. EMRs give him instant access to entire histories, including lab tests and drugs used.

► **Easy creation of referral letters.** Print them by pressing a couple of buttons.

► **A tool for research.** Patient data can be graphed to show results of treatment over time, which provides a good source of private practice research.

► **Access to databases.** Data extracted from the EMR database can readily be shared with existing databases, such as the Consortium of Rheumatology Researchers of North America (CORRONA), and the National Data Bank for Rheumatic Diseases.

Patient data typically collected in an EMR include demographic information, active and comorbid diagnoses, currently and formerly used medications, lab reports, DAS28 findings, both physician and patient global scores, Rheumatology Assessment Patient Index Data (RAPID) findings, and patient-reported measures such as pain, functionality, fatigue, and tender and swollen joint counts, he said during his presentation at a symposium sponsored by Excellence in Rheumatology Education.

EMR software offers two basic options: template software or database software. The choice might depend on whether the rheumatologist is in a solo or group practice.

The solo rheumatologist will be better served by database software, which is flexible and can be altered on the fly to fit special information-gathering needs. But a group practice or hospital will more likely want template software, which is more rigid, and requires all users to fill in the same kinds of information in the same format.

Free, month-long demos of software are available that allow rheumatologists to decide which is best for them.

Although patients can enter data directly into their EMRs at an office computer kiosk, older arthritic patients who have limited dexterity might find doing so difficult. A personal digital assistant (PDA), which is often used by physicians to enter patient data in hospitals, also presents problems for older arthritic patients to use at the office. A laptop is another option; however, because it may need to be replaced every few years, it may be a costly one.

Dr. Bergman gives his patients paper questionnaires; the answers are entered into the EMRs. By filling out the questionnaires, patients become more focused on their disease, which helps focus the physician-patient encounter. His questionnaire comprises mostly check-off questions, which are easy for patients to fill it out quickly and for office staff to enter electronically. After the patient's questionnaire information has been entered into an EMR, Dr. Bergman can quickly open the patient's record, see the new information, and easily review information from the previous visit.

Dr. Bergman said that he has been using EMR software from Stat Systems for 12 years. He is neither a spokesman for nor an owner of the company. ■

N.Y. Attorney General Investigates Possible UnitedHealth Group Fraud

BY MARY ELLEN SCHNEIDER
New York Bureau

Following a 6-month initial investigation, New York Attorney General Andrew Cuomo announced plans to file suit against UnitedHealth Group and four of its subsidiaries for allegedly systematically underpaying consumers for their out-of-network medical expenses.

The attorney general claimed UnitedHealth Group used faulty data from its subsidiary, the billing information company Ingenix Inc., which resulted in the underestimation of "usual, customary, and reasonable" rates for out-of-network medical expenses and then provided unreasonably low reimbursement to consumers.

The attorney general's office has issued subpoenas to 16 other health insurance companies who use Ingenix. The subpoenas will seek documents that show how the companies calculate reasonable and customary rates, as well as copies of member complaints and appeals, and communications with Ingenix.

Five of the nation's largest health insurance companies rely on data from Ingenix, according to the attorney general.

UnitedHealth Group has denied that there are problems with the reference data used by Ingenix, which is "rigorously developed, geographically specific, comprehensive and organized using a transparent methodology," according to a company statement.

Ingenix owns a database of billing information that many health insurers use to determine how much to reimburse consumers who go out of network for care. But the attorney general's preliminary investigation found the Ingenix data are provided by insurers with a vested interest in keeping the rates low and that there is no auditing of the data that come in, Linda Lacewell, head of the attorney general's Health Care Industry Task Force, said at a press conference to announce the industry-wide investigation.

The database also doesn't take into account whether a service was provided by a physician or a non–physician provider, a factor that would affect the price, Ms. Lacewell said.

"Our investigation has revealed that Ingenix is nothing more than a conduit for rigged information that is defrauding consumers of their right to fair payment," she said.

About 70% of insured Americans pay higher premiums for the right to go out of their insurer's network for care. In exchange, the insurer typically promises to pay about 80% of the usual, customary, and reasonable rate. The consumer then is responsible for the bill's balance.

But the attorney general says UnitedHealth Group subscribers haven't been getting what they paid for when going out of network. For example, for a 15-minute office visit in which most physicians charged $200, United Health told subscribers that the typical cost was $77 and agreed to pay only $62, leaving consumers to pay the remainder of the $138 bill.

The situation also can create problems for the physician, Dr. Robert B. Goldberg, president of the Medical Society of the State of New York, said. When patients receive an underpayment from their insurer, it's usually the physician's bill they challenge, since it appears the doctor has overcharged.

The same charges were also made by the American Medical Association in an ongoing class action lawsuit it filed against UnitedHealth Group in 2000. ■

Upcoming ACR White Paper Will Address NSAID Use

BY GREG MUIRHEAD
Contributing Writer

MAUI, HAWAII — An as-yet unpublished white paper on the appropriate use of nonsteroidal anti-inflammatory drugs contains mostly common sense advice, save for a small controversy over whether to use naproxen in patients taking low-dose aspirin for cardioprotection.

The white paper, from the American College of Rheumatology, sanctions acetaminophen or naproxen in such patients, said co-author Dr. John Cush, director of clinical rheumatology, Baylor Research Institute, and professor of medicine and rheumatology, Baylor University Medical Center, Dallas, at a symposium sponsored by Excellence in Rheumatology Education. But Dr. Vibeke Strand of Stanford (Calif.) University, an audience member, said there is no statistically significant evidence to support its use.

Dr. Cush said: "If aspirin is required for any patient for cardioprotection, you should seriously consider avoiding nonsteroidals of all kinds, including [cyclooxygenase-2s]."

When aspirin is needed, a gastroprotective drug like misoprostol or a proton pump inhibitor like esomeprazole should be used. For patients at GI risk, a selective cyclooxygenase-2 inhibitor is best, he said. But, "if you're going to use a nonselective nonsteroidal, you should use a PPI or misoprostol with it."

Dr. Cush said that the white paper is based on existing osteoarthritis guidelines from the ACR, OA guidelines from EULAR (the European League Against Rheumatism), and reviews by the Cochrane Collaboration.

If a patient takes aspirin for heart protection, 'you should seriously consider avoiding nonsteroidals of all kinds.'

DR. CUSH

Other tenets of the white paper hold that patients on long-term NSAIDs require close monitoring of the complete blood count, liver function, and blood pressure. Physicians should avoid nonselective NSAIDs and cyclooxygenase-2 inhibitors in patients with renal or liver disease. and avoid nonselective NSAID use in patients on anticoagulants or who have chronic thrombocytopenia.

Dr. Cush has financial ties to: Abbot, Biogen/Idec, Genentech, Pfizer, Targeted Genetics, UCB, Wyeth, Centocor, and Novartis. ■