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Electronic Health Record (EHR) Technology: Fraud & Abuse Risks and Compliance Strategies

February 21, 2014

Fraud and Abuse - Risks

- Government Concerns with EHRs have been identified by:
  - Congress
  - DOJ (Department of Justice)
  - HHS (Department of Health and Human Services)
  - ONC (Office of the National Coordinator)
  - CMS (Centers for Medicare and Medicaid Services) and CMS Medicare Contractors
  - OIG (Office of Inspector General)

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Consequences?

- Claims denied on audits – which can lead to pre-pay reviews, overpayments, payment suspensions
- Whistleblower complaints and investigations for potential false claims
  - $5,500 - $11,000 per claim
  - Treble Damages
  - CIA
  - CMPs or worse

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The Center for Public Integrity

Health : Medicare : Cracking the Codes

Growth of electronic medical records eases path to inflated bills

Billing software helps medical professionals document higher fees

Electronic medical records, long touted by government officials as a critical tool for cutting health care costs, appear to be prompting some doctors and hospitals to bill higher fees to Medicare for treating seniors.

Source: http://www.publicintegrity.org/2012/09/19/10812/growth-electronic-medical-records-eases-path-inflated-bills

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Timeline

- 2012 - OIG Work Plan indicates audit target for physician claims with "repeat documentation"
- 9/21/2012 - NY Times article, "Medicare Bills Rise as Records Turn Electronic"
- 9/24/2012 – HHS/DOJ letter to hospital associations warning of EHR fraud risks
- 10/2012 – ONC indicates it will look for upcoding
- 3/15/2013 – CMS revises PIM Chap. 3, Sec. 3.3.2.1.1 (templates)

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Timeline (cont.)

- 4/16/2013 - Senators John Thune (R-S.D.), Lamar Alexander (R-Tenn.), Pat Roberts (R-Kan.), Richard Burr (R-N.C.), Tom Coburn (R-Okla.), and Mike Enzi (R-Wyo.) white paper, "REBOOT: Re-examining the Strategies Needed to Successfully Adopt Health IT" - "Cloned" or Copied Records Can Increase Medical Errors"
- December 2013 – OIG Audit Report on failure to implement hospital EHR fraud safeguards
- January 2014 – OIG Audit Report on CMS' Contractor Practices failure to implement EHR fraud safeguards

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NY Times, "Medicare Bills Rise as Records Turn Electronic" (9/21/2012) (cont.)

- Some experts blame a substantial share of the higher payments on the increasingly widespread use of electronic health record systems. Some of these programs can automatically generate detailed patient histories, or allow doctors to cut and paste the same examination findings for multiple patients — a practice called cloning — with the click of a button or the swipe of a finger on an iPad, making it appear that the physicians conducted more thorough exams than, perhaps, they did.

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NY Times, "Medicare Bills Rise as Records Turn Electronic" (9/21/2012) (cont.)

- Critics say the abuses are widespread. "It's like doping and bicycling," said Dr. Donald W. Simborg, who was the chairman of federal panels examining the potential for fraud with electronic systems." Everybody knows it's going on."

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NY Times, "Medicare Bills Rise as Records Turn Electronic" (9/21/2012) (cont.)

- Many hospitals and doctors say that the new systems allow them to better document the care they provide, justifying the higher payments they are receiving. Many doctors and hospitals were actually underbilling before they began keeping electronic records, said Dr. David J. Brailer, an early federal proponent of digitizing records and an official in the George W. Bush administration. But Dr. Brailer, who invests in health care companies, acknowledged that the use of electronic records "makes it faster and easier to be fraudulent."

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HHS/DOJ Letter (9/24/2012)

- Addressed to five trade associations: American Hospital Association, Federation of American Hospitals, Association of Academic Health Centers, Association of American Medical Colleges, National Association of Public Hospitals and Health Systems

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HHS/DOJ Letter (9/24/2012) (cont.)

- "[T]here are troubling indications that some providers are using this technology to game the system, possibly to obtain payments to which they are not entitled. False documentation of care is not just bad patient care; it's illegal. These indications include potential 'cloning' of medical records in order to inflate what providers get paid. There are also reports that some hospitals may be using electronic health records to facilitate "upcoding" of the intensity of care or severity of patients' condition as a means to profit with no commensurate improvement in the quality of care."

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ONC Looks at Upcoding

A SERVICE OF THE CALIFORNIA HEALTHCARE FOUNDATIO

iHealthBeat
Reporting Technology's Impact on Health Care

Mostashari To Launch Review of Using EHRs for 'Upcoding'

Wednesday, October 17, 2012

National Coordinator for Health IT Farzad Mostashari plans to launch an internal review to determine whether electronic health record systems are prompting some health care providers to overbill Medicare by selecting higher-paying treatment codes, a process known as "upcoding," the Center for Public Integrity reports.

In an interview with CPI on Monday, Mostashari said that his office's Health IT Policy Committee will examine the issue and offer recommendations for addressing it (Schulte, Center for Public Integrity, 10/16).

Background

Mostashari's comments came after a recent Center for Public Integrity investigation, as well as a *New York Times* analysis, found that EHR systems could be contributing to a rise in upcoding.

Last month, Attorney General Eric Holder and HHS Secretary Kathleen Sebelius sent a letter to several health care and hospital associations warning that the Obama administration will not tolerate hospitals' attempts to "game the system" by using EHR systems to boost Medicare and Medicaid payments (*iHealthBeat*, 9/26).

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OIG Audit Report on Hospitals

- EHR technology can make it easier to commit fraud
- EHR documentation features, if poorly designed or used inappropriately, can result in poor data quality or fraud
- Examples: (1) Copy-pasting, AKA cloning; (2) Overdocumentation – inserting false or irrelevant documentation to support billing for higher level services – systems which auto-populate or generate extensive documentation with one single click of a checkbox

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OIG Audit Report on Hospitals (cont.)

- Recommendations:
  - Audit logs should be operational and not disabled
  - CMS should develop guidance on the use of the copy-paste function

- *Source*: HHS Office of Inspector General, "Not All Recommended Fraud Safeguards Have Been Implemented in Hospital EHR Technology", OEI-01-11-00570 (December 2013)

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OIG Audit Report on Medicare Contractors

- Key Findings:
  - Few contractors reviewed EHRs differently from paper medical records
  - Not all contractors could determine if a provider had copied language or overdocumented in a medical record
  - CMS has provided limited guidance to its contractors on fraud vulnerabilities in EHRs

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OIG Audit Report on Medicare Contractors (cont.)

- Key Recommendations
  - CMS should provide guidance on detecting fraud associated with EHRs (CMS said that it intends to develop guidance on the appropriate use of copy-paste functions, and will work on developing best practices for detecting fraud associated with EHRs)
  - Contractors should be directed to use providers' audit logs (CMS said audit logs are helpful but may not be appropriate in every circumstance and tat review of audit logs requires special training)

Source: HHS Office of Inspector General, "CMS and its Contractors Have Adopted Few Program Integrity Practices to Address Vulnerabilities in EHRs", OEI-01-11-00571 (January 2014)

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OIG: 2014 Work Plan

- Evaluation and management services — Inappropriate payments
  - Billing and Payments. We will determine the extent to which selected payments for evaluation and management (E/M) services were inappropriate. We will also review multiple E/M services associated with the same providers and beneficiaries to determine the extent to which electronic or paper medical records had documentation vulnerabilities. Context—Medicare contractors have noted an increased frequency of medical records with identical documentation across services.

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OIG: 2014 Work Plan (cont.)

  - (cont.) Medicare requires providers to select the billing code for the service on the basis of the content of the service and to have documentation to support the level of service reported. *Claims Processing Manual*, Pub. No. 100-04, Ch. 12, § 30.6.1.) (OEI; 04-10-00181; 04-10-00182; expected issue date: FY 2014; work in progress)
- Also in 2012 and 2013 Work Plan

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CMS

Jurisdiction 11 Part B

MEDICAL RECORD CLONING

The word 'cloning' refers to documentation that is worded exactly like previous entries. This may also be referred to as 'cut and paste' or 'carried forward.' Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an Electronic Health Record (EHR). While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter.

Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

last updated on 11/06/2012

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CMS' View: Templates

- CMS does not prohibit the use of templates to facilitate record-keeping. CMS also does not endorse or approve any particular templates. A physician/LCMP may choose any template to assist in documenting medical information.
- Some templates provide limited options and/or space for the collection of information such as by using "check boxes," predefined answers, limited space to enter information, etc. CMS discourages the use of such templates. Claim review experience shows that that limited space templates often fail to capture sufficient detailed clinical information to demonstrate that all coverage and coding requirements are met.

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CMS' View: Templates (cont.)

- Physician/LCMPs should be aware that templates designed to gather selected information focused primarily for reimbursement purposes are often insufficient to demonstrate that all coverage and coding requirements are met. This is often because these documents generally do not provide sufficient information to adequately show that the medical necessity criteria for the item/service are met.
- If a physician/LCMP chooses to use a template during the patient visit, CMS encourages them to select one that allows for a full and complete collection of information to demonstrate that the applicable coverage and coding criteria are met.

Source: Program Integrity Manual, Chap. 3, Sec. 3.3.2.1.1.B (rev. 3/2013)

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Cases: Clinical Protocols

- 2006 FCA case alleged (among other things) that software automatically ordered a series of lab tests which were not necessarily medically necessary and reasonable for all patients (E.D. Wa. – case voluntarily dismissed 2009)

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Cases: Clinical Protocols (cont.)

- Note: COPs for Hospitals, 42 C.F.R. 482.24(c)(3) (use of electronic standing orders, order sets and protocols are allowed IF all conditions are met):
  - (iv) Ensures that such orders and protocols are dated, timed, and authenticated promptly in the patient's medical record by the ordering practitioner or by another practitioner responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

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Cases: Drop-Down Menus (Diagnoses)

- The coders would then code malnutrition for the patient by typing the words "Protein Malnutrition" into the computer system that included the ICD-9-CM information. *Id*. ¶ 20 [referencing the government's complaint]. This led the coders to a drop down screen that listed Kwashiorkor as the first choice at the top of the list. *Id*. The government alleges that coders were "not to independently assess the quality of the evidence that led to the coding of 'Kwashiorkor,'" and "were instructed to select it automatically instead of considering any of the other choices." *Id*.

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Cases: Drop-Down Menus (Diagnoses) (cont.)

- (cont.) In so doing, Kernan expected the coders to "suspend [their] independent judgment and code the most severe form of malnutrition as a default just because the computer lists that most severe form at the top of a list of possible choices." *Id*. ¶ 22.

- *USA v. Kernan Hospital*, Memorandum Opinion, 880 F. Supp. 676, 679 (D. Md. 2012) [dismissing case for lack of specificity in allegations of fraud]

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Medicare/Medicaid EHR Incentive Programs

- The American Recovery and Reinvestment Act of 2009 allocates billions of dollars in incentive payments to encourage the adoption of EHR systems
- Hospitals and "eligible professionals" (EPs) qualify for incentive payments if they make "meaningful use" of "certified EHR technology"
- Medicare payment penalty applies starting in 2015 if EHR "meaningful use" is not achieved
- Hospitals may participate in both the Medicare and Medicaid EHR incentive programs; EPs must choose one

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Participation and Payments to Date

- Eligible Professional Participation
  - Medicare: 291,368 EPs
  - Medicaid: 144,927 EPs
- Hospital Participation
  - Medicare only: 270 hospitals
  - Medicaid only: 153 hospitals
  - Medicare/Medicaid: 4,270 hospitals
- Total Payments through December 2013
  - Medicare Program: $11.9 billion
  - Medicaid Program: $6.9 billion

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OIG Report on CMS Oversight of MU Program

- "Early Assessment Finds that CMS Faces Obstacles in Overseeing the Medicare EHR Incentive Program" (November 2012)
- OIG Recommended:
  - CMS obtain and review supporting documentation prior to payment
  - CMS issue additional guidance on MU supporting documentation
  - ONC require certified EHR to be capable of producing reports for yes/no MU measures
  - ONC improve certification process for EHR to ensure accurate EHR reports

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Meaningful Use Audits

"We will review Medicare incentive payments to eligible health care professionals and hospitals for adopting electronic health records (EHR) and the Centers for Medicare & Medicaid Services (CMS) safeguards to prevent erroneous incentive payments. We will review Medicare incentive payment data from 2011 to identify payments to providers that should not have received incentive payments (e.g., those not meeting selected meaningful use criteria). We will also assess CMS's plans to oversee incentive payments for the duration of the program and actions taken to remedy erroneous incentive payments."

- OIG Fiscal Year 2014 Work Plan

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Meaningful Use Audits: CMS Process

- Various audit processes
  - Pre-payment edit checks
  - Pre-payment audits
  - Post-payment audits
- Pre and post payment audits
  - Conducted by Figliozzi and Company
  - Initial letter
  - Follow up requests
  - Potential onsite review
- CMS reportedly intends to conduct pre- and post-payment audits on 5-10% of attestations

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Meaningful Use Audits: Potential Penalties

Attestation Disclaimer

General Notice

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Signature of Hospital Representative

I certify that the foregoing information is true, accurate, and complete. I understand that the Medicare EHR Incentive Program payment I requested will be paid from Federal funds, that by filing this attestation I am submitting a claim for Federal funds, and that the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain a Medicare EHR Incentive Program payment, may be prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.

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Meaningful Use Audits: Potential Penalties

- Recoupment
- Where there is fraud
  - Imprisonment
  - Fines
  - Civil liability
  - Loss of license
  - Exclusion

- Medicare payment penalties associated with failure to meet MU objectives
- Examples

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Meaningful Use Audits: Appeals

- Medicare appeal process set forth on CMS website
- Process consists of the submission of an appeal request form and relevant materials
  - Pay attention to MU appeal deadlines, which vary based on whether the submission is by an EP or Hospital
  - Information to be submitted depends on reason for MU appeal
- Certain issues are not appealable
  - Denial of hardship waiver request

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Meaningful Use Audits: Recommendations

- Maintain documentation relevant to MU attestation
  - Source documents
  - Documentation for non-percentage-based objectives
  - Other relevant documents (e.g., ONC EHR certification)

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Meaningful Use Audits: Recommendations (cont.)

- Pay attention to document retention periods
  - 6 years for MU objectives and clinical quality measures under the Medicare EHR Program
  - Payment calculation data (e.g., cost reports) should follow current documentation retention processes
  - States may require longer periods for Medicaid
- Conduct self audits
- Consider development of MU policies

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Amendments to Stark/AKS EHR Donation Regulations

- Extension to December 31, 2021
- Exclusion of laboratory companies
- Modifications to deemed interoperability
- E-Prescribing capability no longer required
- Prohibition on data and referral "lock-in"
- No additional guidance on covered technology

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AHIMA Areas of Concern

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AHIMA EMR/EHR Areas of Concern

1. • Authorship integrity risk
2. • Auditing integrity risk
3. • Documentation integrity risk
4. • Patient identification and demographic data risks

Guidelines for EHR Documentation to Prevent Fraud
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_033097.hcsp

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RTI Recommendations

Audit Functions
1) Requires the use of an audit log function and specifies audit log operation and content for tracking EHR updates. (4.2.1)
2) Requires that the methods (i.e., copy/paste, direct entry, import) for any update to an EHR be documented and tracked. (4.2.4)
3) Requires that the user ID of the original author be tracked when an EHR update is entered "on behalf" of another author (i.e., distinguish between entries made by an assistant and a provider). (4.2.6)
4) Requires that EHR technology be able to record and indicate the method used to confirm patient identity (i.e., photo identification, prior relationship). (4.2.11)
5) Requires that original EHR documents be retained after they are signed off and modifications be tracked as amendments. (4.2.7)

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RTI Recommendations (cont.)

User Authorization and Access Controls
6) Requires the use of user IDs and passwords to restrict unauthorized access to EHRs. (4.2.3)
7) Requires the use of a provider's National Provider Identifier to restrict EHR access and track updates to EHRs by author. (4.2.2)
8) Requires that EHR technology support an "auditor" class of user to have read-only access to patient records. (4.2.8)
Data Transfer Standards
9) Requires that a document ID tracking number be generated and attached to an EHR any time an EHR is exported (i.e., printed or electronically communicated). (4.2.9)
10) Requires that EHRs be exchanged using certain data standards (encryption) to ensure that data have not been altered during the transmission. (4.2.13)
11) Requires that EHR technology have the capacity to directly capture clinical information in structured and coded data and not impact EHR user productivity. (4.2.12)

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RTI Recommendations (cont.)

Patient Involvement in Anti-Fraud
12) Requires that patients be able to access and comment within their EHRs. (4.2.10)
Other
13) Requires that information transmitted for payment of claims be accurately linked and tracked to the appropriate EHR. (4.2.14)
14) Requires that EHR technology not prompt an EHR user to add documentation but be able to alert a user to inconsistencies between documentation and coding. (4.2.5)

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Authorship Integrity

RTI	AHIMA
Methods (i.e., copy/paste, direct entry, import) for any update to an EHR be documented and tracked.	• Identification of the provider of record • Inability to accurately determine services and findings specific to a patient's encounter
	• Cut, copy and paste functionality
User ID of the original author be tracked when an EHR update is entered "on behalf" of another author	• Ability to take over a record and become the author • Inaccurate representation of authorship of documentation

http://www.rti.org/pubs/enhancing_data_quality_in_ehrs.pdf

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Auditing Integrity

RTI	AHIMA
Use of an audit log function and specifies audit log operation and content for tracking EHR updates.	• Inadequate auditing functions • EHR system preserve data produced in response to a specific request, or can it be recreated reliability
Use of user IDs and passwords to restrict unauthorized access to EHRs.	• Does the EHR system provide access control functions? • Access controls based on role of provider
Use of a provider's National Provider Identifier to restrict EHR access and track updates to EHRs by author.	• None
EHR technology support an "auditor" class of user to have read-only access to patient records.	• None

http://www.rti.org/pubs/enhancing_data_quality_in_ehrs.pdf

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Documentation Integrity

RTI	AHIMA
Methods (i.e., copy/paste, direct entry, import) for any update to an EHR be documented and tracked. *	• Automated insertion of data • Templates • Auto population of clinical data • Problem list maintenance
Original EHR documents be retained after they are signed off and modifications be tracked as amendments.	• Inaccurate representation of authorship of documentation • Amendment/correction issues
Requires that EHR technology not prompt an EHR user to add documentation but be able to alert a user to inconsistencies between documentation and coding.	• Inaccurate, automated code generation associated with documentation

http://www.rti.org/pubs/enhancing_data_quality_in_ehrs.pdf

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Patient Identification Integrity

RTI	AHIMA
EHR technology be able to record and indicate the method used to confirm patient identity	• Automated demographic information • Quality of Care • Fraudulent activity
Requires that patients be able to access and comment within their EHRs. (4.2.10)	None

http://www.rti.org/pubs/enhancing_data_quality_in_ehrs.pdf

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RTI International (RTI) to Develop Recommendations:

- Enhance data protection;
- Increase data validity,
- Accuracy, and integrity; and
- Strengthen fraud protection in EHR technology.

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OIG Report - Concern Related to Copy/Pasting

- Copy-pasting, also known as cloning, allows users to select information from one source and replicate it in another location. When doctors, nurses, or other clinicians copy-paste information but fail to update it or ensure accuracy, inaccurate information may enter the patient's medical record and inappropriate charges may be billed to patients and third-party health care payers. Furthermore, inappropriate copy-pasting could facilitate attempts to inflate claims and duplicate or create fraudulent claims.

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Cloning

- Cloning
  - Cut & Paste = Blocks of text or even complete notes from another MD
  - Copy & Paste = Carry forward of prior notes
  - Other terms used =
    - Copy forward,
    - Re-use, and
    - Carry forward.

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What Can We Do?

- One message
- Medical Director support
- Mandatory education
  - Discuss the importance of appropriate documentation in the EMR
  - Outline and describe the ground rules to establish and maintain content integrity
  - Discover further resources for reference and support

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Copy & Paste - Regular Audits of Providers

- Incorporate into ongoing billing compliance audits
- Focus on established patient/subsequent E/Ms
- First established/subsequent encounter in audit sample
  - Compare patient's current note to same physician/same patient previous encounter note

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Other Ways to Audit Cloning

- Review a list of patients re-admitted within a certain amount of time (i.e. within 30 days, 3 months)
- Review patients on a "teaching service" to verify original documentation by medical students & residents
- Determine if you have copy functionalities that originate in software other than the EMR such as copy in Microsoft Windows

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Other Ways to Audit Cloning (cont.)

- A report that compares discrete data elements in the electronic record
- Generate a report on features for copy/paste functionality
- Identify if a copy event be retrospectively identified?
- Is an appropriately detailed audit log generated when a copy event occurs in the course of documentation?

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OIG Report – Overdocumentation

- Overdocumentation is the practice of inserting false or irrelevant documentation to create the appearance of support for billing higher level services. Some EHR technologies auto-populate fields when using templates built into the system. Other systems generate extensive documentation on the basis of a single click of a checkbox, which if not appropriately edited by the provider, may be inaccurate. Such features can produce information suggesting the practitioner preformed more comprehensive services than were actually rendered.13

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Exploding Notes: Explosive Topic

- Check a box, get a sentence.
- Exploding notes and Natural Language Processing - reads and assigns code to the automated information.
  - Does not sort out Medically Necessary information
  - EHR assigns code on **word quantity** not PERTINENCE
- *"Things can get even more perilous with the use of exploding notes, the compliance officer says. Exploding notes or exploding macros means a simple check off of 'normal' or 'negative' prompts the documentation of a complete organ system exam."*

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Templates: Challenges

- Generate canned phrases, may lose uniqueness
- Multiple consecutive canned statements causes a poor read that may misconstrue the intended meaning
- One-size-fits-all templates are incomplete, not comprehensive enough, and only work for one problem
- Subjective observations go undocumented. A VA study saw increased errors with templates
- Templates drive more unnecessary documentation. Many times they cannot be closed until all boxes are checked, which then drives higher E&M levels

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Other Risk Areas

- Monitoring of coding by EHR/EMR is not done
- Assume coding in EMR/EHR matches billing system
- Coding "assistance" via the EMR product itself
- Modifiers
- Abbreviations
- Lack of policies and procedures related to coding and documentation related to EHR
- Lack of EHR retention policies

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Summary

- Develop a audit plan to test the integrity of the system
  - Documentation integrity
  - Authorship
  - Access and security controls
  - Patient quality and identity
- Review tools in the EHR utilized by the providers
- Training
- Revisit EHR controls related to RTI
- Develop policies and procedures

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Thank You

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