Electronic Health Records Provider

The cost of health care in the United States continues to rise, but the overall health of the nation is not necessarily improving or keeping pace with other countries.[1] In 2009, the United States government began taking new steps to transform our nation's health care delivery system with the use of electronic health record (EHR) technology. An EHR is a digital version of a patient's paper chart and broader health history designed to be used both internally and externally by multiple entities.[2, 3]

The 111th Congress passed the American Recovery and Reinvestment Act, and on February 17, 2009, President Obama signed it into law.[4] One of the purposes of this Act is to furnish "funding to strengthen the health information technology infrastructure" through the Health Information Technology for Economic and Clinical Health (HITECH) provision.[5]

At the June 15, 2009, American Medical Association Conference in Chicago,[6] President Obama encouraged health care providers to move from paper health records to EHRs. More recently, The Office of the National Coordinator (ONC) for Health Information Technology (IT) released a 10-year vision paper for the state of health IT by 2024. The goal is to achieve interoperability among the various health IT platforms, which in turn would help reduce costs, allow patients more control over their information and decision making, and generally improve patient health.[7] Why is it so important for providers to implement EHRs?

The Benefits of Electronic Health Records

Documentation is often the communication tool used by and between providers. Documenting a patient's record with all relevant and important facts, and having that information readily available, allows providers to furnish correct and appropriate services that can improve quality, safety, and efficiency. EHRs can help improve communication between providers through real-time access to valuable information. Surveyed medical providers reported the following benefits of using EHRs:

- Real-time access to complete patient records at the point of care (real-time access can improve care delivery and improve care transitions from one service or provider to another, which can lead to improved population health over time[8]);
- Clinical alerts and reminders that reduce and prevent medical errors;
- Decision support, diagnostic aids, and elimination of duplicate tests;
- Reliable e-prescribing with fewer medication errors;
- Interface between e-prescribing systems and State Prescription Drug Monitoring Programs;
- Reduction in paperwork;
- Greater coordination of care;
- Legible records;
- Interface with labs;
- Patient portals that allow electronic interaction between the provider and patient;
- Electronic referrals; and
- Improved coding and billing.[9]

A recent RAND Report, commissioned by the American Medical Association, found physicians agree with the theory and use of EHRs, particularly when they perceive increased quality of care for their patients and anticipated improvements in EHR interfaces and information exchange functions.[10]

Words of Caution

EHRs allow medical professionals a seamless approach for coordinating and managing their patient records. They can help reduce paperwork, eliminate duplicate tests, and facilitate code assignment for billing. However, it should be noted that recent reports indicate physicians are concerned about system interoperability, documentation overload, and untested billing systems.[11]

While EHRs can improve health care delivery and provider services, they can pose provider challenges. Challenges include, but are not limited to, privacy and security, author identification, altering entry dates, cloning, upcoding, and coding modifiers. Further details on each challenge are explained in the following points:

1. **Security and Privacy**—EHRs can offer multiple improvements over paper documentation. They can also pose security and privacy issues, such as allowing a malicious user to obtain patient information. Providers should be aware of security features offered and utilize them when using EHRs. Security features include secure networks, firewalls, encryption of data, and password protection that ensures only appropriate or authorized entities can access certain information. Sites where EHRs are maintained should be locked with facility access restricted. EHRs should be backed up to control the risk of data loss from natural disasters or system failure. In addition, edits, audits, and system logs should be enabled to track all persons accessing and editing EHR information.[12] When using EHRs with mobile equipment, such as laptops and thumb drives, be sure to encrypt the information to prevent disclosure of personal health information.[13]
2. **Author Identification**—Different providers may add information to the same progress note. When this occurs, each provider should be allowed to sign his or her entry, allowing verification of the amount of work performed and which provider performed the work.[14]
3. **Altering Entry Dates**—Be sure the EHR system has the capability to identify changes to an original entry, such as "addendums, corrections, deletions, and patient amendments." When making changes, the date, the time, the author making the change, and the reason for the change should be included. Some systems automatically assign the date an entry was made. Others allow authorized users to change the entry date to the date of the visit or service. Some systems allow providers to make undated amendments without noting that an original entry was changed.[15] If there is no date and time on the original entry or subsequent amendments, providers cannot determine the order of events, which can impact the quality of patient care provided.
4. **Cloning**—This practice involves copying and pasting previously recorded information from a prior note into a new note, and it is a problem in health care institutions that is not broadly addressed.[16, 17] For example, features like auto-fill and auto-prompts can facilitate and improve provider documentation, but they can also be misused. The medical record must contain documentation showing the differences and the needs of the patient for each visit or encounter. Simply changing the date on the EHR without reflecting what occurred during the actual visit is not acceptable. Using electronic signatures or a personal identification number may help deter some of the possible fraud, waste, and abuse that can occur with increased use of EHRs.[18] In its 2013 work plan, the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) indicated that due to the growing problem of cloning, its staff would be paying close attention to EHR cloning.[19, 20]
5. **Upcoding**—Upcoding, sometimes known as "code creep," occurs when a provider bills for a higher Current Procedural Terminology (CPT) code than the service actually furnished, resulting in higher payment.[21] Again, auto-fill and auto-prompts can facilitate and improve documentation, coding, and billing, but if used inappropriately, these tools may suggest a higher billing code and payment than the actual services furnished warrant, resulting in an improper payment.[22] Claims paid without the appropriate supporting documentation are improper payments, and providers must return them.[23]

6. **Code Modifier**—A modifier is an extension of an assigned code, such as a CPT code. Two reasons for using procedure codes include communicating the professional medical services performed and billing for the services provided. Modifiers are used in conjunction with codes to complete the picture of the procedures and services provided.[24] More complex services may require additional modifiers. When using modifiers, medical professionals should only use them to clarify the procedures and services performed and never for the purpose of increasing reimbursement.[25]
7. **Transition from Paper to EHR**—EHR users may continue to use paper records. Paper records are more permanent, and it is easy to discern if they have been altered in any way. Edits to an EHR may not always be obvious, so providers should establish safeguards to protect against fraud, abuse, and human error. Some of the safeguards for paper records can be applied to EHRs, like documenting who enters or edits data in an EHR, and, when creating backups (and, if paper records are retained), cross-checking the EHR with the paper record. Additionally, an EHR may lack the visual cues (for example, the colored letter tabs) that help a provider or staff member know they are working in the correct record. These potential issues require specific training in EHR data entry and management.[26]

Electronic Health Records Delivery System Reform

Using EHRs has the potential to transform our nation's health care delivery system by: providing real-time, authorized, secure access to patient-centered records; protecting patient privacy; improving coordination of care; reducing costs; and going beyond standard clinical data to provide a broader view of a patient's care.[27] This broader view allows providers to document personal, social, and environmental factors affecting the individual's health. For more resources on EHRs, visit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/electronic-health-records.html on the CMS website, or https://healthit.ahrq.gov/health-it-tools-and-resources on the Agency for Healthcare Research and Quality website.

Conclusion

This fact sheet focused on potential program integrity issues while helping providers recognize the value of moving from paper medical record documentation to EHR documentation. The Centers for Medicare & Medicaid Services (CMS) provides health care for millions of Americans and is the "single largest payer for health care in the United States."[28]

Federal and State laws require providers to maintain the records necessary to "fully disclose the extent of services," care, and supplies furnished to beneficiaries,[29, 30] as well as to support claims billed. EHRs facilitate medical record keeping and can improve the quality, safety, and efficiency of health care services. The U.S. government passed laws that assist eligible providers, through financial incentives, to switch from paper health records to EHRs. Visit https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html to learn more about the Medicaid and Medicare EHR Incentive Programs.

To see the electronic version of this fact sheet and the other products included in the "Documentation Matters" Toolkit, visit the Medicaid Program Integrity Education page at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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December 2015