Part B Insider (Multispecialty) Coding Alert

Physician Note: Rampant E/M Overbilling Prompts Violations and Millions in Fines

Plus: 99211 is not your friend for infusions.

The Justice Department continues to crack down on fraudulent E/M claims. The law clearly states that "providers are not permitted to bill both E/M services and a procedure on the same day under the Medicare program's regulations unless a significant, separately identifiable service has been performed."

But in one recent case, a group of Georgia dermatologists repeatedly "upcoded E/M services to higher levels than were appropriate, leading to overpayments by Medicare." The practice was found guilty and is forced to pay back the false claims $1.9 million accordingly under the False Claims Act, an April 18 DOJ news release revealed.

CMS maintains that a thorough understanding of the law is a good place to start to avoid overbilling. Other suggestions under their report, Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians, include taking detailed, readable notes, providing practice education and training, and performing in-house audits.

Lawbreakers like these not only hurt themselves, but by abusing the system, they make it more challenging for other physicians and the patients themselves.

"The improper billing of evaluation and management services cost the taxpayers millions of dollars each year and drain the Medicare Trust Fund," said **Derrick L. Jackson**, an OIG special agent, in the news release. "The OIG and the U.S. Attorney's Office will continue to hold health care providers like these responsible for improper claims."

Resource: To read more about these E/M false claims, visit www.justice.gov/usao-ndga/pr/dermatology-physicians-and-practice-pay-19-million-settle-false-claims-act.

In other news...

If you're still reporting 99211 (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional...) along with your drug infusion and injection codes, your insurer has some words of warning for you: Expect denials for the 99211 charge, even if you append a modifier.

According to the April 6 Palmetto GBA "E/M Weekly Tip," you cannot report 99211 "with a non-chemotherapy drug infusion code or a chemotherapy administration code. This also applies when it is billed with a diagnostic or therapeutic injection code on or after Jan. 1, 2005."

Other payers echo this sentiment. For example, United Healthcare's "Non-Chemotherapy Injection and Infusion Services" policy states, "E/M service code 99211 will not be reimbursed when submitted with a diagnostic or therapeutic Injection code, with or without Modifier 25 (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service). This very low service level code does not meet the requirement for 'significant' as defined by CPT®, and therefore should not be

submitted in addition to the procedure code for the injection."

Therefore, you should consider the nurse's work on the infusion or injection to be included in the payment for the administration code and should not report 99211.

Resource: To read Palmetto's Weekly Tip on this topic, visit www.palmettogba.com.