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Why Providers Should Prioritize Billing & Coding Oversight

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When a miscoded procedure is the result of substantial negligence or fraud, it can be detrimental to a medical practice or physician. That is why it is vital for medical practices to establish robust oversight, audit and remediation procedures that work to ensure accurate coding and billing.

The work billers and coders do for a medical practice plays a large role in its survival. Coders and billers are tasked with translating care delivered by medical professionals into billable services, using a complex system of CPT, ICD-10 and HCPCS codes — all while maintaining compliance with evolving insurance industry regulations.

Due to the tediousness of the job, coding and billing mistakes in medical practices are common. However, when a miscoded procedure is the result of substantial negligence or fraud, it can be detrimental to a medical practice or physician. That is why it is vital for medical practices to establish robust oversight, audit and remediation procedures that work to ensure accurate coding and billing.

The reality of mitigating risk as a solo practitioner or when running a small practice often means spending less time with patients and more time completing management tasks like coding and billing. In many private practices, the doctor is solely responsible for selecting codes at the time the note is complete, based on documentation of the visit in a paper chart or through an electronic health record (EHR). In some health care systems and hospital groups, all the coding is performed by a certified medical coder. Other times, the provider codes the service and the coder then verifies or recodes it.

Although various methods of coding and billing can involve multiple individuals who prepare and submit claims, doctors should know that liability ultimately falls to the provider whose National Provider Identifier number the service was billed under, and a physician's signature on a claim attests that the medical services provided were necessary and reasonable. Because physicians are responsible for ensuring that submitted claims accurately reflect the services they provided, they need to take an active role in their practice's coding and billing processes.

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Many medical coding and billing errors are not malicious but are attributable to incorrect patient information, duplicate billing, unclear claim numbers, wrong codes and poor documentation. Although it is not common for simple errors to escalate to the level of fraud, physicians can establish processes and policies that help them manage that risk.

In contrast to medical coding and billing errors, medical fraud occurs when a false claim misrepresenting the facts is intentionally submitted to insurance to receive payment. Although most physicians oppose outright fraud, some still unknowingly participate in behaviors or systems that inflate health care costs.

The case of Michael Stevens, M.D., is an example of worst-case scenario when fraud affects medical billing and code. An anesthesiologist and owner of a pain management clinic, Stevens was forced to surrender his medical license when it was found that his medical biller was committing fraud. The biller, Edward Bailey — a family member with no experience or expertise in medical billing — had met with a Medicare contract provider to seek guidance on which CPT codes to use for a new treatment the practice had started to provide. Soon, claims that had previously been denied by payers started to come back approved.

However, when the state licensure board began investigating Stevens, they noticed that the practice routinely billed the same five CPT codes for the treatment, one of which was for a neuromuscular junction test that was likely never performed. It turned out that Bailey had taken it upon himself to find the combination of CPT codes that would ensure payment for the new treatment, whether those services were performed or not.

When questioned, Stevens admitted that he did not review the claims that his biller submitted and that he was not aware of the specific CPT codes that were being billed on the claims. Stevens said he believed that Bailey was using the correct CPT codes as directed by the Medicare contract provider.

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Although Bailey pleaded guilty to health care fraud and conspiring to defraud health care benefit programs in connection with the false or fraudulent claims submitted for the CPT code in question, the Kentucky Board of Medical Licensure eventually concluded that Stevens engaged in "dishonorable, unethical or unprofessional conduct" and he relinquished his medical license, ending his medical career.

Several government entities are involved in detecting and overseeing cases of medical abuse and fraud, including the Department of Health and Human Services, the Office of Inspector General, the Centers for Medicare & Medicaid Services, and the Department of Justice, which negotiated $2.3 billion in judgments relating to health care fraud and abuse in 2018, including 1,139 criminal fraud investigations.

It is now easier than ever for these agencies to detect medical fraud through use of algorithms that monitor and analyze incoming claims and payments and flag suspicious patterns of behavior. Practices and providers identified through these systems can be investigated and, if found to have a pattern or history of coding mistakes, may face fines or penalties.

The False Claims Act imposes liability on anyone who knowingly presents or causes to be presented a false or fraudulent claim for payment, or who conspires to submit a false claim for payment. Statute 31 U.S.C. § 3729 (b) defines "knowingly" as:

⇒ Having actual knowledge of the information.
⇒ Acting in deliberate ignorance of the truth or falsity of the information.
⇒ Acting in reckless disregard of the truth or falsity of the information with no proof of specific intent to defraud required.

To reduce risk, doctors need to provide oversight of the billing and coding processes of their practices, whether they hire a credentialed in-house coder or choose to outsource the process. At a minimum, in-house coders, billers and providers should be trained annually on updates to CPT codes and other regulatory changes.

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Coders should also feel empowered to ask providers about anything they identify as questionable before billing to payers and meet with providers regularly to provide feedback and identify risks.

When outsourcing your practice's coding and billing services, it is critical that the service carry errors/omissions insurance and liability coverage, which will pay for breach disclosure communications and lawsuits in the event of a security breach involving patient records. Whether coding and billing are kept in house or outsourced, physicians can always submit reports to their certified public accountants to check for transparency and accuracy and hire additional qualified professionals to perform independent audits.