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Centers for Medicare & Medicaid Services (CMS) Focuses on Fraud Associated with Increased Use of Electronic Health Records

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Acting CMS Administrator, Marilyn Tavenner, recently reaffirmed the agency's concern that the increased use of electronic health records ("EHRs") has contributed to increases in fraudulent billing practices by providers. At a March 5th meeting of the Federation of American Hospitals ("FAH"), Tavenner noted an increase in upcoding from physician offices and hospital emergency departments, and expressed concern that the increased use of EHR systems may be the cause. She reiterated that CMS will conduct audits of providers' billing practices using EHR systems. These "small, targeted audits" will take place in parallel with the meaningful use audit program that started in July 2012 and which is designed to determine whether providers are properly receiving meaningful use incentive payments and complying with program rules. On March 6th, Tavenner also spoke before the Healthcare Information and Management Systems Society Annual Conference and announced a CMS summit in May with providers and EHR vendors to further discuss and address potential upcoding in connection with the use of EHRs.

These upcoding concerns were first prominently expressed in a September 24, 2012 joint letter by Department of Health and Human Services secretary Kathleen Sebelius and Attorney General Eric Holder to five national trade associations, including the American Hospital Association ("AHA"), FAH, and the Association of American Colleges ("AAMC"). The letter recognized that Congress intended the meaningful use incentive payment program to be a mechanism to encourage the adoption of EHR technology, but alleged that "some providers are using this technology to game the system possibly to obtain payments to which they are not entitled." Sebelius and Holder specifically identified the common EHR practice of copying previous clinical entries ("cloning" in the eyes of the government) onto a current record as a method that has the potential "to inflate" amounts claimed. AHA and AAMC responded to these allegations. Among other things, they requested greater coding guidance from the government, and noted that there are clinical reasons for utilizing the "copy functionality," despite the known compliance challenges.

The meaningful use program was originally conceived as a centerpiece of health care reform because the program encourages EHR adoption, holds the promise to lower costs, and requires providers to change clinical practices as a condition of receiving the incentive payments. Recent data and a May 2012 OIG Report, however, show significant increases in Medicare payments due to changes in evaluation and management coding practices, which suggest that EHR adoption may

unintentionally increase costs, likely driven not by fraud but by more accurate coding practices. Nevertheless, the September 2012 HHS/DOJ letter, together with the dual CMS audits on meaningful use compliance and upcoding practices, are reminders of the potential fraud and abuse risks associated with knowingly submitting inaccurate meaningful use attestations and claims for services that are not properly documented.

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