A Fair Bill for Care

Remedies for the all-too-common problem of overcharging for medical rehab services

Consumers expect to get what they pay for. So imagine your surprise if the following happened to you: You pull up to a gasoline pump, where the sign says unleaded regular costs $3 a gallon. It's full-serve, and you ask the attendant for five gallons. When he's done pumping, you hand him $15. In this transaction, the commodity (gasoline) was priced in measurable units (gallons). For your $15, you expected to receive five gallons of gasoline.

What about if the tank would only take 4.75 gallons? You'd expect to be charged $14.25. Hand over $15 and get back 75 cents in change. Not getting any change back would constitute a rip-off, right?

Medical Care and Unit Pricing

Medical providers are generally required to use a uniform system for submitting claims to insurance carriers. Medical procedures are standardized through the Current Procedural Terminology (CPT) coding convention. The CPT code indicates the level of provider contact required for a procedure. Some procedures require supervision. Many others, however, require direct, one-on-one provider contact.

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The provider's charge per unit for individual CPT codes varies based on the service performed, the time involved and the nature of the service. Reimbursement for those codes varies depending on the payer source. Generally, fee schedules memorialize the assignment of prices for each procedure unit.

While fee structures may vary, the CPT coding convention is consistent. For example, CPT Code 97110 requires direct, one-on-one contact by a therapist or physician, in 15-minute increments, regardless of practice locale. Physical medicine procedures, like gasoline, are sold in measurable quantities. The CPT code provides the basis of the understanding between the medical provider and the insurance company. The CPT clearly defines the "product" sold by the provider, a description of the product, and the measurable unit of the product in time increments. Just as a consumer pays for gasoline by the gallon, the insurance company pays for CPT codes by the unit.

Representations of Time

When the provider spends less time delivering the procedure than the CPT code requires, there is a mechanism for the provider to reflect that the services performed were reduced. The CPT manual specifies using "Modifier 52" to accompany the respective CPT code to reflect reduced services. For example, a provider that performs 20 minutes of a CPT code that is expressed in 15 minute increments is faced with a billing choice: to bill only one unit, though the duration of the service exceeded the 15-minute time requirement for that code, or to bill two units of that CPT code, and indicate to the insurance carrier that the service was reduced? Oftentimes the provider instead chooses a third option: bill two units, without any modifier.

Medicare has addressed this issue through what's known as the "eight-

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minute rule," which states that "[p]roviders should not bill for services performed for less than 8 minutes." The CMS transmittal provides a complete delineation of time thresholds to quantify the required amount of time to bill a unit of service and additional units of service. Medicare's rule recognizes that providers are seldom able to provide exactly 15 minutes or 30 minutes of service. The rule strikes a balance of fairness between the provider and the payer. It implicitly recognizes that 16 minutes of service — one more than the defined unit requirement — should not be translated into two units of service. Similarly, eight minutes of service (30 seconds more than the halfway point for the unit requirement) qualifies for the billing of one unit of that CPT code.

A provider's use of the eight-minute rule or the 52 modifier appears to be acceptable mechanisms to accurately bill for services. The provider, as a matter of prudence, should document the amount of time spent performing the procedures. The treatment notes should substantiate the procedures billed on the CMS 1500 claim form (see the sidebar on this page for more about this form). For services that fall below the thresholds of the required time per unit, the provider has an obligation to ensure that the claim form accurately represents the payment sought. Insurance carriers, like ordinary consumers, have a reasonable expectation to pay only for what they receive.

Representations of Service

In the rehabilitation spectrum, a provider's representations pertaining to the mechanism of service delivery are just as important as the representations concerning time. Many physical medicine CPT codes require direct, one-on-one contact by the provider. Under a literal interpretation of "one-on-one," two patients cannot simultaneously receive treatment. The provider cannot be "one-on-one" with two patients at the same time.

The provider's use of CPT codes requiring direct, one-on-one contact has important implications. First, by billing a one-on-one code, the provider is representing that the service was just that – performed in a one-on-one fashion. Second, the use of these CPT codes has a direct impact on the time requirement. Because the billing of each unit of a one-on-one code requires 15 minutes, the provider cannot fulfill this 15-minute requirement if those 15 minutes are shared with another patient. Simultaneous treatment of two or more patients is more accurately and correctly described by the use of the group therapy code.

What's Inside a CMS 1500 Form

The CMS 1500 form functions as a bill of sale, representing to the insurance carrier which procedures were performed, the cost per unit and the quantity of units delivered. The provider's submission of the CMS 1500 form to the insurer is an attestation to several representations. First, the provider is certifying that the services delivered were medically necessary. Second, the provider is representing that the services billed for were actually performed. Third, the provider's responsibility is to accurately bill for the services provided. An insurer has the expectation of receiving what it is paying for. When a lesser quantity is delivered, the insurer's expectations are no different than any other consumer's.

A Legal Perspective

Inaccurate billing can invite trouble for a medical provider. Just how much trouble often depends on whether the inaccuracies were intentional or whether the result of negligence. This important distinction determines whether the billing was fraudulent. Intent is generally harder to prove.

Medical providers are obligated to present an accurate bill to the insurance carrier for services rendered — an obligation that may be reinforced by statute. The tort of negligent misrepresentation is established by the satisfaction of five elements:

1. The misrepresentation must occur in a business or professional capacity.
2. The medical provider must breach the obligation to present accurate bills to the insurance carrier.
3. The provider's breach of this obligation must result in damages to the insurer.
4. The insurance carrier must have relied on the medical provider misrepresentations.
5. The provider's misrepresentations must have caused the insurer's damages.

To put the elements in perspective, an insurer experiences damages when it pays more to the medical provider than it should have paid. The breach occurs when the provider submits claims for services that differ from what was actually performed. The insurance carrier's payment to the medical provider demonstrates that the insurance carrier justifiably relied on the CMS 1500 claims submitted by the provider. The provider's submission of inaccurate claims is the causal factor of the damages.

In contrast, intentional misrepresentation is when a provider misrepresents a material fact, knowing or believing that the claim form contained false information. The provider intends to receive payment from the insurance carrier, and the carrier relies on the claim submitted by the provider. The provider's submission of the claim causes the damages sustained by the insurer. Unlike negligent misrepresentation, the insurance carrier needs to establish that the intent of the provider was to engage in fraudulent billing. With an intentional misrepresentation claim, the provider should take no comfort in claiming lack of knowledge or that they were mistaken. Providers cannot turn a blind eye to their billing operations and recklessly bill claims that they should know are inaccurate and misleading.

Providers' Legal Defenses

The first line of defense for medical providers in an insurer's negligent representation lawsuit will likely be that the CMS 1500 claim form is an accurate representation of the services delivered. The provider would need to corroborate this contention by substantiating the claim forms with the treatment

documentation. Barring the ability to demonstrate this, one of the strongest defenses available to the provider may be the legal theory of "custom or usage."

The "custom or usage" defense arises in response to the insurer's claim that the provider has breached the duty to present accurate claims. The insurance carrier asserts that the provider's performance of their duty has fallen below the applicable standard. In response, the provider may claim that the industry standard is actually created by the conduct of other industry participants — that they are billing the same way everyone else in the field is billing. The "Everybody's doing it" defense. As applied to billing for CPT codes with time requirements, the provider is attempting to justify billing two units of service for a code performed for 20 minutes (a) because no one else is using modifiers; (b) the eight-minute rule is only applicable to Medicare; and (c) every provider purportedly bills two units for 20 minutes of service.

Another provider defense is to claim billing inaccuracies were a mistake. But in that case, the insurance company may still have recourse under the "Unjust Enrichment Doctrine," which permits recovery by an insurance company where a provider wrongly receives payment. The legal theory is one of fairness. It would be unfair for a provider to receive payment in excess of the value of the services actually delivered. This doctrine is the basis of the insurer's recoupment of overpayments to the provider.

Legal Recourse

Insurance carriers bear a tremendous financial burden from inaccurate billing. Consider the following example. A provider's fee for one unit of a direct, one-on-one contact code is $50. The provider delivers 18 minutes of that CPT code, and charges two units. The provider treats 12 patients in that day. By the end of the day, the provider has billed for 24 units of the one-on-one contact code. This represents 360 minutes (six hours) of treatment. In reality, because the provider billed two units for the 20 minutes of treatment provided, only 240 (four hours) should have been billed. At $50 per unit, the insurance carrier was overcharged by $400. The damages multiply over the course of each patient's treatment.

The insurance company carries the burden of proof in any action alleging fraud, negligence or the recovery of overpayments/improper payments. This can be a daunting challenge. The provider's submission of CMS 1500 claim forms reflecting two units CPT code is clearly inappropriate when only 16 minutes of service were performed. Less clear is whether two units were improper when 23 minutes were performed. The latter is acceptable by Medicare standards; the former is not. And, unless provided by statute or contract, Medicare's rules are not binding on other insurers. After 15 minutes of service are performed, the time from minute 16 to minute 22 has not reached the critical mass for a mathematical round up to the next billable unit.

The provider's representation of the time spent may difficult to challenge. The most readily available resource to challenge the time billed is the clinical documentation. The clinical documentation should substantiate the CPT codes used and provide a roadmap for reproduction of the treatment delivered. The discovery process in litigation also provides data to solidify the insurer's claim. Discovery allows the party to seek information to develop the case they have established. The information sought must be "reasonably calculated to lead to the discovery of admissible evidence" at trial. The party seeking to prove the case may not build the case on suspicions and use the court procedures to manufacture the case.

Discovery may provide a glimpse into the scheduling functions of the provider's billing system. Many billing systems are equipped with scheduling functions.

An electronic scheduler is capable of demonstrating that both A and B were treated at 9 a.m. by the same provider. Furthermore, the scheduler can reveal that the provider had patients before 9 a.m. and after 9 a.m. Under this scenario, the provider may have a difficult time substantiating billing four one-on-one CPT units for each patient in the course of that hour's treatment. The distinction between 16 minutes and 22 minutes becomes less important because the one-on-one requirement determines how many units can actually be billed. The assumption is that one-on-one means individualized care, and not simultaneous care.

An expert witness in the Florida case, *State Farm v. Physicians Injury Center*, perhaps captured the essence of the issue, saying: "Coding is based solely upon the medical record and is a material factual representation by the physician regarding the medical service or procedure performed and documented in the medical record. The use of a CPT code is a representation that the medical service has been provided in its entirely, including proper documentation of the service; otherwise stated, a medical service has not been completely performed unless the service has been properly documented."

About the Author

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