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Compliance Today - August 2022
Physician coding and billing risks

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Medical school curriculum is heavy in anatomy, physiology, biochemistry, pathology, and clinical rotations or clerkships. There is very little, if any, instruction on proper coding and billing for professional services. The years a physician spends during residency might result in a little training in coding and billing, but typically it is not extensive. After residency, a physician is thrown into the real world of compliance risks associated with coding, billing, and documentation. Some physicians report the rules don't make sense. Other clinicians report being too busy with patient care to have time to learn billing and coding rules. However, ignoring some common coding and billing risk areas can result in questionable compliance practices, potential audits, and, in some cases, enforcement.

What are some of the most common coding, billing, and documentation compliance risks that physicians face today? There are many, but let's take a closer look at two common areas: upcoding and misuse of modifiers.

Upcoding

One of the most common coding and billing compliance risks that physicians face is the practice of upcoding. For decades, upcoding has resulted in False Claims Act allegations by the government and whistleblowers, resulting in significant financial settlements, corporate integrity agreements, and internal or external audits.

What is upcoding?

Upcoding is a practice of submitting a claim with a higher or more extensive medical code when the documentation and/or circumstances do not warrant it. The higher, or more complex, codes typically get reimbursed at a higher rate than the lower codes. Some of the coding systems involved include the American Medical Association's Current Procedural Terminology (CPT) system, Healthcare Common Procedure Coding System (HCPCS), and International Classification of Diseases (ICD) coding.

For example, evaluation and management (E/M) codes represent the typical nonprocedural work that a physician performs when they see a patient. It usually includes taking a patient's medical history, performing a physical examination, and providing medical decision-making that might include ordering tests or offering treatment such as prescribing a medication. There are different categories of E/M codes, and within a category, there might be multiple levels, such as three, four, or five different levels of codes. For example, you might hear an auditor tell a physician, "the E/M documentation only supports a level three, not a level five."

Upcoding is often cited in announcements of settlements and enforcement actions. For example, in April 2022, two Nebraska surgeons paid more than $43,000 as part of a settlement agreement with the U.S. Department of

Health & Human Services' Office of Inspector General (OIG) to resolve allegations the surgeons submitted claims to Medicare for E/M services that were coded at higher levels of intensity than were medically reasonable and necessary.[1]

In 2021, it was announced that a group of ear, nose, and throat physicians in El Paso, Texas, settled E/M upcoding allegations by paying $750,000.[2]

E/M guidelines

There are written guidelines for proper E/M coding and documentation that have been around for decades. You may hear reference to the 1995 guidelines[3] or the 1997 guidelines.[4] These are written guidelines for evaluating E/M documentation and the various levels of codes. More recently, the E/M guidelines changed in 2021 for select categories of E/M codes, primarily the office visit codes.[5] Future guideline changes are expected for other categories of E/M codes. With this in mind, it is essential to know which guidelines apply when performing any monitoring or auditing. Knowing the category of codes and the applicable dates of service will be important when deciding which guidelines to use.

The 1995 and 1997 guidelines reference certain documentation requirements for medical history components such as a review of systems or organ/body systems examined as part of the physical examination of the patient. With these guidelines, physicians may ask, "How many organ systems do I need to document for a level five?" In some cases, it has been alleged physicians simply documented more organ systems or history components to boost their E/M level when it was not medically necessary or appropriate to do so, submitting claims with the upcoded levels anyway.

Medical necessity

Chapter 12 of the *Medicare Claims Processing Manual* states, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported."[6]

The volume of documentation should not be the primary reason for choosing a code. In a case in New England, a company of urgent care centers paid $2 million to settle allegations related, in part, to improper upcoding.[7] According to the information shared by the U.S. Department of Justice, it was alleged the urgent care centers submitted inappropriate claims "by falsely inflating the level of E/M services performed…including mandating that medical personnel examine and document at least 13 body systems during medical history inquiries, and at least nine body systems during physical examinations, even if patients' specific medical complaints or symptoms did not justify such a comprehensive inquiry or examination."

Some may think that electronic medical records and technology systems could assist in more compliant documentation and coding practices, and in some cases, this might be true. But in the case with the urgent care centers, it was alleged the medical records software was used inappropriately. Specifically, the allegations included the use of "encounter plan templates, loaded onto electronic medical records software, containing 'yes or no' questions." Then, the company instructed their personnel to ask patients about specific body systems even if it was not medically necessary. And if personnel failed to ask the questions, "the template contained a default 'no' response to each inquiry" and "used the default 'no' responses to assert that the associated body systems had been examined and billed accordingly, even when no such examination had occurred."

The more recent 2021 guidelines remove many requirements for the history and physical examination portions of E/M code selection. Choosing the appropriate code depends more on the medical decision-making component of the documented service. There are also options for selecting a level based on documented time spent. Effectively educating physicians and coders on the 2021 guidelines as well as the anticipated future changes is essential for compliance with these rules.

Auditing and monitoring

Though these upcoding issues are as old as the day is long, they are still an active risk area as evidenced by the recent settlements shared earlier and by the OIG's current Work Plan. For example, the OIG plans to review E/M services provided in the emergency department by physicians. It's described the Work Plan item in the following way:

> Medicare reimburses physicians based on a patient's documented needs at the time of a visit. All evaluation and management (E/M) services reported to Medicare must be adequately documented so that medical necessity is clearly evident. This review will determine whether Medicare payments to providers for emergency department E/M services were appropriate, medically necessary, and paid in accordance with Medicare requirements.[8]

The fact the OIG mentions reimbursement is "based on a patient's documented needs at the time of a visit" in the context of emergency department E/M services leads one to believe there may be concern of upcoding in emergency departments. Just because a person is seen in the emergency department doesn't necessarily mean it is an emergency requiring intensive physician involvement with the E/M service. Many people visit an emergency room without an urgent or emergent condition, and it may not be appropriate to code the highest E/M levels under some circumstances even if there is voluminous documentation.

Catching these inappropriate medical necessity errors relating to upcoded E/M services probably goes beyond the standard medical coding audit, which is typically limited to a review for coding/documentation requirements only. Most certified coders do not have the medical training to determine whether it was medically necessary to perform the documented history, exam, and/or medical decision-making given the patient's condition. Engaging someone with both coding and medical expertise to periodically review claims might be necessary. The need for some reviews to be performed by someone with medical training has even been suggested by the OIG. In its compliance guidance for physician practices, it states, "self-audits would ideally include the person in charge of billing (if the practice has such a person) and a medically trained person (e.g., registered nurse or preferably a physician)."[9]