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Physician coding and billing risks

By C. J. Wolf, MD, M.Ed., CHC, CHPC, CHRC, CPC, COC

C. J. Wolf (info@compliancereality.com) is Clinical Asst. Professor, Department of Medical Education, University of Illinois at Chicago College of Medicine, and Compliance Consultant for Compliance Reality, Draper, UT.

- linkedin.com/in/cj-wolf-md-25831020/


C. J. Wolf

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]

Misuse of modifiers

Another major coding and billing risk area for physicians includes the inappropriate use of medical coding modifiers on claims submitted to payers. Some modifiers are associated with greater risks than others. Inappropriate modifier use has often resulted in financial settlements between physician practices and government enforcement agencies. Additionally, inappropriate modifier use can result in denials from payers, wreaking havoc on a practice's revenue cycle.

What are modifiers?

Coding modifiers are typically numeric (or alpha) characters added to a medical code to signify some additional meaning. For example, modifier 25, under some circumstances, might be added to an E/M code to signify it

represents a significant and separate E/M service provided on the same day as a procedure. This is important because Medicare typically does not cover an E/M service on the same day as a procedure unless certain criteria are met. Without the modifier, most payers' claims processing editors will prevent payment for both the E/M and the procedure. However, if modifier 25 is appended, both the E/M and the procedure get paid. The compliance risk arises when the circumstances and/or the documentation do not support the separate nature of the E/M and modifier 25 is used inappropriately to bypass the edit and obtain reimbursement.

Modifier 59 is another example of a modifier that bypasses many payers' claims processing edits. By appending this modifier to a code, the entity submitting the claim is more or less certifying that the procedure or service was distinct or independent from another non-E/M service performed on the same day. For example, assume code A represents a surgical excision of an entire skin lesion, and code B represents a biopsy of a lesion. A biopsy takes only a portion of a lesion. A claims editing system's logic assumes only one procedure is typically done on a date of service. So, if code A and code B are reported on the same date of service for the same patient, the logic is code A (entire lesion excision) would incorporate any biopsy (code B) *of the same lesion*. The editing logic would allow payment for one code only because the assumption is only one lesion was addressed, and the more comprehensive service (code A) in this case would be reimbursed. However, what if there are two separate lesions, and lesion C on the arm was excised, and lesion D on the leg was biopsied? In this second scenario, both codes should be paid, but in order to identify the codes as having been performed on two distinct and separate lesions, modifier 59 would need to be appended, bypassing the claims edit and allowing payment for both codes. The compliance risk occurs when the circumstances do not support truly separate and distinct procedures. When this is done inappropriately, it is often referred to as "unbundling."

Modifier 25 and dermatology

A dermatology practice in Georgia paid $1.9 million to settle allegations of violating the False Claims Act.[10] The government alleged the physicians in the practice were billing for E/M services on the same day as a procedure. As explained previously, Medicare does not typically cover an E/M service on the same day as a procedure unless a significant, separately identifiable E/M service has been performed. In this case, the government alleged the practice billed for E/M services along with procedures where no significant and separately identifiable service was performed.

Dermatology is a specialty where it is common that procedures are performed in the office, such as biopsies, lesion removals, lesion destruction, etc. However, an E/M should only be reported with the modifier 25 when a significant and separate medically necessary E/M has been performed and documented. The OIG appears to have concerns of potential abuse of reporting both an E/M and procedure on the same day. A current item on its Work Plan describes:

> About 56 percent of dermatologists' claims with an E/M service also included minor surgical procedures (such as lesion removals, destructions, and biopsies) on the same day. This may indicate abuse whereby the provider used modifier 25 to bill Medicare for a significant and separately identifiable E/M service when only a minor surgical procedure and related preoperative and postoperative services are supported by the beneficiary's medical record. We will determine whether dermatologists' claims for E/M services on the same day of service as a minor surgical procedure complied with Medicare requirements.[11]

Modifier 59

As previously described, modifier 59 also bypasses payer edits, and reimbursement is likely when the modifier is used. Compliance professionals often hear, "We are getting paid, so we must be doing it right." In fact, if you are getting paid, you should be monitoring and auditing some of those claims to make sure the use of modifier 59 was appropriate.

A pain doctor in Utah settled allegations of misuse of modifier 59 by paying almost $400,000 in a settlement agreement with the OIG.[12] The settlement resolved allegations the doctor and his practice used modifier 59 to obtain reimbursement for multiple units of HCPCS code G0431 when only one unit of that code should have been reimbursed. The G0431 code is for "drug screen, qualitative; multiple drug classes by high complexity test method (for example, immunoassay, enzyme assay), per patient encounter."[13] It would be pretty rare for a patient to have multiple patient encounters on a single date of service with the same physician practice to report multiple units of the G code with the modifier 59. There are scenarios where it might be appropriate, but the documentation should support those rare circumstances, and the modifier should not be used just to get multiple units paid if the circumstances are not appropriate. The fact the code is a "per patient encounter" code should be a red flag if there is high-volume use of modifier 59 for that code.

Seemingly endless scenarios

The specific examples shared are just a few of the scenarios where modifiers might be misused to receive reimbursement inappropriately. Because there are hundreds (and in some coding systems, thousands) of codes, it really takes a trained auditor to catch the inappropriate use. And, in some cases, even trained coders may not be aware of clinical scenarios where the modifiers should or should not be used.

For example, there may be medical scenarios where a separate evaluation of a condition might be warranted on the same day as a billed procedure, or there may be times when the procedure being billed requires a clinical evaluation that is considered an inherent part of the procedure, and a modifier might be inappropriate given the clinical circumstances. This, again, is a reason to occasionally have a medically trained person with coding expertise perform, or be a part of, an audit or review.

Conclusion

Physicians are good at many things. Traditionally, however, many struggle with coding, billing, and documentation rules. E/M coding guidelines as well as proper use of modifiers are two major areas where risks might exist pertaining to physician billing.

As all competent compliance professionals know, we need to be diligent, competent, and fair in our ongoing auditing and monitoring efforts of physician coding and billing.

Takeaways

- Physician coding and billing risks should be a major focus for compliance professionals and programs.
- Medical necessity audits usually require a clinically trained person to perform the review.
- Evaluation and management (E/M) upcoding is an inappropriate practice of choosing a higher-level medical code than the circumstances warrant, resulting in receiving greater reimbursement than the practice is entitled to.
- Modifiers 25 and 59 bypass payer edits and result in additional reimbursement. When modifiers are used incorrectly, the reimbursement is not justified and puts the physician at risk of False Claims Act

allegations.

- Traditionally, coding and billing audits may only involve a certified medical coder who likely does not possess the clinical expertise needed for some reviews. Compliance professionals should include those with clinical and compliance expertise in coding and billing reviews.

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