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Implications of Undercoding and Strategies to Avoid the Dangers

Executive Summary and Outline: According to the American Medical Association, overcoding and misrepresentation of performed clinical services costs the healthcare system over $100 billion annually[i]. This includes failure to report on all services performed, also known as undercoding. Herein, we review the risks of performing fraud and abuse by undercoding, as well as the financial impact that it has on healthcare organizations. We will introduce ways to mitigate this risk by focusing on compliance education programs, including External/Internal audits, and following appropriate billing and coding practices.

I. Introduction

When it comes to mitigating compliance risk and audits, overcoding, also known as the billing and reporting of services not otherwise performed or supported, is often the focal point. What is rarely discussed or reviewed is the risk that comes with healthcare providers trying to "fly under the radar" by undercoding. What was once thought to be a way of mitigating the risk of an audit is no longer the case. By remaining conservative or not reporting all performed services, providers may actually draw greater risk to themselves. Undercoding presents an equal amount of compliance risk to providers and healthcare facilities; increases the rate of incorrect coding and claims processing; and puts providers at risk of inaccurate and in some cases, decreased reimbursement rates. Building a strong Auditing, Compliance and Revenue Integrity program is therefore foundational in preventing fraud and abuse.

II. Identifying Undercoding Risk

Undercoding occurs when providers code a lower level of service than performed and/or documented (i.e., downcoding) or fail to code and report all the services provided. There are two ways to describe undercoding: '1. Failing to report services performed at the encounter; 2. Under-reporting the level of service provided[ii]'. Failing to report on services performed is a misrepresentation of the service provided, particularly if it impacts the payer's decision on reimbursement.

We often see the second scenario occur when providers bill for Evaluation and Management ("E&M") services and are unsure of whether they've met all the requirements to bill level 4 or level 5. E&Ms are used across multiple specialties to evaluate and treat a patient's medical condition. It is commonly known as the way healthcare providers bill for an office visit, and are comprised of three components—history, examination, and medical decision making. Oftentimes, providers play it safe by reporting on a lower-level E&M (e.g., level 2 or 3), to avoid the risk of an audit. However, this intentional reduction or misrepresentation may have a financial impact on the patient's deductible and out of pocket (OOP) expense. One could argue that the provider may have reported a lower level of service to decrease the patient's OOP expense. Lack of coding training would not protect the provider from an audit, or worse, civil penalties from the False Claims Act ("FCA"), as there would be no argument to state that the down-coding was not to produce a financial incentive to the patient.

Providers under-code their claims for multiple reasons. In some cases, they may be unsure of billing and coding practices due to a lack of education. In others, it may be an attempt to mitigate risk in fear of payer scrutiny. Lastly, some providers may be trying to *increase* revenue by not reporting all services provided. Failure to report all services provided is essentially a misrepresentation of the work done and may impact the payer's decision on reimbursement—in some cases, resulting in higher reimbursements.

As seen in this example, some reasons for undercoding are more malicious than others. Regardless, this behavior places providers at risk of an audit. The Federal Civil False Claims Act (FCA), 31 United States Code (U.S.C.) 3729-3733[iii], generally protects the Federal Government from being overcharged for goods and services. However, this encompasses 'any person who knowingly submits, or causes the submission of, a false or fraudulent claim to the Federal Government.' In addition, 'No specific intent to defraud is required to violate the civil FCA.'[iv]

Example of undercoding for financial gain: *'Assume a provider sees a patient and performs three services: A, B, and C. Assume also that the applicable bundling rule establishes that service C is a component of service B, and that service B is a component of service A. Assume no exclusionary modifiers are appropriate or justified. If all three services were reported, only Service A would be paid. Knowing this, the provider omits the billing for Service B. The provider, therefore, reports Service A and Service C. Not knowing that Service B was provided, the payer allows payment for both services[v].*

III. External and Internal Audits

Seeking an external or internal audit to evaluate documentation, controls, and billing practices is key to mitigating risk. External audits led by subject matter experts are typically performed by Certified Coding Auditors and specialists unaffiliated with the healthcare facility or physician practice. An independent, external review and assessment of the medical coding and billing practices is vital for objective feedback and recommendations.

Internal audits are generally led by the physician practice or facility's Billing and Compliance department. However, not all facilities have the bandwidth to perform internal reviews on a continual basis, and external audits have become increasingly common.

The process of an external/internal audit typically requires the review and sampling of the provider's coding and documentation to determine whether there is sufficient information available to justify their coding and billing practices. A coding assessment can also be done to identify any physician outliers who may be at greater risk compared to their peers. This information can be shared with providers and internal coders as a training opportunity, instilling confidence in healthcare providers, and promoting positive billing behaviors. Providers are taught to document based on the patient's presenting problems, symptoms, and concerns—and include the appropriate medical plan based on what is necessary to treat the patient's condition, justifying medical necessity. Once documentation is completed, it is used to code the services rendered in their entirety, recognizing that some services may be bundled.

IV. Providing Compliance Education and Training

On average, as part of medical training, physicians receive approximately 3 hours of education on billing, coding, and compliance[vi]. In today's climate, the need to train, support, and educate healthcare providers on the False Claims Act has never been greater. According to the 2021 Medicare Fee-for-Service Improper Payment report, CPT code 99214 (outpatient office, established moderate, 30–39-

minute visit) contained an incorrect coding rate of 56% and a projected improper payment rate of $340,272,667[vii]. (The report also listed the top 20 services with incorrect coding, which ranged from specialties such as inpatient and outpatient hospital visits to home health and dialysis services.) External/internal audits are the best ways to provide this necessary education and training because chart sampling is used to directly target risky behavior. That information is then used to focus the training on identified opportunities for improvement.

Revenue Integrity (RI) programs are another integral way to ensure consistent education. Healthcare facilities employ Certified Coders and Auditors that specialize in a wide range of services to partner with different physician groups, departments, or specialty divisions within their organization. The RI team provides continuous sampling of charts to monitor progress and billing behavior, and also offers feedback to providers. A follow-up review is scheduled 3 months later to assess progress. In addition, RI can assess the department's processes for further performance improvement opportunities related to the billing and revenue cycle process.

V. Conclusion

Undercoding is a lost revenue opportunity and a potential violation of the False Claims Act. Failure to report services rendered is misrepresentation of the care provided and impacts both provider and patient reimbursement. For consumers, improper payments can mean higher premiums and OOP expenses, as well as potentially reduced benefits. For employers, improper payments increase both the cost of providing insurance benefits and the overall cost of doing business. Beneficiaries also can potentially be harmed through the compromising of their medical records, such as receiving services that are not appropriate for their actual health issues [viii]. This includes *not* receiving services that may be medically necessary due to insufficient documentation and coding to support or justify the need.

In 2012, the Institute of Medicine estimated that the U.S. healthcare system loses about $765 billion a year to waste. Of that $765 billion, about $210 billion is attributable to unnecessary services, $190 billion to excess administrative costs, $130 billion to inefficiently delivered services, $105 billion to excessive prices, $75 billion to fraud, and $55 billion to missed prevention opportunities.[ix]

External and internal proactive audits are necessary to mitigate any potential risk of unethical and non-compliant billing practices. Proactive audits are at the foundation of building any successful compliance program. In addition, implementing a RI training program can assist with consistent evaluation of controls and billing practices, as well as ensure that risky behavior is identified at the earliest stages, to take corrective action before it's too late.

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