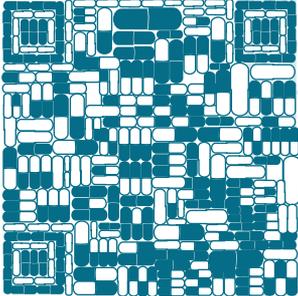
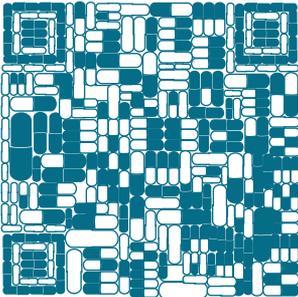


Upcoding and Overpayments: How EHR Use Can Turn a Provider's Practice Upside Down

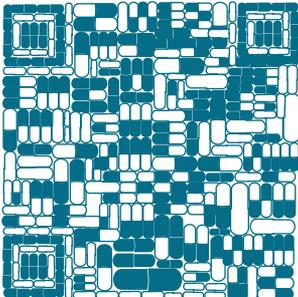
by Kelsey Farbotko



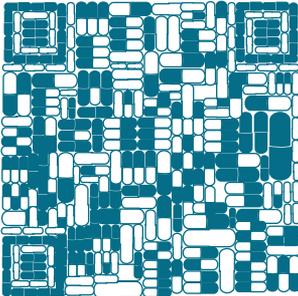
Utter the word “overpayment” around a group of physicians, hospital administrators, or other health-care providers, and you would feel a collective shudder pass through the crowd. For all providers, but particularly those participating in Medicare and Medicaid, the word “overpayment” means financial pain from various angles, including auditors, attorneys, and, of course, repayment of the overpayment. Overpayments can originate from a variety of sources, but overpayments and electronic health records (EHR) converge where the use of an EHR results in undue payments to a physician, hospital, or other entity by Medicare, Medicaid, or other third party.



It is generally accepted that EHR technology provides significant benefits to health-care providers. The Centers for Medicare & Medicaid Services (CMS) observes many such benefits, including immediate access to patient records, automated alerts and reminders, greater legibility, and paperwork reduction.¹ To support EHR adoption, CMS has paid almost \$30 billion to individuals and hospitals that have met “meaningful use” requirements under the EHR Medicare and Medicaid Incentive Programs.² Despite the significant benefits of EHR adoption, the same features that contribute to these benefits can also potentially create circumstances where overpayments occur.



Various stakeholders, including agencies within the Department of Health and Human Services such as CMS and the Office of the Inspector General (OIG), have sounded the alarm regarding certain EHR features, including copy-and-paste, also known as “cloning.”³ Copying and pasting is a common word processing tool and, with regard to an EHR, can greatly reduce the time it takes a provider to draft an encounter note. However, “cloning” capabilities create the risk that outdated or irrelevant information will be brought forward into more recent encounter



notes. Failure to take care while “cloning” a note from an earlier encounter can result in documentation that fails to support the extent of the encounter and may lead to awkward patient-provider interactions or, more seriously, ill-advised treatment.⁴ As a Virginia CMS contractor, Palmetto GBA, reminds providers, “...it would not be expected [that] 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.”⁵ CMS has also warned against similar EHR tools such as automatic field population or templates, which can also yield unintended results affecting the integrity of the documentation.⁶

In addition to quality of care concerns, EHR use may facilitate certain billing irregularities, including one known as “upcoding.” “Upcoding” occurs when a provider bills for a procedure or encounter using a code that is unsupported by the medical record and that results in a higher payment for a physician or provider than should have been received.⁷ This higher payment is an overpayment, and, where a health-care provider identifies circumstances where diagnoses, procedures, or visits were upcoded, the overpayment must be reported and repaid. For example, the OIG investigated billing by multiple hospitals for an extreme form of malnutrition, kwashiorkor, very rarely found in the United States. A few of the hospitals linked the errors, some of which resulted in upcoding, to their billing software.⁸ While individual EHR users may have grown more comfortable with their EHR's features and are now making entries more accurately, an initial learning curve may have led to poor documentation for past records billed to Medicare.

Although there is conflicting evidence whether upcoding resulting from EHR misuse is a widespread problem, or if EHR-related mistakes are made consistently across providers,⁹ CMS has certainly indicated that it considers these tools a

concern and will take steps to protect the integrity of the federal health-care programs. For example, in January 2014, the OIG issued a report chastising CMS for failing to guide its contractors on identification of EHR abuse.¹⁰ The OIG further found that CMS contractors were not implementing sufficient safeguards in their pursuit of overpayments related to EHR misuse or abuse. The report concluded that “although EHR technology may make it easier to perpetuate fraud, CMS and its contractors have not adjusted their practices for identifying and investigating fraud in EHRs” and made meaningful recommendations to CMS for more efficient recoupment of overpayments by its contractors.

Rather than rely solely on contractors' recoupment of overpayments, in 2010 the Patient Protection and Affordable Care Act created a new obligation for providers to report and repay any identified overpayment within sixty days of such identification, or, for cost reporting entities, within sixty days of the date the “corresponding cost report” is due.¹¹ Failure to do so can result in a violation of the False Claims Act, which carries the potential for substantial penalties. Providers may also be subject to penalties under the Civil Money Penalties Law or federal health-care program exclusion.¹² Despite the breadth of enforcement power that can be wielded against providers, CMS has only published a proposed rule governing overpayments for Medicare Parts A and B providers, and announced in February 2015 that it would delay publishing a final rule until 2016.¹³

Under the Medicare Parts A and B Proposed Rule, the duty to report and return an overpayment is triggered by the “identification” of the overpayment, defined as having “actual knowledge of the existence of the overpayment or act[ing] in reckless disregard or deliberate ignorance of the overpayment.”¹⁴ CMS intends for “identification” to go beyond a colloquial definition to create an obligation to investigate, research and self-audit “with all deliberate speed” to find additional potential overpayments, and believes this definition “gives providers and suppliers an *incentive to exercise reasonable diligence* to determine whether an overpayment exists.”¹⁵ Significantly, the Proposed Rule does not address whether the official “identification” of an overpayment arises after the provider is able to investigate the entire scope of a potential overpayment and determine the full amount that needs to be repaid. Hopefully CMS will address this issue in its final rule, because where billing problems result in significant overpayments, it can be taxing

on providers to conduct the full breadth of a self-audit within the sixty-day window.

If this definition of “identification” becomes final, the question remains regarding the extent to which a provider must investigate additional potential overpayments. CMS' Parts A and B Proposed Rule suggests a ten-year “look-back period,” meaning overpayments from submitted claims as far back as ten years can be pursued by CMS, and therefore providers may need to investigate potential overpayments up to ten years prior.¹⁶ Interestingly, when CMS issued its proposed and final rules governing overpayments for Medicare Parts C and D, CMS adopted a six-year look-back period.¹⁷

CMS has reminded Medicare providers that even without specific guidance on overpayment identification and reporting, the statutory sixty-day reporting period is in effect, and providers will have to continue to await CMS guidance for almost another full year.¹⁸ Providers' counsel should encourage practices that prevent or minimize the risk of overpayments, especially with respect to a provider's use of an EHR. These practices include routine self-auditing and policies on conscientious proofreading of encounter notes, particularly those EHR notes with “cloned” text.¹⁹ These practices can facilitate efficient use of EHR technology by allowing providers to stay abreast of potential billing miscues and minimize the magnitude of an overpayment. Ultimately, providers must act quickly in identifying, investigating, and repaying overpayments.

Endnotes:

- Centers for Medicare & Medicaid Services, “Electronic Health Records Provider Fact Sheet,” Dec. 2014, <http://cms.hhs.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/ehr-provider-factsheet.pdf> (last visited May 11, 2015).
- Centers for Medicare & Medicaid Services, “Data and Program Reports,” <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/DataAndReports.html> (last visited May 6, 2015). This data covers the period from May 2011 through March 2015.
- Centers for Medicare & Medicaid Services, *supra* note 1.
- See Terry, K., “Avoiding EHR Note ‘Cloning’ While Maintaining Efficiency,” MEDICALECONOMICS.COM, Apr. 24, 2014, <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/cloning/avoiding-ehr-note-cloning-while-maintaining-efficiency?page=full> (last visited May 11, 2015).

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- 5 Palmetto GBA, "Medical Record Cloning," <http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Jurisdiction-11-Part-B~8MKQK88358> (last visited May 11, 2015).
- 6 Centers for Medicare & Medicaid Services, *supra* note 1.
- 7 *Id.*
- 8 See e.g. "News Briefs", *Report on Medicare Compliance Vol. 23, No. 6*, pg. 8 (Feb. 17, 2014).
- 9 See generally Adler-Milstein, J. & Jha, A., *No Evidence Found that Hospitals are Using New Electronic Health Records to Increase Medicare Reimbursements* 33 HEALTH AFFAIRS 1271 (Jul. 2014).
- 10 Office of the Inspector General, *CMS and its Contractors Have Adopted Few Program Integrity Practices to Address Vulnerabilities in EHRs*, Report (OEI 01-11-00571), Jan. 7, 2014, <https://oig.hhs.gov/oei/reports/oei-01-11-00571.asp>. CMS is also concerned with intentional fraud perpetrated using EHR technology, stating in this report that EHR use also may facilitate the intentional submission of false claims, constituting fraud due to the nature of electronic records, such as lack of physical signatures and handwriting and the ability to alter dates and documentation without easily apparent evidence. *Id.*
- 11 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6402, 124 Stat. 119 (2010) (amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010))(establishing Section 1128J of the Social Security Act, codified at 42 U.S.C. § 1320-7k(d)).
- 12 See 77 Fed. Reg. 9179, 9184 (Feb. 16, 2012).
- 13 80 Fed. Reg. 8247 (Feb. 17, 2015). The final rules for Medicare Parts C and D was published in 2014 at 79 Fed. Reg. at 29918 (May 23, 2014)).
- 14 77 Fed. Reg. 9179, 9182 (Feb. 16, 2012).
- 15 *Id.* (emphasis added).
- 16 *Id.* at 9184.
- 17 79 Fed. Reg. at 29925 (May 23, 2014).
- 18 77 Fed. Reg. 9179, 9180-81 (Feb. 16, 2012).
- 19 See generally Terry, K. *supra* note 4.



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