



Cracking the Codes ^[1]

Growth of electronic medical records eases path to inflated bills ^[2]

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.

The federal government's campaign to wire up medicine started under President George W. Bush. But the initiative hit warp drive with a February 2009 decision by Congress and the Obama administration to spend as much as \$30 billion in economic stimulus money to help doctors and hospitals buy the equipment needed to convert medical record-keeping from paper files.

In the rush to get the program off the ground, though, federal officials failed to impose strict controls over billing software, despite warnings from several prominent medical fraud authorities. Now that decision could come back to haunt policy makers and taxpayers alike, a Center for Public Integrity investigation has found.

Experts say digital medical records may prove — as promised — to be cost-effective, allowing smoother information sharing that helps cut down on wasteful spending and medical errors.

Yet Medicare regulators also acknowledge they are struggling to rein in a surge of aggressive — and potentially expensive — billing by doctors and hospitals that they have linked, at least anecdotally, to the rapid proliferation of the billing software and electronic medical records. A variety of federal reports and whistleblower suits reflect these concerns.

Regulators may lack the auditing tools to verify the legitimacy of millions of medical bills spit out by computerized records programs, which can create exquisitely detailed patient files with just a few mouse clicks.

"This is a new era for investigators," said Jennifer Trussell, who directs the investigations unit of the U.S. Department of Health and Human Services Office of Inspector General.

"We are all excited about the many benefits of electronic health records, but we need to be on the lookout for unscrupulous providers who take advantage of this new technology," she said.

The Center for Public Integrity has recently documented how some health professionals have seemingly manipulated Medicare billing codes to gain higher fees. The investigation unmasked thousands of doctors consistently billing higher-paying treatment codes than their peers, despite little evidence in many cases that they provided more care.

Some of the sharpest surges in more costly coding have occurred in hospital emergency rooms, according to the Center's data analysis, where billing software has been widely used.

Interviews with hospital administrators, doctors and health information technology professionals confirmed that digital billing gear often prompts higher coding, though many in the medical field argue that they are simply recouping money that they previously failed to collect.

For example, Holy Name Medical Center in Teaneck, N.J., saw a spike in billing codes after wiring up its emergency room in 2007, according to hospital CEO Joe Lemaire.

Coding 'Slam Dunk'

Electronic medical records can influence pay scales known as "Evaluation and Management" codes. Medicare spent more than \$33.5 billion in 2010 using these numeric codes for services ranging from routine doctor office visits to outpatient hospital or nursing home care. More than half the doctors billing Medicare were using electronic records in 2011, and more are expected to follow.

For an office visit, a doctor must choose one of five escalating payment codes that best reflects the amount of time spent with a patient as well as the complexity of the care. The lowest-level code for a minor problem, 99211, pays about \$20. But the doctor can bill roughly \$100 more for the top level. Hospitals use similar codes for billing emergency room and outpatient services.

The subjective nature of the coding process has left the medical community and those who pay its bills in constant conflict. Many doctors and billing consultants argue that most practitioners habitually charge too little because they neglect to put down on paper all of the work they do, which if done more diligently would justify higher codes and fees.

The HHS Agency for Healthcare Research and Quality, an advocate for pressing ahead with electronic health records, accepted that view when it wrote in September 2009 that doctors may choose billing codes that are too low. The agency suggested ^[3] that converting to digital systems would enable doctors to bill higher fees, "translating into enhanced revenue."

By contrast, government auditors and many private insurance investigators see evidence that some doctors pick higher codes to inflate their bills — a practice known in medical circles as "upcoding."

The rapid expansion of electronic health records is adding a whole new dimension to that quarrel. Government officials, however, have yet to step in and settle whether the hundreds of software products on the market consistently prompt doctors and hospitals to bill at higher levels than they did prior to going electronic — and if the higher fees are merited.

Doctor Backlash

Warnings that digital billing equipment could unleash a torrent of inflated charges date back to the administration of President George W. Bush.

In July 2005, the American Health Information Management Association identified an "unintended incentive for fraud because healthcare organizations and

software developers need to prove a return on investment for the coding products,” reads the [report](#) ^[4], which was commissioned by HHS officials.

Two months later, a second American Health Information Management Association panel [stated](#) ^[5] that “without a deliberative effort to build fraud management” into networks of digital medical records “health care payers and consumers will be exposed to new and potentially increased vulnerability to electronically-enabled healthcare fraud.”

Dr. Donald W. Simborg, a California physician who co-chaired that panel, said its findings were dismissed out of fear that doctors would shun the digital devices if they thought buying one might lead the government to second-guess their fees, and perhaps even accuse them of impropriety.

Simborg also headed up an executive team HHS turned to in 2007 to recommend fraud controls in digital gear certified for sale to doctors and hospitals.

In a May 2007 report, the 23-member group, which included representatives from medical groups, health insurers and government, warned against approving software that assisted doctors in selecting billing codes. It is “not appropriate to suggest to the provider that certain additional data, if entered, would increase the level” of the billing code, according to the report.

“Our report was totally ignored for fear of a physician backlash,” said Simborg. The [report](#) ^[6] saw print under the bland title “Recommended Requirements for Enhancing Data Quality in Electronic Health Records” that gave little hint it dealt with the sensitive fraud issue, he said.

The billing tools that the study panel panned have been trumpeted in recent years by electronic health record manufacturers hoping to persuade doctors and hospitals to shell out thousands of dollars — millions in the case of a hospital — to computerize.

“This is the big elephant right now and we aren’t touching it,” said Simborg.

Dr. Robert Kolodner, a physician who headed the federal push for electronic medical records in 2007, acknowledged that billing abuse took a backseat to steps likely to entice the medical community to embrace the new technology.

Kolodner said officials were certain the savings achieved by computerizing medicine would be so great that billing abuse, “while needing to be monitored, was not something that should be put as the primary issue at that time.”

That view [didn’t change much](#) ^[7] with the 2009 arrival of the Obama team, which was sympathetic to some of the tech companies that stood to benefit handsomely from the conversion.

For instance, giant tech vendor McKesson submitted to the Obama-Biden Transition Team [its vision](#) ^[8] for the rollout, which recommended “significant start-up funds” to get the ball rolling.

Since 2009, the Obama administration has held dozens of public meetings on electronic health record policies and standards, but none that focused primarily on fraud control and billing integrity.

The administration’s Office of National Coordinator for Health Information Technology, which is spearheading the drive, declined to discuss the billing controversy.

But on April 27 of this year that office asked the HHS Office of Inspector General to study the issue. Spokesman Peter Ashkenaz said that ONC “will review any recommendations that are made in the report and will address those at that time.”

Donald White, a spokesman for the inspector general’s office, said that the issue “is on the radar” and the office will be “looking into these codes and how electronic health records may be affecting them.”

But government officials admit they lack a system to monitor the hundreds of billing and medical software packages in use across the country. That shortcoming caught the eye of the American Medical Association, which helped develop the billing codes and favors stricter government standards. In May, the doctors’ group urged officials to require testing that assures digital devices bill accurately and “do not facilitate upcoding.”

‘Improper Payments’

Connecticut doctor Stephen R. Levinson, who authored a major textbook on medical coding published by the AMA, strongly believes that many electronic medical records systems improperly raise coding levels.

He said the units are programmed to easily allow doctors to cut and paste records from prior encounters with a patient so that “records of every visit read almost word for word the same except for minor variations confined almost exclusively to the chief complaint.”

That extra documentation often triggers the software to raise the billing level and the size of the patient’s bill. But Levinson said information from previous visits is often not “medically necessary” to treat a current problem — and thus not a legitimate factor in charges.

Levinson said “cloned documentation” in a patient’s file often “doesn’t make sense clinically,” but it steps up billing and rewards the doctors with a “slam dunk” higher billing level, even though it takes 30 seconds to copy and paste.

“This is done in the wrong way and doesn’t satisfy the patient’s needs,” he said.

These “cut and paste” features produce voluminous files that are difficult for auditors to challenge, even when they suspect that the doctor did very little to warrant the higher fees.

That’s starting to change, however, greatly raising the stakes for doctors and hospitals that could face a demand for repayment from the government on behalf of patients.

Insurance auditors criticized “over documentation” as a billing ploy as far back as 2006. That year Medicare contractor First Coast Service Options chided Connecticut doctors who “frequently over-documented” to justify higher billing codes.

The Department of Health and Human Services Office of Inspector General late last year [announced](#) ^[9] it would ratchet up audits of “potentially improper payments” linked to electronic medical records. The office also advised doctors they could be held accountable if the codes they used didn’t “accurately reflect the services they provide.”

Electronic health records figured prominently in a critical Medicare audit of Texas and Oklahoma hospital emergency rooms in March. The audit concluded that \$45.14 of every \$100 billed for emergency room care “was paid in error.”

Auditors said that billing codes were “higher than was reasonable and necessary to adequately care for the patient’s needs or treat the presenting problem.”

One unidentified hospital billed Medicare for the highest level code, 99285, for treating a woman who arrived at the emergency room complaining of mild to

moderate abdominal pain. The code is generally reserved for conditions of “high severity” that “pose an immediate significant threat to life and limb,” auditors wrote.

After a battery of tests, including a CT scan, and intravenous antibiotics and morphine, the doctor diagnosed a urinary tract infection, sent the woman home and told her to follow up with her regular doctor.

Auditors said the woman’s case should have been coded two rungs lower based on the degree of medical decision-making required.

They also criticized the electronic record system for generating “testis and penile assessment findings” for a female, noting “coding at a higher level based on clinically unnecessary (or anatomically incorrect) systems examined is not acceptable.”

Hospitals have faced scrutiny over their use of electronic billing in emergency rooms from other quarters as well.

Dr. Alan Gravett, an Illinois emergency physician, argues in a federal “whistleblower” lawsuit that hospitals have jacked up emergency room bills with the help of aggressive billing software.

The doctor filed suit under seal in the U.S. District Court for Northern Illinois in January 2007. He alleges Methodist Medical Center in Peoria, Ill., where he worked for six years, installed a McKesson Corporation digital records system in March 2006 “specifically to increase its billings and recovery from government funded health insurance programs.”

Gravett alleges that the billing system had a “tendency to inflate nearly every” emergency room code. This happened “despite the physicians’ belief that lower ... codes were warranted based on the degree of care they provided,” according to the suit.

The lawsuit alleged that patients who were treated in the emergency room for many seemingly simple conditions were “as a matter of course” coded at high levels. The diagnoses included toe injury, sprained ankle and toothache.

The software, according to Gravett, prompted charges for conditions such as “alcoholic intoxication” or “psychiatric cases” to a code four or five, “even when such patients are treated and released, or released with no treatment.”

The screen also prompts doctors to add documentation to reach a higher coding level, according to Gravett’s court filings.

To pressure doctors to go along, the hospital distributed a monthly report called a “lost charge analysis,” which ranked doctors by how much revenue they produced, according to the suit.

“This was done to pressure the physicians to out-bill one another, and weed out physicians that were not generating as much income as those willing to upcode,” according to the court filing.

Methodist hospital spokesman Duane Funk said the hospital has yet to be served with the suit and would have no comment. McKesson did not respond to requests for comment.

A second “whistleblower” lawsuit filed in the state of Washington in 2006 alleged that Health Management Associates, a Florida-based hospital chain, used software called Pro-Med Clinical Systems that prompted questionable billing.

The suit was brought by two emergency room physicians at one of the company’s hospitals, Yakima Regional Medical and Heart Center. The doctors alleged that using Pro-Med led to “misleading medical charts,” including “examinations which had not occurred and physical observations which had not been noted by the physician.”

The software “automatically ordered a series of expensive and unnecessary tests,” according to the suit, which was dismissed in February 2009.

Pro-Med, based in Coral Springs, Fla., was not named as a defendant. Pro-Med CEO Thomas Grossjung said the hospital, not the software company, set the treatment protocols.

Maryann Hodge, vice president of marketing for Health Management Associates, said the hospital chain was never served with a copy of the suit, though it had cooperated with federal officials investigating the matter.

The hospital chain’s use of Pro-Med has come under review in a more recent federal investigation of emergency room billing, records show.

Health Management Associates, which owns or leases more than 60 hospitals in 15 states, disclosed in a May Securities and Exchange Commission [filing](#) ^[10] that the HHS inspector general’s office was investigating its business operations, including whether “Pro-Med software has led to any medically unnecessary tests or admissions.” Hodge said the company could not comment further on the investigation.

A second hospital chain that has used Pro-Med also has been served with a subpoena from federal investigators.

Community Health Systems, Inc., which owns and operates some 130 hospitals in more than two-dozen states, [told investors](#) ^[11] in April 2011 that HHS was investigating “possible improper claims.” The subpoena requested documents concerning use of the Pro-Med software in emergency rooms, according to the SEC filing. Tomi Galin, Community Health Systems’ vice-president for corporate communications, said at the chain’s hospitals the software does not order tests or “make any recommendation to physicians about whether to admit patients, place patients in observation or discharge patients.”

Both hospital chains said in SEC filings that they are cooperating with investigators. Pro-Med CEO Grossjung said his firm also had met with federal investigators, but the probe had “nothing to do with the software itself.”

Doctors’ groups also are reporting higher fees associated with electronic records, though they argue that the systems merely allow them to catch up with billing practices that for years did not pay them enough.

[Robert Tennant](#) ^[12], a Washington lobbyist with the Medical Group Management Association, which represents large medical practices, said the software simply helps doctors pick the correct code. “With a paper based system there’s a little bit of concern from providers that they don’t have sufficient documentation to support a particular” coding level, he said. Electronic systems, however, can quickly retrieve a patient’s documented history.

“I don’t use the term ‘upcode.’ I use ‘correct code.’ I see it more as physicians being reimbursed more appropriately for the work that they’re doing,” he said.

After the Gold Rush

Judging from their marketing strategies, there’s little doubt among the makers of electronic health records that their products will pay for themselves — and then some — through higher coding of patient bills.

Sales literature touts features such as “charge capture,” highlighting the computer’s skill at never missing a billable item that a human might overlook.

Many companies stress that the software can pay for itself through more lucrative codes, a benefit called “ROI,” short for return on investment. That pitch suggests a doctor who collects stimulus payments over time will cover the purchase costs and eventually turn a nice profit as a result of higher fees from higher coding.

For instance, one manufacturer predicts a rise of one coding level for each patient visit, which it said could add up to \$225,000 over the course of a year. Another cites a medical journal report that a medical practice in Utah “produced an average billable gain of \$26 per patient visit.”

Ross Koppel ^[13], a sociology professor at the University of Pennsylvania who has studied design weaknesses in the software, said that sales agents stress how the machines help doctors document the work they do.

“That presumably is fair and good, but everybody knows there is a ‘wink, wink’ behind that indicating it will help ... make the patient’s visit look more involved than it is.” That “generates additional revenue” for doctors, Koppel said.

The industry’s trade association, the Healthcare Information and Management Systems Society, has published a guide for doctors to use in estimating how much new revenue they can expect by going electronic. It cites as one key benefit, “increased coding due to elimination of lost charges and using appropriate coding levels based on services delivered.”

But some others note that doctors may initially lose money from wiring up their practices, mainly due to the time it takes them and their staffs to learn how to use the equipment and its high upfront cost.

‘Unintended Consequences’

The emphasis on improving the bottom line, rather than the quality of medical care, has disappointed some longtime health policy hands.

The Obama administration’s foray into digital medicine “has backfired at this point,” said Dr. Robert Berenson ^[14], a former vice chairman of MedPac, a commission that advises Congress on Medicare payment issues.

Berenson said that the current crop of electronic medical records encourage too much medical documentation “for the purposes of billing” and not better patient care.

The software helps doctors submit bills for “a higher level code than was performed,” said Berenson, who served as a member of the 2008 Obama transition team on health policy. “It’s a lot of money and the money goes right to the bottom line,” he said.

The criticisms are not just about money. The American College of Physicians, which represents more than 100,000 internists, considered the threat to patient safety serious enough that in May it announced a class for doctors in “potential problems associated with the use” of electronic medical records and “strategies to overcome these problems.”

Some doctors grumble about slogging through pages of redundant information that appears to be in a patient’s file simply to satisfy requirements for stepped up billing codes.

Just like in the days of poor physician handwriting, the voluminous computer generated files can prove tough for doctors to quickly decipher and decide how to treat a patient’s illness.

“We’re getting a whole generation of records that are not illegible, they are largely un-interpretable. It’s a horrific problem,” said Dr. Bob Elson, a former health information technology specialist, now a physician at the Cleveland Clinic.

These criticisms aside, many in the medical community regard the switchover not only as inevitable, but also as an opportunity to revolutionize medicine. For starters, researchers hope to be able to mine data from millions of patients to discover better ways to treat disease and improve the nation’s overall health.

The initiative continues to pick up speed behind a broad coalition of political players, from an elite corps of technology experts to organized labor groups that support moving medicine into the 21st century with dispatch.

Tennant, whose group represents medical practices, noted that Congress and the Obama administration have sent a “clear message” that they want physicians to adopt electronic health records.

He said “a slight uptick” in codes would be more than offset by savings on duplicative tests and other waste associated with paper records systems, and by higher quality care.

So far, the government has shelled out about \$5 billion in incentive payments to doctors and hospitals that have adopted the technology, according to the Government Accounting Office.

How much Medicare has paid out in higher codes related to digital billing is trickier to assess. In 2011, 57% of Medicare doctors were using an electronic health record, most for three years or less, according to an HHS survey. Officials expect those numbers to climb as doctors scramble to avoid Medicare payment cuts to those who fail to adopt the technology starting in 2015.

But Elson, the Cleveland clinic doctor, said that government officials may have oversold the benefits to Congress by failing to account for health care costs to rise from higher coding, at least in the short term.

“That’s a huge oversight if that whole issue wasn’t factored into the strategy,” Elson said.

Billing software helps medical professionals document higher fees



[2]

Kicker:

Electronic inflation

Billing software helps medical professionals document higher fees.

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[1] <http://www.publicintegrity.org/health/medicare/cracking-codes>

[2] <http://www.publicintegrity.org/2012/09/19/10812/growth-electronic-medical-records-eases-path-inflated-bills>

[3] http://healthit.ahrq.gov/portal/server.pt/gateway/PTARGS_0_898611_0_0_18/09-0095.pdf

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[6] http://www.rti.org/pubs/enhancing_data_quality_in_ehrs.pdf

[7] http://www.youtube.com/watch?v=9B_85ZoufN4&feature=related

[8] http://otrans.3cdn.net/595bb81f6a97958fc0_8zm6i2uwt.pdf

[9] <http://oig.hhs.gov/reports-and-publications/archives/workplan/2012/Work-Plan-2012.pdf>

[10] <http://services.corporate-ir.net/SEC/Document.Service?id=P3VybD1odHRwOi8vaXluaW50Lndlc3RsYXdidXNpbmVzcy5jb20vZG9jdW1lbnQvdjEvMDAwMTE5MzEyNS0xMi0yMDY2NzZG9jL0hYVWx0aE1hbmFnZW1lbnRBc3NvY2lhdGVzSW5jLnBkZiZC>

[11] <http://services.corporate-ir.net/SEC/Document.Service?id=P3VybD1odHRwOi8vaXluaW50Lndlc3RsYXdidXNpbmVzcy5jb20vZG9jdW1lbnQvdjEvMDAwMDk1MDEyMy0xMS0wNDIxNzlvZG9jL0Nvbw11bm10eUhlYWx0aFN5c3RlbXNjbMucGRmJnR5cG>

[12] <http://www.mgma.com/govaffstaff/#tennant>

[13] http://sociology.sas.upenn.edu/r_koppel

[14] <http://www.urban.org/about/RobertBerenson.cfm>

