Bean counters do not understand medicine. They count beans. Beans cost money, so the “Golden Rule” gets applied: He who has the gold makes the rules. Unfortunately, that is not the patient anymore. Instead, CMS and the private insurers (PIs) have the gold. Since they must show accountability, they need something to count. That’s why the AMA, CMS, et al. invented “bullets.” As a result, we began to be paid based on how many bullets we produce—like Winchester and Hornady and Remington. The PIs went along for the ride.

Since one often gets what one pays for, these entities found themselves collecting bullets. Lots of bullets. The American physician, always the innovator, arranged his world so as to produce as many bullets as possible. He even assisted programmers to develop electronic health records systems that not only count the bullets for him but show him how to make even more bullets. These systems could point out bullets that the physician might have missed.

After all, that is what the bean counters want, right? More bullets!

Perhaps more accurately, more bullets may be what they thought they wanted. However, those behind the bullets were not entirely satisfied with the system, and they made attempts to modify it. They tried to design a bullet-counting system in 1995, but it didn’t work. So they tried again in 1997, and it didn’t work. Through about 1999, they continued to investigate alternatives, but they never even got a new plan off the drawing board. They gave up, seeming to acknowledge, “We can’t figure this out so just go ahead and do the 1995 thing or the 1997 thing, and the computers will figure it out.”

In fact, the computers did figure it out. Those physicians using electronic billing systems—those who were young enough to possibly amortize the cost of the computers and their service contracts and other associated expenses during (Continued on page 51)
their practice lifetimes—saw that their billings went up. All of this was a surprise to the bean counters, who I believe have yet to take a look at how medicine is really practiced.

Among some electronically enhanced billing practices, electronically enhanced coding occurred. That should be no surprise. It’s easier and quicker to upcode with a computer. You can find the stuff that you don’t need to do (but which will pay the next level) so much more easily with a helpful computer. Some people were “gaming” the system, and now they’ve been uncovered. But that is only half the computer problem: the ‘speeding up’ half.

There is also a more common problem: the ‘slowing down’ half. Studies have shown up to a 40 percent decrease in ‘throughput’ (i.e., billing) in the first two years of computerization of an office. Just ask the VA. This is a wonderful gift to CMS and the PIs. Less throughput means less “medical loss” and that means, for the PIs, more money falling through from the premium hopper to the bottom line (that is where the CEO lives). For CMS, it means less deficit accounting that needs to be explained at year-end. No wonder the folks who have the gold want us to follow their “get on the EHR bandwagon” rules. CMS is prepared to bribe us to get us in line to save them money. The PIs know that they will be the beneficiaries of the government’s adoption “incentives” without spending a nickel themselves. This is the opposite of the “unfunded mandate.” This is a “free ride” on taxpayers’ dollars.

The way things stand now, ethical doctors who use EHRs as intended will be penalized financially by being slowed down. They mete out their own punishment. And the “other” doctors using the EHRs (as designed) for gain will be penalized in the courts. CMS has already hired the teams (ahem, armed with real bullets, by the way) to do the latter. So either way, they’ve got us. But only if we go the EHR route, which I will not.

I prefer to spend my time talking to my patients, dictating the results of the visit (can’t make up stuff in front of the patients), sending copies of the transcription to the referring physician (or even to a caregiver), with a copy to the patient for reference (the Indian model). Patients are amazed and delighted at this novel approach. Many even ask, “Why don’t all doctors do it this way?”

I bill on basis of time plus procedures as appropriate. Mess less and live longer. And bean counters still do not understand medicine. As far as I know, they haven’t even taken a good look. Well, maybe it is better that way.

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