Who is coming for you?

- Medicare Administrative Contractors (MACs)
- Recovery Audit Contractors (RACs)
- Medicaid Recovery Audit Contractors (MACs)
- Comprehensive Error Rate Testing (CERT)
- Zone Program Integrity Contractors (ZPICs)
- Private Payors
- Auto Insurance

Targeted Probe and Educate

- The CMS is expanding the existing Targeted Probe and Educate (TPE) Pilot to include all MACs. The purpose of this expansion is to reduce appeals, decrease provider burden, and improve the medical review/education process.
- IMPLEMENTATION DATE: October 1, 2017
“CMS has seen very positive results from a currently running pilot for this program as well as modifications to existing programs as a result of lessons learned.

CMS believes that this strategy will continue to demonstrate measurable reductions in the number of claims denied and the number and merit of appeals”.

Replace all current medical record reviews in the MAC’s Improper Payment Reduction Strategy (IPRS) with up to three rounds of a pre-payment Targeted Probe & Educate process.

If high denial rates continue after three rounds refer to CMS for additional action, ie extrapolation, referral to the (ZPIC) or (UPIC), referral to the RAC, 100% pre-pay review, etc.

The MAC, rather than CMS, will select the topics for review (based on existing data analysis procedures)

The MAC can target the strategy on the providers most likely to be submitting non-compliant claims, rather than reviewing 100% of the providers

Limit the sample for each probe “round” to a minimum of twenty (20) and a maximum of forty (40) claims.
Targeted Probe and Educate

Be on alert

Know who your local MAC, RAC, ZPIC, CERT, etc... contractors are.
- Billing staff should know how to recognize records requests and inquiries from local contractors.

What do to

- Respond as directed ASAP!! (per CMS “Non-responses count as an error when considering a provider’s or supplier’s error rate”)
- Review the documentation and coding and prepare a rebuttal in the event of a negative outcome.
- Appeal downcoding with supporting documentation and justification of coding.
Know the rules

- Know the coding guidelines and policies for your payers.
- Some payers have unique rules for E&M components.
  - ROS
  - Exam
  - MDM
- Review the payer websites regularly for updates to policies.

Willful ignorance in not a defense

- After Missing Alerts on Sedation Billing, New York Anesthesiology Medical Specialties agreed to pay $1.94 million to settle false claims allegations that it overbilled for moderate sedation services.
- NYAMS billed Medicare for moderate sedation when the physician didn’t spend at least 16 minutes face to face with the patient and/or the medical record did not document that there had been at least 16 minutes of face-to-face time from Jan. 1, 2012, to Jan. 5, 2016,

“The information needed to bill this code properly was available, but the mechanisms were not in place to obtain and process that information.” - Assistant U.S. Attorney Michael Gadarian

- Oct 2011 – CPT Asst publishes Guidelines for Time-Based Codes
- “NYAMS did not subscribe to or otherwise receive the CPT Assistant publication,” the settlement said.
In February 2012, National Government Services, the MAC for New York, posted an alert on its listserv explaining that providers had to perform and document 16 minutes of face-to-face time to bill under 99144, consistent with CPT Assistant, according to the settlement. NGS kept the notice on its website for about one year.

“No one at NYAMS subscribed to the NGS listserv,” the settlement states.

Staff members at the billing service for NYAMS did receive NGS listserv notification but failed to inform NYAMS.

In January 2015, a commercial payer denied payment for moderate sedation billed by NYAMS.

Internal communication at billing service indicates staff did not appeal finding due to 16-minute rule to bill code wasn’t met.

Five months later, additional MCS claims were denied “did not find documentation to support that the procedure lasted more than 16 minutes,” the settlement states. NYAMS denies being notified of this by the billing company.
Allergies as ROS

Q14. Can an allergy be part of the ROS rather than the past history? For example, patient has allergy to penicillin; it causes hives?

A14. No, questions and responses concerning any past allergies and the resulting reactions are part of the Past, Family, and Social History (PFSH). They are not part of the Review of Systems (ROS).

WPS ROS

Q9. The 1995 and 1997 DGs indicate “all other systems are negative” is acceptable for a comprehensive level of the Review of Systems. Does WPS accept this?

A9. Yes. For a comprehensive ROS, the physician must document the review of at least 10 organ systems. The physician must document both the positive and the problem pertinent negative responses relating to the chief complaint. Indicating the individual systems leaves no room for doubt as to the number of systems reviewed, but “all other systems negative” is acceptable.
**PMH as ROS**

**Question:** If the past medical section states a chronic or current illness (that the provider is not treating), can it be used in the Review of Systems (ROS)? If the past medical section lists several conditions and there is no mention of controlled or uncontrolled, could this be used in the ROS?

**Answer:** No, per both the 1995 and 1997 Evaluation and Management (E & M) Documentation Guidelines, "a Review of Systems is an inventory of body systems obtained through a series of questions seeking to identify signs or symptoms that the patient may be experiencing or has experienced."

A past medical history would not contain a patient's pertinent positive and/or negative responses as related to the problems identified in the patient's history of the present illness.

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**Exam**

<table>
<thead>
<tr>
<th>Problem Focused</th>
<th>1995 E&amp;M DG</th>
<th>Narrative Interpretation</th>
</tr>
</thead>
<tbody>
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</table>

- **Problem Focused**
  - a limited examination of the affected body area or organ system
  - 1 Body Area or Organ System

- **Expanded Problem Focused**
  - a limited examination of the affected body area or organ system and other symptomatic or related organ systems
  - 2-4 Body Areas or Systems

- **Detailed**
  - an extended examination of the affected body area(s) and other symptomatic or related organ system(s)
  - 5-7 Body Areas or Systems

- **Comprehensive**
  - a general multi-system examination or complete examination of a single organ system - The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems
  - 8 or more Organ Systems

---

**Examination**

- The 2-4, 5-7 breakdown originated with then HCFA Medical Director, Bart McCann at the CPT Editorial Panel Advisory Committee meeting in November of 1995.

- Indicated that a new version of the DGs were to be released in 1996 that would reflect the 2-4, 5-7 to more clearly refine the exam requirements.
Many sources changed their version of the DGs to reflect the expected update that was never made official.

Still sources, including many of the Medicare carriers, that use the numerical breakdown to assign a level to the exam.

<table>
<thead>
<tr>
<th>NHIC Examination</th>
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<tbody>
<tr>
<td>Examination</td>
</tr>
<tr>
<td>Organs &amp; Areas</td>
</tr>
<tr>
<td>TSS Guidelines</td>
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<tr>
<td>(Organ)</td>
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<td>1 (B)</td>
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<td>1 (B)</td>
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<table>
<thead>
<tr>
<th>Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGS: Audit Tool</td>
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</tbody>
</table>
CIGNA E&M Tips

Understand the difference between "Expanded Problem-Focused (EPF)" and "Limited" examination under 1995 guidelines.

The difference is not the number of systems examined. Two to seven systems are required for both examinations.

The difference is the detail in which the examined systems are described.
Under the 1995 guidelines both the expanded problem focused examination and the detailed examination provide for the examination of "up to 7 systems" or 7 body areas.

This has led to variability in reviews utilizing the '95 guidelines, and required an interpretation for proper and consistent implementation of the E/M guidelines.

By providing a tool (4 elements examined in 4 body areas or 4 organ systems satisfies a detailed examination) our reviewers and the physicians have a clinically derived tool to assist in implementing the E/M guidelines and decreasing one area of ambiguity.

This is a tool that is consistent with the way medicine is practiced, as confirmed in Documentation Coding & Billing by Laxmaiah Manchikanti, M.D., and A Guide to Physical Examination by Barbara Bates, M.D. And, it is a tool to reduce reviewer variability.

How many vital signs do you require for a 1995 Constitutional exam?

Any one vital sign or general appearance counts for a 1995 Constitutional exam.

For "HEENT Normal", how many body areas/organ systems would you give credit?

Documentation of "HEENT Normal" would result in 1 Body area and 2 Organ systems as shown below:

- Head = 1 Body area
- Eyes = 1 Organ system
- ENT = 1 Organ system
Confirm information before setting policy.

- Relating to HPI: Can one element be used more than one time to determine the level of HPI? Example: If a patient comes in with complaints of ankle pain and wrist pain, can location be counted twice?
  - Yes, one element can be used more than one time. Evaluation and Management guidelines for the documentation of the HPI must be followed.

MDM Controversies

- Additional work-up planned
- 2 Points for interps and/or 93010
- Check box for "Old records reviewed"
- Discussion w/ another "health care provider"

MDM variables

- Marshfield MDM scoring
**Marshfield Scoring - Number of Diagnoses / Treatment Options**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Problem, no add’l work-up planned</td>
<td>3</td>
</tr>
<tr>
<td>New Problem, add’l work-up planned</td>
<td>4</td>
</tr>
</tbody>
</table>

**2 common definitions**

A. Additional diagnostic work-up after the current E&M service is completed.

B. Diagnostic work-up during the current E&M service.

---

**Additional work-up planned**

Per Noridian:

- **Q3.** Please clarify if "new problem to provider, additional workup" means that the additional workup must be done beyond that encounter at that time.

- **A3.** There is no specific indication that "further workup needed" must be completed at a future date.

---

**Additional work-up planned**

Definitions:

- **Additional Work-up Planned:** Any testing, consultation, referral, that is being done beyond that Encounter to assist the provider in medical decision making.
Additional work-up planned

▶ An example of Additional Work-up Planned is if the physician schedules testing him/herself or communicates directly with the patient's primary physician or representative the need for testing which is to be done after discharge from the ED, and the appropriate documentation has been recorded. Credit for “Additional Work-up” Planned is granted (4 points assigned).
▶ Credit is not given for the work up if it occurs during the ER Encounter.
▶ Patients admitted to the hospital under the care of a physician other than the ER physician may have testing done as part of the admitting physician’s care for that patient. The ER physician will not receive credit for the Additional Work-up Planned done under the care of the admitting physician.

Novitas Add’l W/U

▶ What constitutes additional workup in the Amount and Complexity of Data grid for Medical Decision Making?

▶ Additional workup is anything done beyond that encounter at that time. For example, if a physician sees a patient in his office and needs to send that patient on for further testing, that would be additional workup. The physician needs to obtain more information for his medical decision-making.

Novitas Add’l W/U

▶ Is the physician doing additional workup?

▶ Additional workup will require the physician to review the results/make decisions on a day other than the day of the patient encounter.
Q6. My question centers on the number of diagnosis or management options in the MDM of the E/M service. When coding an Emergency department encounter, would all presenting problems fall under the "new problem" category (either with or without additional workup)?

A6. The 1995 and the 1997 DGs have a table the provider can use in determining the level of MDM. There is no specific "new problem" category.

The number of possible diagnosis and/or the number of management options your provider considers is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician. The highest level of risk in any one category determines the overall risk.

Q2. Define self-limited or minor problem in the medical decision making grid under minimal level of risk. At times, it is difficult to determine whether a problem is self-limited or minor or whether it is a new problem with no additional work-up planned.

A2. The 1995 and 1997 DGs indicate the determination of risk is complex and not readily quantifiable and includes some examples in each of the categories. The DGs do not address a new problem with no additional work up planned. Therefore, you can use the examples provided in the DGs to determine the level of the presenting problem.
Noridian MDM

Medical necessity cannot be quantified using a points system. Determining the medically necessary level of service (LOS) involves many factors and is not the same from patient to patient and day to day. Medical necessity is determined through a culmination of vital factors, including, but not limited to:

- Clinical judgment
- Standards of practice
- Why the patient needs to be seen (chief complaint),
- Any acute exacerbations/onsets of medical conditions or injuries,
- The stability/futility of the patient,
- Multiple medical co-morbidities,
- And the management of the patient for that specific DOS.

MDM Controversies

<table>
<thead>
<tr>
<th>MDM Controversies</th>
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<tbody>
<tr>
<td><img src="image1.png" alt="MDM Controversies" /></td>
</tr>
</tbody>
</table>

EMR MDM

Medical Decision Making

- Discussion of test results with the performing providers: yes
- Decide to obtain previous medical records: yes
- Obtain history from someone other than the patient: no
- Review and summarize previous medical records: yes
- Discuss the patient with another provider: yes
- Independent visualization of image, tracing, or specimen: yes
Auditor response

- “These statements provide no clinical insight as to what happened in the ED or how these steps impacted the diagnosis or treatment of the patient. Documentation that is aimed to meet the guidelines for payment but is clinically irrelevant to the patient presenting problem will not increase the level assigned to that visit.”

EKG Pay vs Points

- The ordering of the EKG would be part of the Medical Decision Making (MDM) under the Risk category under Diagnostic Procedures Ordered.
- The interpretation of the ordered EKG is considered part of the EKG reimbursement, and as such is not part of the Amount and/or Complexity of Data to be Reviewed category under the MDM portion of the E/M service.
- Counting both a review of the ordered EKG and billing for the interpretation and report of the same EKG is incorrect.

Independent visualization of image, tracing or specimen itself

- If I personally review a film, e.g. x-ray, electrocardiogram (EKG) in my office, will I receive 2 points on the E/M score sheet?
- Yes, you may get two points for independent visualization of an image, tracing or specimen on the E/M score sheet in the Amount and/or Complexity of Data Reviewed section under the Medical Decision Making key component.
- The medical record documentation must clearly indicate that the physician/qualified NPP personally (independently) visualized and performed the interpretation of the image, tracing or specimen and that he/she did not simply read/review a report from another physician/qualified NPP.
Automated Down coding

In September, we communicated that when CPT code 99285 is billed with a minor diagnosis, we will need code 99284. This policy will not be implemented. The following review process will be implemented in its place.

CPT code 99285 is used to indicate medical conditions that are of high severity, are potentially life threatening, and require the immediate attention of a physician. Services for constipation, earaches and colds, for example, should not be billed using CPT code 99285. When a hospital or physician bills a level 5 emergency room service (CPT 99280) with a designated minor diagnosis code, we will accept documentation to support this. If the documentation/medical records support the level five service it will be paid per Aetna Standard Guidelines. If records do not indicate a level five is warranted, the service will be recoded.

Automated Down coding

Visit https://www.aetna.com/providers/resources/clinical-payment-policies.html to find these policies. The effective date for the below policies is October 8, 2017.

<table>
<thead>
<tr>
<th>Number</th>
<th>Policy Name</th>
<th>Policy Description</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.PP-05</td>
<td>Non-Emergent ER Services</td>
<td>The purpose of this policy is to define payment criteria for non-emergent emergency room services to be used in making payment decisions and administering benefits. When a hospital, free-standing emergency center or physician bills a level 4 (99284) or level 5 (99285) emergency room service, with a non-emergency diagnosis, WeCare Health will reimburse the provider at a level 3 (99283) contracted reimbursement rate.</td>
<td>Medicaid Medicare Aetna</td>
</tr>
</tbody>
</table>
Automated Down coding

Centene (operates in 26 states, include Medicaid MCO plans, exchange plans and Medicare/Medicaid plans)

Policy Overview
- To encourage providers to direct patients to more appropriate care settings, the health plan has adopted a payment strategy that will provide lower levels of reimbursement for services indicating lower levels of complexity or severity rendered in the emergency room.
- The purpose of this policy is to define payment criteria for emergency room services to be used in making payment decisions and administering benefits.

Automated Down coding

Reimbursement
- When a hospital, free-standing emergency center or physician bills a level 4 (99284) or level 5 (99285) emergency room service, with a diagnosis indicating a lower level of complexity or severity, the health plan will reimburse the provider at a level 3 (99283) reimbursement rate.

Automated Down coding

Anthem Blue Cross and Blue Shield of Indiana
Provider information for avoidable emergency room visits
- The below clinical areas and respective codes will be reviewed if they are the emergency room discharge diagnosis. Prudent layperson language (law) was taken into consideration in development of these clinical areas. The members presenting symptoms in conjunction with prudent layperson language may allow approval of the ER visit. The program is effective for Indiana commercial local accounts on 01/01/2018.
Automated Down coding

FROM: Iowa Department of Human Services (DHS), Iowa Medicaid Enterprise (IME)
RE: Emergency Room (ER) Visits and Emergency Diagnosis Codes
EFFECTIVE: August 1, 2018

Effective for claims with date of service on or after August 1, 2018, a claim for an emergent service must contain an approved emergent diagnosis code in the primary (first) position to receive the full reimbursement amount on the claim. If the primary (first) diagnosis on the claim is not emergent, the member will be responsible for any applicable copay amounts.

- R06.2 Wheezing
- R07.1 Chest Pain on Breathing
- R07.89 Other Chest Pain
- R07.9 Chest Pain, Unspecified
- R10.12 Left Upper Quadrant Pain
- R10.13 Epigastric Pain
- R10.815 Periumbilical Abdominal Tenderness
- R10.816 Epigastric Abdominal Tenderness

Removed from the emergent diagnosis code listing as of 6/30/18. These codes are no longer considered emergent by IME. Claim will only pay at 50% if these codes are in the 1st position.

- R01.817 Generalized Abdominal Tenderness
- R01.8 Nausea
- R01.11 Vomiting without Nausea
- R03.7 Diarrhea, Unspecified
- R03.9 Hematuria, Unspecified
- R05.9 Fever, Unspecified
- R051 Headache
- R053.1 Weakness

Plus dozens of Fractures, Sprains, Contusions, etc.
Automated Reviews

Iowa Department of Human Services

Issue 1 of 1

The algorithm identified coding errors on claims for surgical services. The algorithm identified instances when the professional and facility claims, for the same surgical services, were billed with different CPT codes. The procedure codes billed should accurately reflect the services provided.

Please be advised, Iowa Medicaid will be adjusting the Medicaid Management Information System (MMIS) to correct the procedure code. The overpayment amount will be the difference in payment between the procedure code that you billed and the correct one.

Please refer to the enclosed letter for further detail.

Summary

Please complete the attached form and return it within 10 days. If the coding error is not corrected, your claim will be denied. Please refer to the enclosed letter for the contact information of the appropriate Medicaid Regional Team.

Automated review finding

36 claims listed on letter.

21 re: 10061 vs 10060

Filed appeals for 35 of the claims w/ 100% success.

1 claim was not appealed due inconsistent documentation of laceration length.

CERT Audit
CERT Audit

REASON FOR AUDIT

This review was conducted based on data identified through the Comprehensive Error Rate Testing program (CERT). A large proportion of errors identified from the CERT program, both nationally and locally, have resulted from the inappropriate coding of evaluation and management (E & M) services. CERT is conducting numerous post-pay probe reviews to evaluate local evaluation and management billing and to provide education regarding these services.

CERT Audit

HOW THE OVERPAYMENT WAS DETERMINED

A randomly selected sample of forty claims for evaluation and management codes for emergency room care were selected for audit. The claims selected were for CPT 99323 - 99326.

The purpose of the audit was to determine if the services billed were reasonable and necessary and met other requirements for Medicare coverage. Our medical review staff examined the submitted documentation for the selected claims.

CERT Audit

MEDICAL REVIEW AUDIT DETERMINATION

You have received Medicare payment in error for an estimated overpayment of $1,169.90 for forty-four services on forty claims dated January 1, 2016 through June 30, 2016. This is not a request for payment. The Overpayment Recovery Unit will determine the actual overpayment when all claim adjustments are considered.
CERTAudit

A total of forty-four evaluation and management/emergency room services were examined. Sixteen services were allowed as billed. Thirteen services were downcoded from CPT 99285 to CPT 99284. Six services were downcoded from CPT 99284 to CPT 99283. One service was downcoded from CPT 99284 to CPT 99282. Three services were downcoded from CPT 99285 to CPT 99283. One service was downcoded from CPT 99283 to CPT 99282.

CERTAudit

CORRECTIVE ACTION TO BE TAKEN

Due to the provider error rate of 50%, prepayment review of your billing for service codes CPT 99283 – 99285 will be initiated.

CERTAudit

RECOUPMENT AND YOUR RIGHT TO SUBMIT A REBUTTAL STATEMENT

These Medical Review post-payment audit results have been forwarded to the Medicare Payment Correction Unit (PCU) for processing. This is not a request for payment. You will receive a future letter from the PCU with the final determined overpayment (final demand letter). That letter will provide an explanation of the procedures for recovery of the overpayment as well as your right to submit a rebuttal statement.

You have the right to submit a rebuttal statement to the PCU in writing within fifteen days from the date of the final demand letter. Your rebuttal statement should
CERT Audit

A. For services provided, the code billed was CPT 99285. Documentation supports the history as detailed, the exam as comprehensive and the decision making as moderately complex. For CPT 99285 "usually the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function" the reason this gentleman sought emergency room care was complaints of weakness, shaking, and chills, which had occurred in the morning of his visit. He stated on arrival to the emergency room that he "...feels well except he still feels slightly weak..." Evaluating these factors together, the service more closely meets CPT 99284 and was downcoded accordingly.

CERT Audit

This is an 87 year old gentleman who seeks this morning with some shaking spell. He felt like he had a shaking spell and has fever. His status after he woke up, felt this shaking spell and now feels well except he still feels slightly weak. Regarding the fever: he denies any headache, neck pain, neck stiffness, sore throat, nasal congestion, hoarseness, or ear and the patient denies any cough, congestion, epistaxis, hemoptysis, or shortness of breath. The patient denies any cardiovascular chest pain, palpitations, syncope, RNO, or otherwise. DI: States that he did not have "dry heaves" three or four times. He actually has no actual vomiting; however, there is no nausea. They did eat at O’Keely’s yesterday and they both ate the same thing and no other sick contacts. No drenches. No abdominal pain, no urgency, frequency, dysuria, hematuria and no skin rashes and no joint swelling or inflammation.

PAST MEDICAL HISTORY: One of long-standing hypertension. Black pain and right hip surgery.

SOCIAL HISTORY: The patient is done smoking, drink or use drugs. He lives with his wife.

CERT Audit

PHYSICAL EXAMINATION: Revealed a very pleasant 87 year old gentleman with temperature of 102. The blood pressure 140/90.

CNS: The patient is awake, alert and aware of surroundings. There are no focal findings. Mental status is normal. No illusion of thought. No muscle tremors. Conjugate deviation of the eyes without nystagmus, seeking or edema.

CHEST: Essentially clear without wheezes, rales, or rhonchi. There is no murmurization.

CARDIOVASCULAR: S1 and S2 normal and no 53 or 94 and no murmurs, rales or rhonchi.

ABDOMEN: Soft and nontender and normal bowel sounds. No hepatosplenomegaly and no hernias. No anorexia, good femoral pulses.

EXTREMITIES: Without edema, cyanosis. No cut and Horner’s is negative.

Skin: Healthy

PSYCHIATRIC: Oriented times 3. Appropriate.
CERT Audit

44 charts reviewed.
- CMS agreed with client on 16 charts
- 20 were 1 level downcodes
- 4 were 2 level downcodes
- 4 denied as billed by wrong provider
- Consultant agreed with CMS on 20 of the 24 downcoded charts.

Utilization Audit

This letter is to provide you with thirty days’ notice that the Department of Social Services, Office of Quality Assurance (the “Department”) will be performing an audit of Medicaid Assistance paid claims for services rendered by [Provider Name] during the period of [Date 1] through [Date 2].

Enrolled in the final report covering our audit of Medicaid claims paid during the period January 1, 2011 through December 31, 2013.

The final report shows that the overpayment due to the Department of Social Services is $3,529.725. Except as explained below, within 45 days from the receipt of this report, the Department will instruct [Provider Name] to deduct this amount from future payments to the provider identified above.
Qui Tam / Whistleblowing

- *qui tam pro domino rege quam pro se ipso in hac parte sequitur*, meaning "he who sues in this matter for the king as well as for himself."

- The False Claims Act allows people who are not affiliated with the government to file actions claiming fraud against the government.

Whistleblower #1

**INTRODUCTION**

1. For more than ten years, the above-named Defendants have created, employed, operated and contracted with fraudulent billing systems designed to systematically overcharge federal and state health care systems, including Medicare and Medicaid.

2. The fraudulent overcharges were achieved primarily by "upcoding" medical patient interviews and examinations, e.g., regularly charging for more complicated and more expensive services or procedures than those actually performed by physicians and other health care providers in emergency rooms and urgent care facilities.

3. By creating false and misleading medical records and correspondingly upcoded billing records, and by actively falsifying medical and billing records, Defendants intended to, and did, misuse funds due to be paid by federal and state health care systems.

4. This action is brought under the Federal False Claims Act, 31 U.S.C. §3729, et seq., and the various state false claims statutes.
Whistleblower #1

12. During the time period described in this Complaint, Relator has worked as a physician responsible for interviewing patients, investigating their ailments, and treating them.

13. Whistleblower #1 acquired direct personal knowledge of and non-public information about the Defendants’ fraudulent billing of federal and state health care systems.

Whistleblower #2

1. This is an action to recover damages and civil penalties on behalf of the United States of America, for violations of The False Claims Act arising from Defendants’ actions.

2. The scheme allows for skyrocket by, for example, shortening the time consuming tax area.

3. 'Review of Systems' procedure. This step was reduced to a single box check-off to generate higher billing codes.

4. "Standard billing codes" were used to manipulate the documentation.

5. The system for billing incorrectly documented a Level 5 billing code if the documentation indicated that the physician had reviewed all the electronic systems. The doctors were encouraged to routinely mark that they had reviewed all the electronic systems in order to increase their billing to achieve a Level 5 code as many times as possible.

6. Different electronic systems had been reviewed, presenting the physician to do more work when they had not, in fact, been reviewed.

7. When the doctors reviewed the chief complaint, they used the term "urgent and emergent" and "all other non-urgent or other" language to increase revenue.
Whistleblower #2

Wherefore, plaintiff prays for the following relief:
A. Full restitution to the United States of all money damages sustained;
B. For those times the dollar amount proven to have been wrongfully paid by, or withheld from the United States;
C. For maximum civil penalties for all false records, statements, certifications and claims submitted to the United States;
D. For costs of suit, reasonable attorney’s fees and the maximum relief sought;
E. For such other and further relief as the Court deems just and proper.

JURY DEMAND

Qui Tam Plaintiff hereby demands trial by jury.

Whistleblower #3

2. INTRODUCTION

1. Plaintiffs file this qui tam action against the Defendants for themselves and on behalf of the United States under the False Claims Act (FCA), 31 U.S.C. § 3729 et seq., and seek to recover damages and civil penalties from the Defendants for violations of the FCA based upon Defendants’ presentation of false claims to the United States for medical services and procedures allegedly performed by Defendants in the treatment of Medicare, Medicaid, and Tricare patients.

Whistleblower #3

13. Plaintiff was employed by [redacted] under the title of Billing and Office Manager. [Redacted] duties included coding the patient charts and preparing the claims for filing by the third-party billing company.

VI. Defendants’ Fraudulent Conduct

24. Since at least 2010, false claims for medical services have been fraudulently and knowingly presented at the Defendants’ directions to government health care programs by [redacted]. In numerous instances where 1) Nurse Practitioner (NP) or Physician Assistant (PA) services were billed under the name of and with the provider number of the attending physician who did not treat or evaluate the patient, 2) Nurse Practitioner (NP) and Physician Assistant (PA) services were billed under the name of and with the provider number of the attending physician who simply assigned the patient chart without documenting their evaluation of the patient.
AnMed Health Agrees to Pay $7 Million to Settle False Claims Act Allegations

- The settlement also resolves allegations that AnMed Health systematically billed a minor care clinic as if it was an Emergency Department, and billed Emergency Department services as if they were provided by a physician when, in fact, the services were rendered by mid-level providers. Each of these billing practices resulted in higher reimbursements to AnMed Health.

- ...arose from a lawsuit filed by a whistleblower formerly employed by AnMed Health under the whistleblower provisions of the False Claims Act.
- Whistleblower will receive $1,202,500 of the United States’ False Claims Act recovery.
- will also receive $850,136.50 from AnMed Health to resolve wrongful termination claims under the False Claims Act.

Appeal, Appeal, Appeal

- Always file at least one appeal of any findings that lower the assigned E&M code or decrease the reimbursement for services rendered.
Key Hot Spots in ED E&M

- 99283 vs 99284
- 99284 vs 99285
- Medical necessity is the key.
  - No longer a numbers game of counting elements.

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