

The HMA/EmCare Whistleblower Suits and the Implications for Coding

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*Coding and billing might seem esoteric and boring — because they are. Coding/billing is certainly a world unto itself. However, coding and billing determine your income and thus your lifestyle. This is true whether you are in academics and far removed from coding and billing, selecting a coding/billing company to serve your independent emergency medicine group at a community ED, or one of the rare emergency physicians who does his or her own coding. Whatever their practice situation, every emergency physician should have at least a superficial understanding of coding and its financial and legal implications. Even if someone else codes your charts for billing and you have no input into that coding at all — even if it's someone you didn't hire yourself and had no hand in choosing — **you** are legally responsible for the accuracy of that coding and the resulting bills. If **your** name is the one on the chart, **you're** the one who will be charged with fraud if the coding is found to be fraudulent. It's true that the coders will be charged too, but will being one of many defendants make you feel better?*

— The Editor

The HMA/EmCare whistleblower lawsuits have been well covered in print and on TV (*Sixty Minutes*). The suits involve allegations by physicians and an administrator employed by EmCare that they were pressured by HMA to admit patients, with the collusion of EmCare, because more admissions meant more revenue for HMA. Stark law violations, fraud, and other criminal issues are in play. And the demonstrated interest of the U.S. Department of Justice certainly raises the stakes on these lawsuits. Perhaps not coincidentally, HMA has sent its CEO on a one year mission to South America.

Another aspect of these allegations has been overlooked by the media: the impact of allegedly improper admissions on the coding of emergency department services. In some ways this oversight is understandable, since coding tends to be an inside-the-industry issue and is not as sexy as allegations of pressuring doctors to make unnecessary admissions. This is similar to the recent SGR fix that was widely reported in the press, while yet another delay in initiating the ICD-10 was barely noticed. Industry insiders are aware that the ICD-10 delay has implications that go well beyond another SGR fix, but the news simply isn't interesting to the media or general public.

EmCare and Coding Issues — A Brief History

This is not the first brush that EmCare has had with whistleblower suits. In the 1990s a whistleblower coding suit was brought against EPBS (Emergency Physician Billing Services). At the time EmCare used EPBS on the majority of its contracts. The president of EPBS was caught, on tape and in writing, making statements about coding that were completely inappropriate. EPBS coders were pressured to fraudulently up-code, much like EmCare emergency physicians were more recently allegedly pressured to increase admissions through the ED. EmCare quickly dropped EPBS and moved their coding and billing accounts to a start-up billing company called Reimbursement Technologies, Inc (RTI). EmCare

then purchased RTI. RTI continues to code and bill for EmCare. Since EmCare owns RTI it is effectively a captive billing service, although RTI does retain some outside clients. Another recent industry development is that RTI, along with many other ED coding and billing companies, now processes a significant percentage of its ED charts overseas. Although there is no tie-in between off-shoring and alleged wrongdoing, shipping Protected Health Information that is subject to HIPAA guidelines overseas for coding could become an issue if coding is questioned by regulators or plaintiffs.

Coding Implications

Let's take a look at the coding implications of the HMA/EmCare lawsuits. A bit of digging into the morass of ED coding guidelines will be required, but I will try to keep it simple.

According to *The Tampa Bay Business Journal* of Feb 1, 2014, "EmCare colluded with HMA and Newsome to increase inpatient admissions and demanded that, as a condition of employment, its physicians maximize admissions and order HMA selected medical tests regardless of whether the tests were necessary." Besides the obvious Stark issue, this statement is fraught with implications for the coding process. Shedding light on this tie-in requires an understanding of documentation guidelines.

History/Physical Exam/Medical Decision Making

In order to code the highest and most lucrative non-time-based ED level (99285), a *Comprehensive* History and Physical Exam and *High Complexity* Medical Decision Making (MDM) must be documented. Unlike other sites of service that might require only two of three, in the ED all three elements (History, Exam, and MDM) must be documented at that level in order to code a 99285.

With the proliferation of EMRs with all kinds of documentation tools embedded in them (whether right or wrong), most Histories and Physical Exams are now documented at a *Detailed* level at least, and often at the *Comprehensive* level required for 99285. This trend has resulted in Medical Decision Making and the related Medical Necessity being the real documentation tie-breakers that coders use to determine if they are looking at a 99284 or 99285.

Most coders and most state Medicare carriers use something called The Marshfield Clinic Tool to determine the level of MDM. The tool consists of three parts that are consistent with CPT Guidelines. The first two, Diagnosis and Management Options and Amount/Complexity of Data, assign points for each management option or each element of data that is ordered or reviewed by the emergency physician — such as lab tests, old records, X-rays, etc. The third element of MDM is Risk. Risk is broken into three levels and the tool provides examples of each for guidance. The usefulness of the Table of Risk for ED Services has been debated for years, since the examples do not sync up well with ED services. For

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example, chest X-rays, ultrasonograms, and EKGs are in the minimal risk section of the table, but certainly don't go with low risk scenarios in the ED. The other two sections, Presenting Problems and Management Options, come closer to being in line with ED reality.

A coder needs to identify a *Comprehensive* History and Physical Exam as well as High Complexity MDM in the ED chart to code a 99285. We will assume a *Comprehensive* History and Exam are documented. Now MDM becomes critical in determining the coding level. To justify a 99285 level of service code, the coder needs to identify sufficient elements in two of these three sections: Management Options, Data Elements (diagnostic tests), and Risk. **The simplest way for Management Options to support a 99285 is for the patient to be admitted.** An admission "with additional work up planned" gets the coder to the necessary Management Options complexity for a 99285. Then the coder will look at the tests ordered and interpreted. If several tests were ordered and interpreted, the coder now has the necessary documentation in Data Elements to justify a 99285. And if unnecessary diagnostic tests were ordered and interpreted to support an unnecessary admission, the coder — again following the rules — will have the necessary documentation of complex Medical Decision Making to code a 99285. **Even without High Risk, the coder can support a 99285 based on the (allegedly unnecessary) diagnostic tests and admission, since only two of three MDM elements are required.** This may have resulted in high volumes of unintentionally (by the coders at least) up-coded ED services at HMA hospitals, based on allegedly unnecessary tests and admissions.

Medical Necessity is also a key element in determining the appropriate ED level of service code. The problem with Medical Necessity is that the definition used by CMS is subjective, and there is no quantifiable way to audit Medical Necessity. But even the most skeptical coder will code based on the H&P and MDM, and will not question the necessity of an admission or tests that support the *High Complexity* MDM for a 99285. Additionally, much ED coding is done overseas. Overseas coders, even more than domestic ones, will not question the information provided in the medical record and will strictly adhere to the guidelines provided by their stateside clients. Questioning guidelines typically may fall outside cultural norms in South Asia. This issue, along with the fact that there hasn't been full — or often any — disclosure of off-shoring by large billing companies, should be a cause for concern because massive numbers of ED charts (with Protected Health Information governed by HIPAA) are being reviewed in much less regulated environments overseas. The potential issue with the HMA/EmCare coding controversy is that coders did follow guidelines, but the guidelines were applied to allegedly unnecessary diagnostic tests done to support allegedly unnecessary admissions.

Conclusion

ED Level of Service coding would almost certainly be affected by an unnecessary admission. Coders code based on the documentation and CMS/CPT guidelines that are given to them. It is likely that many 99285s were coded based on allegedly unnecessary tests leading up to allegedly unnecessary admissions. In addition to the obvious Stark issues involved in the HMA/EmCare lawsuits, it is reasonable to expect that at some

point the Health and Human Services Office of Inspector General (or the Department of Justice) will take a hard look at this coding issue too.

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Glossary

CEO: Chief executive officer. The head of a company.

CMS: The Centers for Medicare and Medicaid Services, also known in the medical world as "the feds."

CPT: *Current Procedural Terminology*, a big book of codes used in billing for medical procedures.

EmCare: The nation's largest ED contract management group, at least in terms of number of EDs under contract. Team Health is the biggest in terms of revenue.

EMR: The electronic medical record, also known as the electronic health record (EHR).

HIPAA: The Health Insurance Portability and Accountability Act. Among other things, it seeks to protect the confidentiality of "protected health information."

HMA: Health Management Associates, a hospital chain.

ICD-10: *The International Classification of Diseases, 10th Edition*. The ICD-9 is currently used by physicians, coders, and the feds. The ICD-10 has been ready for years but is so much larger, more detailed, and more complicated than the ICD-9 that its implementation keeps getting delayed by the feds in response to protests from physicians and other users.

Level of Service code: Numerical codes from the ICD-9 and CPT that determine how much EPs, other physicians, and hospitals are paid for particular services.

SGR: Sustainable Growth Rate. A formula used by the federal government to determine how much EPs and other physicians are paid. Without an annual "SGR fix," physician compensation would automatically be cut by more than 25%. Congress aspires to a permanent SGR fix, but has been spectacularly unsuccessful.

Stark: Named after its congressional author, a body of federal laws against medical self-referrals. Physicians are prohibited from referring their patients to entities they own or have a large ownership stake in. Included in Stark are exceptions to this prohibition known as "safe harbors," which makes the law quite complicated.

Whistleblower suit: a *qui tam* lawsuit, in which a private citizen who knows of a fraud perpetrated against the federal government sues the perpetrator for damages. The federal government may then choose to take over the suit and bear the associated costs, and if the suit is successful it shares the damage award with the original plaintiff or "relator" who brought the suit. *Qui tam* suits alleging Medicare or Medicaid billing fraud seem increasingly common, and when a large hospital chain is alleged to have systematically defrauded Medicare or Medicaid, hundreds of millions of dollars in damages could be at stake.

According to the Legal Information Institute at the Cornell University Law School (http://www.law.cornell.edu/wex/qui_tam_action), in a *qui tam* action, a private party called a relator brings an action on the government's behalf. The government, not the relator, is considered the real plaintiff. If the government succeeds, the relator receives a share of the award. Also called a popular action.

For example, the federal False Claims Act authorizes *qui tam* actions against parties who have defrauded the federal government. 31 U.S.C. § 3279 et seq. If successful, a relator in a False Claims Act *qui tam* action may receive up to 30% of the government's award.

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Appendix I: Amount and/or Complexity of Data Reviewed

For each category of reviewed data identified, circle the number in the points column. Total the points.

Reviewed Data	Points
Review and/or order of clinical lab tests	1
Review and/or order of tests in the radiology section of CPT	1
Review and/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2

Note: Points are assigned for labs, X-rays, other tests etc. Two points are assigned for an "Independent Visualization" which is often done in ED. So if ED physicians were allegedly under pressure to order unnecessary tests to support the allegedly unnecessary admissions, they would typically get to the 4 Data points that support MDM for 99285.

Appendix II: Medical Decision Making

Number of Diagnoses or Treatment Options

Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (There are maximum number in two categories.)

A	B x	C	= D
Problem(s) Status	Number	Points	Result
Self-limited or minor (stable, improved or worsening)	Max=2	1	
Est. problem (to examiner); stable, improved		1	
Est. problem (to examiner); worsening		2	
New problem (to examiner); no additional workup planned	Max=1	3	
New prob. (to examiner); add. workup planned		4	
			Total =

Note: The highlighted "New prob; add workup planned" — which is pretty much every Emergency Department admission — gets the coder the 4 points needed for 99285 Level Management Options. ■



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