Electronic Records Put New Focus on Accuracy

With the advent of computerization, medical records are evolving into patients' health records.

BY CHRISTINE KILGORE
Contributing Writer

The long-held perception that medical records should never be altered at a patient's request is quickly becoming erroneous, according to health lawyer and ethicist George Annas.

"We can delete [items from the record], as long as we note that something has been deleted and who did it," said Mr. Annas, chairman of the department of health law, bioethics, and human rights at Boston University.

In a Webcast sponsored by the National Institutes of Health, he braced physicians for a future in which patients will increasingly ask them to correct, delete, or change items in the medical record that are either errors or items that they are concerned may pose harm to them.

"The real reason patients don't ask to make deletions [now] is because most people don't look at their records," he said. But with the advent of HIPAA (the Health Insurance Portability and Accountability Act of 1996), "now there's a federal right of access to medical records."

Moreover, President Bush's current emphasis on electronic medical records (EMRs) embraces "the idea that patients should be in control," and patients are generally much more concerned about the content of electronic records than paper records, said Mr. Annas, who is also professor of sociomedical sciences and community medicine at Boston University.

The Bush administration has not addressed, in the context of its EMR proposals, whether "a patient [should] be able to delete accurate, factual information [from medical records]," he said.

The bottom line, however, is that "we're in the process of radically changing the medical record … into the patient's record," Mr. Annas said.

There are "lots of mistakes in medical records," making it likely that many changes made in the future will address actual errors. Debate about other types of alterations will ensue, but under this new climate "you could argue that patients should be able to change anything," he told the physicians.

HIPAA addresses the issue of corrections to medical records, saying that "patients have a right to request corrections in the record, and if there's no response, they can write their own letter and have it added," Mr. Annas explained.

The physicians who attended the NIH session reviewed a case in which a patient presented at the National Institute of Neurological Diseases and Stroke to enroll in a sleep study. He had a chief complaint of insomnia but, during a visit with an NIH clinical social worker, he also reported symptoms of severe depression and a history of drug use.

The day after the social worker evaluated the 37-year-old unemployed man, he requested that the information entered in the computerized record be deleted. "He was vague in his request, but he was concerned that someone would illegally obtain access … and use [the information] against him," said Elaine Chase, of the social work department at the NIH Clinical Center, Bethesda, Md.

Under HIPAA, 'patients have a right to request corrections in the record, and if there's no response, they can write their own letter and have it added.'

Mr. Annas said that if he were the provider faced with this request, he would agree to delete the information most disconcerting to the patient. "And if he wanted it out of a paper record, I'd still say yes," though, in the interest of research integrity, the patient should then be excluded from the NIH study, he said.

He offered his verdict on the case example after a free-ranging discussion in which some physicians voiced concern that a move from "physician's record" to "patient's record" would hinder communication among providers.

"Part of the purpose [of the medical record] is it helps individuals plan care," said one physician. "So from this standpoint, you can't just delete things. … Or if there's going to be a patient medical record, maybe there needs to be another record [for providers]," she said.

It's true, Mr. Annas said, that "defense attorneys still say today that your best defense is a complete medical record."

Still, physicians, overall, "take the record too seriously" and, although questions remain, they are going to have to be more willing to consider patients' requests to alter the medical records, Mr. Annas told this newspaper.

Theoretically, at least, the doctor and patient should review the content of the record before the visit ends, he said. "It makes sense that when you take a history, you should go over it with the patient and ask, 'Is this what you tell me? Is it right?' " ■

High-Tech Imaging Has Costs Up; Insurers Are Cracking Down

BY JOYCE FRIEDEN
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As the public focuses on problems with the safety and cost of prescription drugs, insurers are training their sights on a different cost issue: imaging procedures.

On average, costs of imaging—especially high-tech procedures, such as MRI, CT, and magnetic resonance angiograms—have been going up 20% a year for the last several years, according to Thomas Dehn, M.D., cofounder of National Imaging Associates, a radiology utilization–management firm in Hackensack, N.J.

"Some will say it's the aging of the population, but the key issue is really demand," said Dr. Dehn, the company's executive vice president and chief medical officer. "Patients are bright. They're good consumers. They want a shoulder MRI if their shoulder hurts."

Physician demand is also an important part of the equation, he said. "If you have physicians who want increased [patient volume] in their offices, it is possible that rather than spending cognitive time, for which they're poorly reimbursed, they may choose to use a technical alternative."

For example, a doctor trying to figure out the source of a patient's chronic headaches "may get frustrated and refer the patient for an MRI of the brain, just to show them they're normal," Dr. Dehn said. "The treating physician knows in the back of his mind that there isn't going to be anything [on the imaging], but it will calm the patient down."

As to which physicians are responsible for the increase in imaging, the answer depends on whom you ask. The American College of Radiology contends that the growth is largely due to self-referral by nonradiologists who have bought their own imaging equipment. But others say that all specialties are doing more imaging, largely because of improved technology and the improvement in care that it brings.

Whatever the reason that more scans are being done, insurers have decided they've had enough. Take Highmark Blue Cross and Blue Shield, a Pittsburgh-based insurer whose imaging costs have risen to $500 million annually in the last few years.

Don't be surprised if immunologists enter the arena as more and more molecular imaging is done to design tumor-specific antibodies.

One Highmark strategy for paring down its imaging costs is to develop a smaller network of imaging providers. To be included in Highmark's network, outpatient imaging centers must now offer multiple imaging modalities, such as mammography, MRIs, CTs, and bone densitometry.

"We were seeing many facilities that were single modality—just CT or just MRI," said Cary Vinson, M.D., Highmark's vice president of quality and medical performance management. "They were being set up by for-profit companies to siphon away high-margin procedures from hospitals and other multimodality freestanding facilities. We were seeing access problems for referring physicians because the single modality centers were outcompeting the multimodality centers, and they couldn't keep up."

In addition to credentialing the imaging centers, Highmark is going to start requiring providers to preauthorize all CT, MRI, and PET scans. At first, while everyone adapts to the new system, the preauthorization procedure will be voluntary and no procedures will be denied. But eventually—perhaps by the end of this year—the preauthorization will become mandatory, Dr. Vinson said.

Harvard Pilgrim Health Care (HPHC) of Wellesley, Mass., is taking a slightly different approach. Instead of mandatory preauthorization, HPHC is using a "soft denial" process in which physicians must call for imaging preauthorization, but they can overrule a negative decision if they want to.

"We made a decision based on our network being a very sophisticated, highly academic referral environment, that a hard denial program might not be best way to go," said William Corwin, M.D., the plan's medical director for utilization management and clinical policy. "Instead, we elected to use a more consultative approach." The program started in July, so no concrete results are available yet, he noted.

Plans that start a preauthorization program must first figure out who should be authorized to perform scans. At Highmark, the plan tried to be as inclusive as possible, Dr. Vinson said.

"In some cases within a specialty, we tried to determine who was qualified and who was not," he said. "For instance, for breast ultrasound, we listed radiologists, but we also included surgeons with breast ultrasound certification from the American Society of Breast Surgeons."

Highmark ran into a turf battle as it tried to credential providers. In this case, the American College of Cardiology and the American College of Radiology "definitely have differences of opinion about who's qualified and who's not" when it comes to cardiology-related imaging exams, Dr. Vinson said. "Highmark took the approach of accepting either society's qualifications. They clearly wanted us to decide between the two, and we would not do that."

To design their preauthorization programs, both Highmark and Harvard Pilgrim worked with National Imaging Associates, which now has "more than two dozen" clients nationwide and is active in 32 states, according to Dr. Dehn.

He predicts that at least one more specialty will come into the picture, as more and more molecular imaging is being done to design tumor-specific antibodies. "You may have immunologists who are doing diagnostic imaging," he said. ■

Pages 74a—74b