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Hospitals Pay $12.7M in CMP Settlement Over Pain Management Procedures, E/M Services

In a case that appears fundamentally to be about modifier 25, two Florida hospitals agreed to pay $12.7 million in a civil monetary penalty settlement with the HHS Office of Inspector General (OIG). Lee Memorial Health System, doing business as Lee Health, and Cape Memorial Hospital Inc., doing business as Cape Coral Hospital, allegedly billed Medicare, Medicaid and TRICARE for items or services that were false or fraudulent, according to the settlement. Cape Coral Hospital is part of Lee Health, which is in Fort Myers.

OIG alleged that from Jan. 1, 2011, through May 10, 2018, the two hospitals submitted claims "for certain professional and technical pain management procedures and evaluation and management services performed by two independent contractor physicians" at the two hospitals that failed to comply with federal health care program coverage criteria. The settlement, which was obtained through the Freedom of Information Act, stemmed from a self-disclosure. The hospitals were accepted into OIG's Self-Disclosure Protocol in July 2019. About $9.09 million of the settlement amount was restitution. Typically in self-disclosures, settlement amounts are 1.5 times the calculated damages.

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Managing Editor
Nina Youngstrom
nina.youngstrom@hcca-info.org

Senior Copy Editor
Bill Anholzer
bill.anholzer@hcca-info.org

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Because additional details weren't available from OIG, and Lee Health and its outside attorney didn't respond to *RMC*'s requests for comment, there's no way to know exactly what happened. But providers often face compliance challenges with procedures billed at the same time as evaluation and management (E/M) services, said Valerie Rock, a principal with PYA in Atlanta, who has no direct knowledge of the Lee Health allegations. "Physicians generally don't understand how to document and support E/Ms in addition to the procedure," she said.

Medicare doesn't pay physicians or other providers for E/M services (e.g., CPT codes 99213-99215) performed on the same patient on the same day as a procedure unless the E/M services are significant and separately identifiable. When services are significant and separately identifiable, providers append modifier 25 to receive reimbursement for the E/M services. Misunderstanding and/or misuse of the modifier has made it a top billing compliance risk area. Modifier 25 has been at the heart of several False Claims Act and civil monetary penalty (CMP) settlements and is the focus of a CMS comparative billing report.

Pain Management Has Its Gray Areas

In terms of pain management, physicians may be able to bill for both E/M services and injections/infusions for pain relief (e.g., facet joint injections) performed on the same patient at the same time depending on the circumstances, Rock said. During the E/M service, the physician takes the patient's history, does an exam and discusses medications, setting the stage for the pain relief. When the patient subsequently shows up for injections, there may not be a medically necessary reason for a separate E/M service. The injections themselves also must be medically necessary, and Medicare administrative contractors have local coverage articles articulating the coverage requirements for some of them.[1] "Usually it goes wrong when a patient is scheduled to come in for an injection and the E/M service is not supported separate from the injection," Rock said.

But it's not always black and white. "It gets gray whether the E/M is really supported uniquely from the injection," she explained. In other words, when the patient comes in with pain in a specific area and the physician's assessment focuses on that pain and administers an injection accordingly, "there is no E/M warranted." Generally, she said, the physician is doing that over and over.

But in a lot of cases physicians "take a wider look at patients" who have pain everywhere from conditions like rheumatoid arthritis, Rock said. When physicians are managing patients for more than one body system connected to the injection, they may have support for an E/M service. "You have to support why you're doing a more fulsome service or doing something separate," Rock said. Maybe the patient's appointment was for a hip injection but their shoulder also hurts. That precipitates an evaluation of the shoulder pain, which may be a separate E/M service. "It's kind of a fine line," she said. "If the doctor determines an injection is warranted, then you would do the injection."

To get their arms around this, Rock recommends providers run data on their use of injections and infusions with and without the reporting of an E/M or the percentage use of modifier 25 on E/M codes. They can compare the numbers to comparable providers in the state with respect to modifier use on Medicare comparative billing reports.[2] Local coverage determinations also are available for use of facet joint injections. "Make sure your review is apples to apples and get a sense of whether you're off track or not."

Contact Rock at vrock@pyapc.com. ✧

Endnotes

1. CMS, "Facet Joint Interventions for Pain Management," L38803, updated February 3, 2022, https://go.cms.gov/3KzSUgZ.
2. "Past Comparative Billing Reports," Comparative Billing Reports, accessed April 7, 2022, https://bit.ly/3JjtOkL.