THE EHR AND RISK OF BILLING RELATED FRAUD

HFMA Mississippi Chapter
Summer Workshop 8/23/19

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EHR INCENTIVES

- Per CMS over 4,800 hospitals have qualified for incentive payments for the electronic health record.
- Per CMS, as of October 2108, more than 546,644 health care providers have received incentive payments.
- More than $24.8 billion in Medicare incentives
- More than $6 billion in Medicaid incentives

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FRAUD AND ABUSE

The DOJ reached a settlement with:

- ❖ Louisville-based HH agency for $3.3 million for violating the federal False Claims Act in submitting false medical claims to Medicare and other federal healthcare programs.
  - Medically unnecessary home visits
  - Grossly exaggerated level of care
- ❖ Oncology Practice to Pay $4.1 Million to Settle False Claims Act Investigation
  - ❖ Georgia Cancer Specialists Overbilled Medicare for Evaluation and Management Services

    The civil settlement resolves the United States' investigation into Georgia Cancer Specialists' practices relating to billing for evaluation and management (E&M) services on the same day as a related procedure.

False Claim Act Recoveries in Health Care

$2.8 billion 2018

$59 billion since 1986

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AMA

Most Common:

- Unbundling codes
- Upcoding
- NCCI edits
- Modifiers
- Improper reporting of infusion, hydration, and injection codes
- Cloned documentation

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CLONING

Template documentation

Cut and Paste

Both identified as "carry forward"

Reviewers have noted greater use of "identical information"
Subsequent perception of lack of medical necessity

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LAB TESTING

Protocols:

- "Translation" of test orders per protocol
  - Order for CBC
    - CBC with automated differential performed
  - Order for UA
    - UA with microscopy performed
  - Order for UA with micro
    - Urine culture performed "per protocol"
  - Internal test names
    - Cardiac panel
      - There is no cardiac panel in CPT

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DRUG UNITS

CMS:
Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the description for the drug code is 6 mg, and 6 mg of the drug was administered to the patient, the units billed should be 1. As another example, if the description for the drug code is 50 mg, but 200 mg of the drug was administered to the patient, the units billed should be 4. **Providers and hospitals should not bill the units based on the way the drug is packaged, stored, or stocked**

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SELF ADMINISTERED AND TAKE HOME DRUGS

The EHR must clearly identify the drug, the dosage, and the route of administration

- In the outpatient setting, all oral medications are considered self administrable and should be reported with Revenue Code 637
- Review the self administrable drug list established by your Medicare Contractor on a routine basis to determine the injectable drugs that are considered self administrable
  - Insulin is always considered self administrable regardless of the condition of the patient. Neither the drug nor the administration are reportable as a covered service in the outpatient setting
- Take home drugs should be clearly documented, and reported on the claim with Revenue Code 253

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NON-PHYSICIAN PRACTITIONERS

All documentation in the electronic health record should clearly identify the credentials of the staff member providing the service

In the CAH Method II reimbursement setting:

- GF – Services rendered by a nurse practitioner, clinical nurse specialist, or physician assistant.
  - Services billed with the GF modifier are paid based on the lesser of the actual charge or a reduced fee scheduled amount of 85 percent.
- AH – Clinical Psychologist
- AE – nutrition professional/registered dietician
- SB – certified nurse-midwife

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DOCUMENTATION AND MEDICAL NECESSITY

Occurs in all settings by personnel throughout the healthcare facility

Cloning of Medical Notes

Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

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DOCUMENTATION AND MEDICAL NECESSITY

Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning documentation is considered a misrepresentation of the medical necessity requirement 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.

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DISCREPANCIES WITH AUTO POPULATION/SMART TEXT

Review of Systems normals don't match the History of Present Illness

Physical Exam normals don't match the HPI or the Past History

Examples – patient presents with abdominal pain

- ROS – "Abdomen – reports no symptoms"
- Physical Examination –
  - "Abdomen" – soft, non-tender in all four quadrants"
- Discrepancies occurred in the paper record due to poor documentation habits, but have increased significantly in the electronic record

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CARRY FORWARD

- Carry forward allows a provider to "push a button" and automatically drop a previous patient note into a new encounter
- Requires close editing by the provider
- Erroneous information can be carried forward from visit to visit
- Resolved issues are carried forward from clinic visit to clinic visit or one hospital day to the next which results in misrepresentation of the patient's condition, the number of diagnoses being treated, and does not reflect the severity of illness appropriately.

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ACTUAL EXAMPLE

Patient presents for shoulder and upper arm pain
Patient is a quadriplegic at the level of T9
Only has function of arms, upper back, and above
Uses his arms to move from wheelchair
Documentation in the record
"No pertinent past history"
"Review of Systems –"all negative other than HPI"
Physical Examination – all reported as normal, except HPI. This includes normal neurological exam, normal gait, normal genitourinary function, etc.

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ACTUAL EXAMPLE

Medication List included two pain medications for use three times a day, one of which was a narcotic. However, his Review of Systems was entirely negative and Past History was "not pertinent".

RED FLAGS throughout this documentation of auto-population

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UPCODING

Upcoding an E/M level occurs when cloned, carried forward, or auto-population is used to report elements of an E/M level which have not been questioned, examined, or are not pertinent to the visit.

- Includes the facility ED level
- Facility ED level must "appear reasonable" to a reviewer

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UPCODING EXAMPLE

Example – patient presents for ear pain.

- Comprehensive Review of Systems is documented (every body system)
- Comprehensive Physical Examination is documented (every body system)
- Per the documentation the E/M level meets the criteria for a Level 4 ER visit - 99284 (ER visit, high, urgent severity)
- Diagnosis is otitis media - i.e. ear infection

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UPCODING EXAMPLE

Per the medical necessity of the presenting problem, a Level II E/M code is appropriate – (ER visit, low/moderate severity).

However, some hospitals/clinics are assigning the E/M level per the documentation in the EHR

Some EHR systems automatically assign the physician and facility E/M based on the "amount" of documentation

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MODIFIER 25

CMS does not normally allow additional payments for separate E/M services performed by a provider on the same day as a procedure

However, if a provider performs an E/M service as above that is significant, separately identifiable, and above and beyond the usual care associated with the procedure, modifier 25 may be attached to the E/M service code

This applies to both the provider and the facility

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OIG REVIEW

The OIG has been conducting reviews of claims and records for which modifier 25 has been attached to the E/M.

Significant findings report these reviews which have resulted in take back of reimbursement.

The facility E/M in conjunction with a procedure is labeled in the media as the “surprise charge”.

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UPCODING IN THE INPATIENT SETTING

OIG review for diagnosis code of Severe Malnutrition:

- University of Wisconsin –
- 90 claims/records reviewed
- 88 claims/record reviewed in error
- $562,361 in net overpayments
- $2,412,137 – estimated overpayments in that two year period

Recommendations:

- Refund the Medicare program $2,412,137 for the incorrectly coded claims

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OIG ADDITIONAL FOCUS

- Medical device information identified in the EHR and an on the claim
- IRF facilities – "$5.7 billion in 2013 for care to beneficiaries that was not reasonable and necessary"
- EHR incentive payments to eligible providers: $729.4 million to EPs who did not meet meaningful use requirements

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VENDOR FRAUD

- EHR vendor fraud:
  - Greenway Health $57.25 million – “caused it’s users to submit false claims by misrepresenting the capabilities of its EHR products”
  - eClinical Works $155 million – “misrepresented the capabilities of its software. Also resolved allegation that ECW paid kickbacks to certain customers”

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ZPIC

Zone Program Integrity Contractors

Advance Med:

AR, LA, MS, TN, AL, GA, NC, SC, VA, WV.

ND, SD, MT, WA, OR, ID, UT, AZ, WY, NE, KS, IA, MO, and AK

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ZPIC FUNCTIONS

ZPIC Functions • Investigating potential fraud and abuse for CMS administrative action or referral to law enforcement;
• Conducting investigations in accordance with the priorities established by CPI's Fraud Prevention System;
• Performing medical review, as appropriate;
• Performing data analysis in coordination with CPI's Fraud Prevention System;
• Identifying the need for administrative actions such as payment suspensions and prepayment or auto-denial edits; and,
• Referring cases to law enforcement for consideration and initiation of civil or criminal prosecution. In performing these functions, ZPICs may, as appropriate:
• Request medical records and documentation;
• Conduct an interview; •
• Identify the need for a prepayment or auto-denial edit and refer these edits to the MAC for installation;

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ZPIC FUNCTIONS

• Withhold payments; and,
• Refer cases to law enforcement.
ZPICs also support victims of Medicare identity theft. A provider or supplier who believes that he/she may have had their provider information stolen and used to submit Medicare claims for which payment was made can request that the ZPIC for their zone investigate the case. The ZPIC will then work with CMS to determine the appropriate remedial action to assist the provider. Guidance on how to avoid and report Medicare identity theft and information on current scams can be found at:
http://www.cms.gov/MedicareProviderSupEnroll/downloads/ProviderVictimPOCs.pdf on the CMS website.

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DECREASE RISK

Documentation integrity

- Information governance
- Patient identification
- Authorship validation
- Audit for documentation validity
- Establish policies and procedures for audit and coding functions
- Safeguards
- Education
- Patient review of records will highlight inaccuracies

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QUESTIONS?

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THANK YOU

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