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Coding Guidance

Coding Misuse Prompts Fraud Investigations

Introduction:

Over the last several years, the Office of the Inspector General has increased its anti-fraud efforts in health care. Intentional misuse of CPT coding constitutes fraud in both the public and private sectors. Nearly all insurers employ in-house Special Investigation Units (SIU) that have now shifted their focus from the arsonist and car thief to the medical provider who commits fraud. While a greater number of suspected fraud cases are being investigated in both the public and private sectors, you can take steps to avoid this potentially expensive and reputation-damaging experience. Below are some risk areas to be aware of and to avoid.

Definition:

The Centers for Medicare and Medicaid Services (CMS) describes fraudulent billing practices as "knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to obtain a Federal health care payment for which no entitlement would otherwise exist."

Risk Areas:

Most practice management seminars are helpful for many reasons and offer practical ideas to grow your business. Some practice management companies recommend reimbursement practices that are unethical and fraudulent. Here is a sampling of common practices being devised and promoted to gain reimbursement without regard to proper coding:

Billing an Evaluation and Management (E/M) Code on Every Visit with CMT: In general, it is inappropriate to bill an established office/outpatient E/M CPT® code (99211-99215) on the same visit as Chiropractic Manipulative Treatment (CPT ® code 98940-98943) because CMT codes already include a brief pre-manipulation assessment. There are times when it would be appropriate, but it should not be routine. Examples of when it may be appropriate to bill an additional E/M service would be the evaluation of new patients, new injuries, exacerbations, or periodic re-evaluations. If you are being told that billing an E/M code on every visit is a proper form of billing, it is incorrect. Please refer to the American Chiropractic Association (ACA) website at www.acatoday.org, Coding Policies section, for specific guidance on the proper use of E/M with a Chiropractic Manipulative Treatment Code (CMT).

***Billing an Evaluation and Management Code in Place of CMT*:** In cases where a limited number of manipulations are allowed, DCs are being advised to use an E/M code instead of a CMT code to get around the limit on CMT. This is inappropriate. You are required to bill the code that best describes the service rendered. Pattern software used by many insurers will easily pick up the code deviation and refer that doctor's billings to the Special Investigations Unit (SIU) for fraud investigation. Fraud prosecutions have been initiated against providers who have deliberately changed codes. Fraud prosecutions have also been initiated for other code deviations and have not been just limited to E/M codes billed with CMTs.

Inappropriately Billing CPT 97140 in Place of CMT: Billing for multiple time-based codes such as several manual therapies (CPT 97140), when a CMT was the only service performed, is inappropriate. You cannot replace a CMT CPT code with another CPT code if the CMT was the actual service performed. Once again, you are required to use the code that best describes the service rendered. In addition, each unit of CPT 97140 describes

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15 minutes of office time-it normally does not take 45 minutes to perform manipulative therapy and payers are fully aware of this.

Unbundling: Some providers are requiring a patient to return to the office on the next day to perform a service that would not otherwise be covered, or that may allow higher reimbursement if it is done as a "stand-alone" procedure on a separate day. Insurers respond to this form of coding manipulation by, at a minimum, combining services into bundled coding edits or, at worse, with limits or caps on services for the entire profession.

Up-coding/down-coding CMT: When billing for CMT, it is important that your billing code represents the service performed and that the documentation represents the level billed. It must be based on the number of levels treated, which can vary from visit to visit. Routinely billing a 98942 (5 level manipulation code) can be a red flag and put you under more scrutiny. This also applies to billing a 98940 routinely when you are treating more than 2 areas. Doctors sometimes hope to stay under the radar by down-coding. It is important to code what you do at each visit.

Application:

The American Chiropractic Association (ACA) feels it is important to let you know that using these or other questionable practices put both you and the entire chiropractic profession at risk. Make sure that you use proper coding procedures. Intentional acts that misuse CPT codes hurt the entire chiropractic profession and thwart the profession in its ability to fully integrate into mainstream health care.

ACA sponsors a doctor of chiropractic who sits on the American Medical Association (AMA) CPT Advisory Coding Committee and is intimately familiar with coding intent in order to accurately convey AMA CPT positions and policies. ACA consistently publishes and keeps current on any new codes or changes to previous codes as determined by AMA CPT.

Doctors are advised to consult with their state licensing boards and payers for additional guidance.

References:
CMS. Medicare Fraud & Abuse: Prevent, Detect, Report; 2021. Accessed June 14, 2023. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Abuse-MLN4649244.pdf

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