

## SIGN OF THE TIMES: PART I

## Do Electronic Medical Records Result in Higher Physician Billing?

Neeraj H. Tayal MD, FACP, Christine Sinsky, MD, FACP

*Dr. Tayal is a member of the Forum editorial board, and Dr. Sinsky is a physician at Medical Associates Clinic (MAC) of Dubuque, Iowa. Dr. Tayal can be reached at Neeraj.Tayal@osumc.edu.*

The implementation of electronic medical records (EMRs) certainly holds great promise for improving quality and efficiency of health care delivery. It may even allow us to bend the cost curve. To date, though, this last assumption has not been demonstrated, and many in fact worry it may increase health care costs. One way in which EMRs may be increasing health care expenditures is by increasing professional billing costs. A recent *New York Times* (NYT) article shined a light on this possibility and raises questions about physician overbilling and fraud.<sup>1</sup>

The publication from September 2012 detailed the changing professional billing patterns documented over the past 10 years by the Office of Inspector General (OIG) and the Department of Health and Human Services (DHHS). The report analyzed Evaluation and Management (E/M) coding patterns for 442,000 providers from 2001 and 2010. The report describes a steady increase in billing higher, more expensive codes and a corresponding drop in the lower, less expensive codes. As an example they report that for the visit type Office Visit Subsequent, the selection of the two highest codes collectively increased by 17% (15% for level four 99214 and 2% for level five 99215; see Figure 1). These services were reimbursed at approximately \$97 and \$132, respectively, in 2010. The same pattern was described for the visit type Inpatient Subsequent. For this visit type, there has been a 16% drop in the lowest level 99231 code with a corresponding increase in the higher level 99232 and 99233 codes of 6% and 9%, respectively. The most dramatic increase has been with emergency room visits with all four of the lowest billing levels (99281, 99282, 99283, 99284) dropping with a corresponding increase of 21% in the high-

est code (99285). The report goes on to say that approximately 1,700 physicians were identified to bill the two highest codes 95% of the time. The OIG singled these individuals out from the rest as “high billers” and recommended further action targeting these individuals.<sup>2</sup>

The OIG report focused on changing billing patterns, but the NYT investigators have rightfully asked the next logical question: Why have physicians steadily increased the selection of more expensive, higher level services? Many critics point to EMRs as a potential contributor. Certainly there is anecdotal evidence that EMRs may contribute to higher billing selection. The NYT article lists a number of hospitals that tallied 40% to 50% increases in billing the highest-level professional codes after EMR implementation. They even quote an EMR vendor bragging that their systems will facilitate higher billing levels. This vendor is quoted as saying it “plays the level-of-service game on your behalf and beats them at their own game using their own rules.”<sup>1</sup> One might also consider the many documentation tools in an EMR intended to improve efficiency. Systems allow users to copy forward previous notes and use functions such as “make me the author.” We now have a lexicon of terms to describe these tools, such as record cloning, default notes, single-click templates, and E/M optimizers.<sup>3</sup> These tools allow physicians to create lengthy progress notes with elaborate reviews of systems and physical exams. They also allow users to pull in large amounts of discrete data into notes. The resulting notes, sometimes five pages long, might lead one to conclude that more work has been done and thus justifies a higher billing level. Some are concerned that these tools create a situa-

tion in which a physician might cross the line into improper and possibly even fraudulent documentation. The OIG certainly thinks EMRs may be a culprit. In their work plan for 2012, they state: “We will assess the extent to which CMS made potentially inappropriate payments.... We will also review multiple E/M services for the same providers and beneficiaries to identify EMR documentation practices associated with potentially improper payments.... We will identify fraud and abuse vulnerabilities in electronic health record (EHR) systems.”<sup>4</sup>

On the other side of the argument, physicians—especially in primary care—may have historically underbilled and are now simply coding more accurately. The old adage has been: If you don’t know the answer, pick “C.” Perhaps for physicians, the adage has been: If you don’t know the answer pick “3” as in “99213.” They are both in the middle and are “safe.” Certainly, the complexity of the documentation guidelines has befuddled many of us and perhaps resulted in this middle-of-the-road behavior. It remains difficult to believe that a majority of patients seen by internal medicine physicians should ever have been billed as “low complexity.” Perhaps the 54% of established office visits billed at a level 3 in 2001 should not be the baseline for comparison. The higher billing trend documented by CMS has been gradual and might better be explained by a decade-long effort to teach coding and documentation guidelines to physicians. These efforts may have gradually given physicians the confidence to bill more appropriately for the correct level of service. These new electronic documentation tools of the EMR may simply be facilitating the application of this improved understanding.

continued on page 2

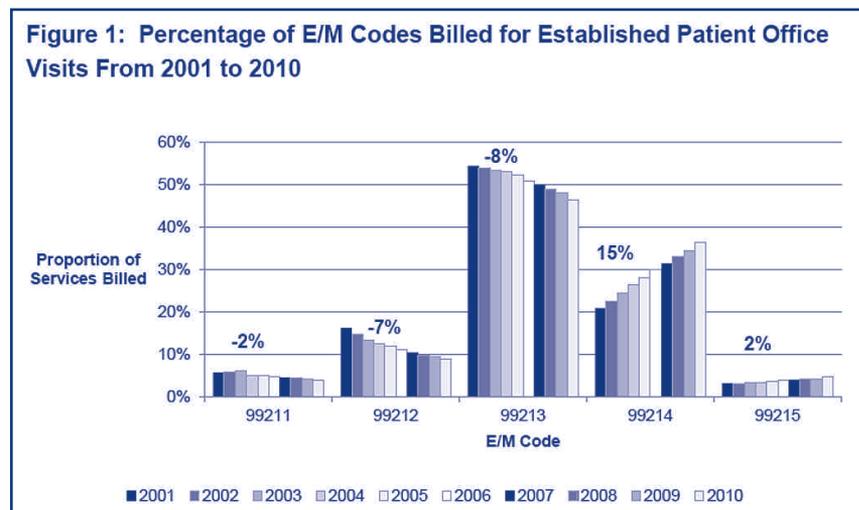
## SIGN OF THE TIMES: PART I

continued from page 2

Another possibility might be that EMRs allows physicians to accomplish more during each office visit. In well-designed EMRs, physicians might be able to process more information and as a result make more medical decisions. One could also argue that the complexity of patient management has likely increased. There would certainly be evidence to support this position. The last decade has brought additional diagnostic tests and medication combinations for diseases that were previously not treatable. Our aging population and obesity epidemic are increasing the number of patients with multiple chronic conditions. The number of practice guidelines has certainly ballooned over the past decade. Another factor that might warrant consideration is that with a higher shift of medical expenses to patients, patients are apt to handle more complaints in a single visit as apposed to paying multiple co-pays over several visits.

All of these are possible counter arguments to the claim that physicians are simply bilking the system by selecting higher billing levels for the same amount of work. As of 2012, we simply do not know the contribution of each of these factors to changes in billing patterns over the past decade. There are no studies analyzing the factors described above, but this area would likely be of high interest to payers. Certainly, there are blatant fraudsters who should be identified and rooted out as always. The bigger concern though remains the "others" who must answer to an increasingly suspicious population of regulators, policy makers, auditors, and even patients.

Physicians are wise to pay attention to the OIGs efforts to address improper documentation of E/M services. Previous OIG efforts have resulted in significant financial impacts



Source: Coding Trends of Medicare Evaluation and Management Services, Department of Health and Human Services, Office of Inspector General May, 2012 OEI-04-10-00180.

to physicians. In 2006, the OIG reported that 75% of consultations did not meet Medicare coverage requirements and that 95% of consultations billed at the highest level were mis-coded. As a result of this analysis, Medicare discontinued payments for consultations in 2010. With attention now being focused on new and established office codes, let's hope the outcome is not more audits and denials of payment. Rather, let's hope for a completely revamped system of documenting physician work. The current system is an expensive distraction from patient care. This is a waste that cannot be afforded in an economy where the demand for physicians is outstripped by supply. Our current documentation and billing system was formulated 17 years ago. A large majority of physicians will be working on EMRs within the next couple of years. We need a documentation and billing system that leverages the EMR to maximize time for clinical work rather than for generating invoices.

It's time for an "upgrade" in technology and in policy!

### References

1. Simborg D. There is no neutral position on fraud! J Am Med Inform Assoc 2011;18:675e677. doi:10.1136/amiajnl-2011-000206
2. Abelson R, Creswell J, Palmer G. Medicare bills rise as records turn electronic. New York Times, September 9, 2012. <http://www.nytimes.com/2012/09/22/business/medicare-billing-rises-at-hospitals-with-electronic-records.html>
3. US Department of Health and Human Services Office of Inspector General. Work plan fiscal year 2012. <https://oig.hhs.gov/reports-and-publications/archives/workplan/2012/Work-Plan-2012.pdf>
4. US Department of Health and Human Services Office of Inspector General. Coding trends of Medicare evaluation and management services. Daniel R Levinson Inspector General, May 2012 OEI-04-10-00180. <https://oig.hhs.gov/oei/reports/oei-04-10-00180.pdf>

SGIM