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When billing gets too easy

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Every office manager knows the mantra: "Do not bill for care that is not documented." Submitting a bill for services not proved by the patient chart may lead to allegations of improper billing, which could result in a civil monetary penalty of up to $1,100 plus three times the amount charged. If an office is found to be *knowingly* fabricating charges, the penalties could escalate to criminal liability, as intentional fraud is a felony.

The problem for many offices has been sufficiently documenting care rendered in the time-consuming, traditional paper chart. In this arena, transition to a digital record is a benefit. Many, if not most, medical offices discover there are services they have always provided that were not captured for payment in their old system. This is particularly true in primary care.

Once adjusted to a new method for charting, many physicians find it easier (and quicker) to chart electronically, especially as all electronic health records (EHRs) use templates extensively. The ease of charting is not limited to the templates, which were never intended to create an *entire* record. Patient-specific observations, concerns and the provider's professional judgments and decision-making all should be added as a narrative into the electronic chart. But even here, technology assists as these narrative comments can be (and often are) copied and pasted in visit after visit after visit.

In this new digital world, with a series of mouse clicks a provider can document an entire office visit in the patient's record, and -- *voila!* -- those clicks turn into a bill for services, frequently higher than the norm for the old paper-based method.

To the extent offices are documenting and billing for previously "lost" services this is all well and good; the peril lies in the potential for going beyond.

After years of toeing the line on not billing for undocumented care, some offices are turning the old precaution on its head: "If it is documented, it is okay to bill!" Many EHRs will actually suggest additions and enhancements to the person entering patient care into the record with the incentive to increase billing. There is an odd phenomenon when conscientious, honest people see a suggestion on a computer screen to "enhance" a record and somehow feel excused because the screen is telling them it is okay.

The result is a record that increases the charge, but is it accurate?

Offices walking toward inaccurate digital documentation are not peopled by dishonest criminals; they are practices excited by new technology that actually helps to improve income. In fact, this benefit is frequently used as a marketing tool by EHR vendors.

What happens when one of these records is subject to a billing investigation? Will the

inquiry stop just because the bill matches the record? Certainly not. What will raise suspicions about an otherwise perfect record?

"Cutting and pasting" is one dead giveaway, and increasingly warnings are being raised about this practice. If every patient visit is identical, an obvious question will be "are any of these visits real?" Consistent billing at a high level will also raise concerns; regardless of the field of practice, billed charges should create a bell curve reflecting charges low to high (with a preponderance in the middle), not a flat line. Ultimately, the greatest clue to improper billing will be the face-to-face time reflected by the record. If a series of clicks, cuts and pastes creates a record reflecting care that would require 30 minutes of face-to-face time, and every patient record is the same for any given day, what is an investigator likely to believe when the sum of all those charts suggest the physician was in the office for more than 24 hours that day?

Most alarming, the next logical questions will be: "Did this office *know* the physician did not practice that many hours consecutively? Was this a *deliberate* misrepresentation? Does this constitute *intentional* [i.e., criminal] culpability?"

The transition to an EHR is an arduous process. It is understandable why the one great asset may be abused, especially when that feature was encouraged at the time of adoption. However, all office managers will serve their practices well by adopting a new mantra: "Only click what was actually done and enter new narratives for every visit." Appropriate billing will follow.

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