

Avoid these missteps to slash your medical coding audit risk

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Whether you are dealing with a commercial payer, Medicare, or Medicaid, there are certain types of improper claims that should be avoided if you want to reduce your risk of a medical coding audit. That bit of wisdom comes from an entity that ought to know: the U.S. Department of Health and Human Services' Office of the Inspector General (OIG).

The OIG has released a roadmap to help new physicians avoid medical billing fraud and abuse in the Medicare and Medicaid programs. But this advice also broadly applies to how you approach reimbursement from commercial payers, and can also serve as a helpful reminder for physicians with years of experience in practice.

The agency warns, sternly, about consequences, noting in bold type that “when the federal government covers items or services rendered to Medicare and Medicaid beneficiaries, the federal fraud and abuse laws apply.”

When it comes to medical coding errors, the broad categories of “fraud” and “abuse” have distinct meanings. Fraud involves intentional misrepresentation. Abuse means “the falsification was an innocent mistake, but nonetheless representative,” according to the AMA's *Principles of CPT® Coding*, ninth edition.

The AMA has a number of resources to help you accurately report procedures and services with Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System codes, and avoid these improper claim types.

Caution: upcoding ahead

In its guidance, the OIG calls out upcoding for special attention in a separate box lined with yellow caution tape. This “refers to using billing codes that reflect a more severe illness than actually existed or a more expensive treatment than was provided.”

The agency calls special attention to proper reporting for evaluation and management (E/M) services. The OIG guidance offers as an example of upcoding “an instance when you provide a follow-up office visit or follow-up inpatient consultation but bill using a higher level E/M code as if you had provided a comprehensive new patient office visit or an initial inpatient consultation.”

The OIG notes misuse of modifier 25 as another example of upcoding. The modifier allows for extra payment for a separate E/M service provided on the same day as a procedure. Upcoding may happen if you append modifier 25 on claims in which the care you provided was “not significant, was not separately identifiable, and was not above and beyond the care usually associated with the procedure.”

The OIG also warns against billing for services:

- | You did not actually render.
- | Were not medically necessary.
- | Were performed by an improperly supervised or unqualified employee.
- | Were performed by an employee who has been excluded from participation in the federal health care programs.
- | That were of such low quality that they are virtually worthless.
- | That were already included in the global fee, such as billing for an E/M service the day after surgery.

Fraudulent billing can result in severe consequences. The OIG notes the case of an endocrinologist who billed routine blood draws as critical blood draws. He had to pay nearly \$500,000 to settle allegations of upcoding and other violations.

Learn more by reading the OIG publication, “A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse.” The Centers for Medicare & Medicaid Services also offers a web-training CME course on this material that has been approved for *AMA PRA Category 1 Credit™*.

The AMA strongly believes that the vast majority of physicians are honest and make a good faith effort to comply with Medicare program requirements.



Unfortunately, many of the federal government's efforts to address waste, fraud and abuse add unnecessary costs and burdens for honest physicians focused on patient care. The AMA works to ensure that the federal government's program integrity policies are equitable. Learn more about the AMA's advocacy efforts on Medicare waste, fraud and abuse.