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Urgent Care Centers Settle FCA Case; Overdocumentation Was Alleged

By Nina Youngstrom

An urgent care company has agreed to pay $2 million to settle false claims allegations in a case about corporate pressure on clinicians to do more extensive patient exams and histories than medically necessary. Armed with the additional documentation, Urgent Care Centers of New England Inc., CareWell Urgent Care Centers of MA P.C., and CareWell Urgent Care of Rhode Island P.C. allegedly upcoded evaluation and management (E/M) services, the U.S. Attorney's Office for the District of Boston said March 29.

CareWell was accused of submitting false claims to Medicare and the Medicaid programs of Massachusetts and Rhode Island from March 1, 2013, to Aug. 31, 2018. The complaint was filed by whistleblower Aileen Cartier, a former CareWell nurse practitioner, who alleged the urgent care centers misused the Medicare documentation guidelines.

"Anytime you make anyone uncomfortable asking them to code a higher level of service—such as a level three to a level four—you're [potentially] promoting a whistleblower," says Marion Salwin, director of physician and regulatory compliance at Trinity Health in Livonia, Michigan. "You don't want people to be uncomfortable clicking all the elements in electronic health records so it appears they did a complete review of systems when they didn't."

In a statement, CareWell Urgent Care said it fully cooperated with the investigation. "Our top priority at CareWell is to provide safe and high-quality medical care to our patients. We believe it is crucial to be thorough with each patient's examination in order to provide the best possible care. We remain committed to serving our communities by delivering accessible and affordable care to patients in the most appropriate healthcare setting, as well as working with our hospital partners [to] coordinate care within the community."

According to the complaint, when patients visit a CareWell facility, they go to an examination room, where a nurse or medical assistant takes their history, including a review of systems (e.g., cardiovascular, respiratory, gastrointestinal, musculoskeletal). Then a physician, nurse practitioner (NP) or physician assistant (PA) reviews the information, documents it in CareWell's Athena software, and examines and treats the patient.

On its face, there was nothing unusual about that. But DOJ alleged the nurses and medical assistants were required to do a "limited complete" review of systems for all patients, regardless of why they were at CareWell, and document that they asked at least one question about 13 body systems even when it wasn't medically necessary based on the patient's chief complaint. The same was required of physicians, PAs and NPs, according to the lawsuit.

Template Sometimes Defaulted to 'No'

"Contrary to Medicare regulations, the defendants mandate that the physicians, nurse practitioners and physician assistants examining the patients perform a limited complete physical examination on all patients, rather than relying on the patient's individual clinical needs. This means that the physicians and nurse

practitioners must examine every body system and document at least one element from each system during all patient visits, without relation to the nature of the patients' presenting problems, history, or conditions as observed during the visit," the 2018 complaint alleged. "By requiring that all patients have at least 13 body systems examined, the defendants supersede the examining physicians' or nurse practitioners' clinical judgment of what's medically necessary."

When clinicians didn't ask patients all the questions in encounter plan templates, they defaulted to a "no" response, DOJ alleged. CareWell used the default "no" responses to make it seem like the body systems had been examined even when that wasn't the case.

As a result, E/M services allegedly were upcoded from a level two to a level three or a level three to a level four, the complaint alleged. The patient visits usually were upcoded by practice managers, market leaders or third-party billers.

For example, a 17-year-old with Massachusetts Medicaid as the secondary payer came to CareWell's Worcester clinic with a chief complaint of earache and sore throat. The patient had 11 systems reviewed (constitutional, eyes, ears/nose/mouth/throat, cardiovascular, respiratory, gastrointestinal, musculoskeletal, genitourinary, integumentary, neurologic and endocrine) and 10 organ systems examined (including psychiatric and lungs). A rapid strep test was performed and the patient was prescribed antibiotics for an ear infection. The whistleblower coded the visit as a level three (CPT 99203), but three days later, a biller changed the code to a level four (CPT 99204), the complaint alleged. That was fraudulent upcoding, the whistleblower alleged, "because the patient presented with an uncomplicated complaint and no comorbidities. As such, a complete review of systems was not medically necessary and was only performed to meet the defendants' mandates." The patient also received a medically unnecessary physical exam "beyond what was clinically required for his condition," and the medical decision-making was low. Altogether, the visit didn't rise to the level of an E/M level four, the complaint alleged.

In 2016, the whistleblower was informed by a CareWell practice manager that she didn't document enough reviews of systems for four patients. In response, the whistleblower said she documented according to the patients' chief complaints/histories of present illness. That wasn't the right answer. In an email, one executive said the CareWell "default" review of systems is still 13, as required "per risk management" by CareWell's malpractice insurance, the complaint alleged. "Every urgent care visit, every patient, gets this done," the executive allegedly wrote to the whistleblower.

'It's a Hard Conversation to Have With the Doctor'

Physicians are welcome to perform "head-to-toe examinations" of patients, but payment is driven by medical necessity and coding, Salwin says. "It's one thing to document to a level five; it's another thing to choose a code regardless of the patient's complaint," she says. As CMS states in the *Medicare Claims Processing Manual* (Pub. 100-04), "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code." And going overboard with documentation creates "note bloat," which Salwin says "can make it impossible to figure out what's relevant and not relevant to the clinical management of the patient. That being said, choosing the right E/M code is challenging because, relevant or not, the documentation supports a level five."

For example, when physicians see patients for a complaint of an injured wrist, they would note redness, soreness, swelling and pain. But it's not uncommon for physicians to also document "all systems negative outside pertinent positives," meaning the patients were asked questions far afield of a swollen wrist, Salwin says. Physicians are driven by a template that prompts them to check boxes whether or not it's medically necessary, and that contributes to coding a higher level of service. "It's a hard conversation to have with the doctor: 'The patient came for wrist pain; why are you assessing their thyroid?'" Salwin often enlists another physician (peer

to peer) to explain that the evaluation of a patient must be reasonable and necessary to diagnose and treat the patient.

A complete review of systems and/or "head-to-toe exam" isn't necessary at every encounter, she says. If the physician continues to evaluate the patient beyond what's considered medically appropriate, the coding should correlate with the documentation associated with the patient complaint, not the templated boxes that are checked to meet a particular E/M level, Salwin explains. "All we can do is have the conversation." If the conversation isn't "fruitful," she says, "the physician will face a peer-to-peer audit, and billing will be put on hold until coding is improved and aligned with documentation and coding requirements."

Salwin talks to physicians all the time. She tells them if they can say all the other systems were negative, that's fine, but make sure they are truly negative. If they didn't evaluate a particular system, "don't say it was negative."

Some of the angst over documentation and E/M decision-making will evaporate when Medicare changes take effect in 2021. CMS in the 2019 Medicare Physician Fee Schedule regulation finalized a proposal to pay physicians the same blended rate for CPT levels two, three and four, although it was delayed for two years. When 2021 rolls around, physicians also will have more documentation options. They can stick with the 1995 and 1997 Medicare documentation guidelines or support their E/M services with medical decision-making only—no more exam and history—or with the time they spend with patients, and they only have to document to E/M level two for payment and medical review purposes unless they bill for level five CPT codes ("CMS Finalizes M.D. Payment Changes, With Delay And Level Five; Documentation Is Eased," *RMC* 27, no. 39).

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