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ACC EXPERT CONSENSUS DOCUMENT

ACC Expert Consensus Document on Ethical Coding and Billing Practices for Cardiovascular Medicine Specialists

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EXECUTIVE SUMMARY

This document provides guidance to cardiovascular specialists on appropriate and ethical coding of physician services and procedures.

The rapid evolution of coding practice and policy has confused physicians and office personnel about how to code for physicians' services. Recent attempts by the federal government to identify inappropriate or fraudulent claims have increased concern among physicians that unintentional mistakes in coding could lead to prosecution for Medicare fraud.

We surveyed professional medical societies and coding professionals for guidelines on appropriate and ethical

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Abbreviations and Acronyms

ACC = American College of Cardiology
AHA = American Heart Association
AMA = American Medical Association
CCI = Correct Coding Initiative
CPT = Current Procedural Terminology
DOJ = Department of Justice
HCFA = Health Care Financing Administration
IL = Intermediary Letter
OIG = Office of the Inspector General
PATH = Physicians at Teaching Hospitals

coding of physician services. Cardiovascular coding experts were consulted for cardiovascular coding applications of ethical coding principles.

Factors making accurate coding difficult include frequent changes and ambiguity in codes and in national Medicare coding policy. Physicians may be subject to accusations of fraud for coding performed by office personnel if coding is incorrect and the physician knew or should have known that the coding practices were incorrect. However, most pitfalls in coding can be avoided with a thorough knowledge of codes and coding policy. It is the ethical responsibility of physicians to code for their services accurately, and accurate coding has the additional benefit of minimizing exposure to allegations of Medicare fraud. Physicians should advocate that the federal government and insurance carriers accept their ethical and fiduciary obligation to reimburse for appropriate services quickly and efficiently.

I. PREAMBLE

The present document is an expert consensus. This type of document is intended to inform practitioners, payers and other interested parties of the opinion of the American College of Cardiology (ACC) concerning evolving areas of clinical practice and/or technologies that are widely available or are new to the practice community. Topics chosen for coverage by Expert Consensus documents are so designated because the evidence base and experience with the technology or clinical practice are not sufficiently well developed to be evaluated by the formal ACC/American Heart Association (AHA) Practice Guidelines process. Thus, the reader should view the Expert Consensus documents as the best attempt of the ACC to inform and guide clinical practice in areas where rigorous evidence is not yet available. Where feasible, Expert Consensus documents will include indications and contraindications. Some topics covered by Expert Consensus documents will be addressed subsequently by the ACC/AHA Practice Guidelines process.

II. INTRODUCTION

This document provides guidance to cardiovascular specialists in the areas of ethical and appropriate coding and billing for services they provide. It is consistent with previous position statements published by the ACC in 1990 from the 21st Bethesda Conference on Ethics, and in 1997 from the 29th Bethesda Conference on Ethics (1,2). These statements emphasize the ethical obligation of cardiologists to place the patient's interest first, to maintain high moral standards in all aspects of medical practice and to seek only appropriate compensation from patients and insurers. The principles discussed in this document are independent of the current controversy over guidelines for coding Evaluation and Management services (3).

Although the application of ethics to coding practices may be complex, the ethical principles relevant to this discipline are not hard to grasp (4) (Table 1). The most important ethical principles relevant to this report are justice and veracity. Justice in this context is defined as receiving that to which one is entitled. Physicians are entitled to receive compensation for their services; accurate coding of services is a prerequisite to receiving fair compensation. Veracity is truth-telling. Physicians are obligated to report truthfully to insurers, by accurate coding of services, what services were provided. Most references to ethical practices in this report are derived from the principles of justice and veracity.

The importance of coding for services and procedures has evolved and increased rapidly in recent years. Ten years ago, coding was seen as a method to classify the services and procedures that physicians provided to their patients. Since then, coding has evolved into a system used principally to determine (and limit) the reimbursement physicians receive

Table 1. Ethical Principles Relevant to Coding Practices

Ethical Principle	Definition	Example of Ethical Violation
Nonmaleficence	Obligation to not harm the patient	Unnecessary services could result in harm to the patient Inappropriate coding to increase physician revenue may increase out of pocket expense to the patient
Justice	Receiving that to which one is entitled	Inappropriate coding to increase revenue beyond that normally provided for the service
Veracity	Obligation to deal honestly with patients and colleagues	Coding that misrepresents the services provided
Confidentiality	Obligation to protect the privacy of information that was privately disclosed	When the medical record is used as an audit tool, patient confidentiality may be compromised

Table 2. Major Changes in CPT Coding and Health Care Financing, 1965–1999

Year	Event
1965	Passage of the Medicare Act established federally financed medical care for elderly Americans.
1966	The American Medical Association published the first edition of *Physicians' Current Procedural Terminology.*
1977	The AMA published its fourth edition of *Physicians' Current Procedural Terminology,* called CPT-4. The coding system in CPT-4 was based on the 1974 California Relative Value Study and used five-digit codes and two-digit modifiers, similar to today's CPT system.
1983	The American Medical Association (AMA) and the United States Department of Health and Human Services agreed to use CPT-4 coding for reporting services provided under Medicare Part B. CPT-4 has been updated yearly since 1984 and published yearly as CPT 1984 through CPT 1999 by the AMA CPT Editorial Panel.
1989	The Omnibus Budget Reconciliation Act of 1989 mandated the development of the Resource-Based Relative Value System (RBRVS) for physician work, initiated in 1992 and phased in through 1996. (The federally mandated 5-year review of the RBRVS was completed in 1996, and revisions were implemented in January 1997.)
1996	The Correct Coding Initiative was initiated by the Health Care Financing Administration (HCFA) to clarify ambiguities in coding of services relating to bundling or unbundling of services. The resulting National Correct Coding Policy has undergone three revisions in 2 years.
1997–1998	HCFA's initiative to revise Evaluation and Management (E & M) coding guidelines to make E & M services easier to audit stalled when physicians vehemently objected. Currently two previous sets of E & M guidelines are recognized by the HCFA.

for their services. Recommendations for correct coding have been published in the American College of Cardiology's *Practical Reporting of Cardiovascular Services and Procedures* (5), but the American College of Cardiology has not specifically addressed the ethics of coding and billing. These issues have been addressed by several other professional societies (6–10).

CODING FOR PROCEDURES AND SERVICES: DIFFICULT AND DANGEROUS

Change and ambiguity. Ambiguities and major changes in coding policy and health care financing (Table 2) have made accurate coding and billing for medical services increasingly difficult over the past two decades. Even coding experts find current national coding policies to be ambiguous. Recognizing this, the American Medical Association (AMA) regularly publishes clarifications of coding policy in its newsletter *CPT Assistant.* The Health Care Financing Administration (HCFA) has undertaken major projects to clarify coding policies, including the Correct Coding Initiative (11) and the recent Evaluation and Management documentation guidelines revisions (12). Local Medicare carriers attempt to clarify local policies through their own publications. Despite these efforts, there is widespread confusion among physicians and coding personnel about coding and insurer payment policies.

Complexity. Current Procedural Terminology (CPT) codes and coding policies are so complex and difficult for physicians to use that correct coding has become an industry. Correct use of CPT codes requires extensive experience and training (13,14). Certification in coding physician services has been offered by the American Academy of Professional Coders since 1988. The American Health Information Management Association also offers a Certified Coding Specialist–Physician-based program, which provides instruction and certification in coding physicians' services. Seminars on coding are offered by many consulting companies, and the AMA sponsors annual CPT Update seminars to publicize changes in the CPT system.

Financial pressures. Most cardiologists have experienced reduced compensation for their services; many feel that this is unfair. Physicians may compensate by working harder, providing additional legitimate services to patients. Another response may be more careful coding, including legitimate services that in the past were performed but not routinely billed. Physicians may also be tempted to code "aggressively" with inappropriate or unethical coding strategies. This article points out some of these unethical practices so that cardiologists may avoid them and the problems they can cause (15,16).

CODING VERSUS PRICING VERSUS BILLING

This document draws distinctions among coding, billing and pricing. Coding is the process by which a service or procedure is labeled with a code (either numerical or alphanumerical) to categorize the service or procedure. Billing is the submission of charges or claims for payment for services rendered. Pricing, the fee a physician sets for a particular service, is not addressed further in this document.

CORRECT CODING PRACTICES

Speak the language. Procedures and services performed by physicians are reported using the American Medical Association's CPT coding system. The goal of the CPT system is to provide a uniform language for the accurate description of physicians' services. Other coding systems are used for different purposes:

Table 3. Fundamentals of Accurate Coding

1. Provide adequate and legible documentation of services and procedures. Estimates of face to face patient encounter time or floor time (time spent on the inpatient floor with the patient or the patient's chart) are necessary for some evaluation and management codes (17).
2. Learn the CPT coding system. Provide office staff with enough formal training to make them coding experts.
3. Consider every patient encounter to be a unique situation. Avoid routine coding. For example, do not code every established patient clinic visit with the same evaluation and management code, when in fact some visits should be coded with less complex and others with more complex codes. The documentation for each patient encounter must support the CPT code assigned to the encounter.
4. Add modifiers to procedure codes when appropriate. Most modifiers identify a variation from the usual service described by that code. Often this distinction is so subtle that the physician performing the procedure must personally specify the modifier instead of leaving coding personnel to deduce it from the chart.
5. Seek written instruction from the local Medicare carrier, the AMA Department of Coding and Nomenclature, the American College of Cardiology or the HCFA when there is doubt regarding appropriate coding.

Abbreviations as in Table 2.

1. HCPCS, the Health Care Financing Administration's Common Procedure Coding System, contains three levels of codes. Level I consists of the AMA CPT codes. Level II includes codes that cover materials (drugs, disposable supplies) used in providing the services reported by CPT codes. Level III includes local codes.
2. ICD-9-CM, the World Health Organization's *International Classifications of Diseases, Ninth Revision Clinical Modification* coding system, is used to code diseases. Volumes 1 and 2 list codes for diseases that can be paired with CPT codes to demonstrate medical necessity of the services provided. Volume 3 is used by hospitals to identify procedures. ICD-9-CM is updated annually by the ICD-9-CM Coordination and Maintenance Committee, which consists of members of the National Center for Health Statistics and the HCFA.

Current Procedural Terminology has become the common language of coding physician services and procedures across the United States. (Occasionally other coding systems may be used by individual insurers to describe physicians' services, but these are encountered rarely.) This document focuses on ethical and accurate coding using the CPT system. Physicians can facilitate accurate coding by following the practices listed in Table 3.

Obtain expert advice. Physicians should be sure that coding is performed by trained personnel, supervised or checked by experts and audited internally for accuracy. Office personnel should keep up to date on changes in coding policy by attending seminars and updating of coding manuals yearly.

Consulting companies have responded to confusion about correct coding practices with coding seminars and on-site consultations. A legitimate goal of these companies is to help physicians avoid losing income due to inaccurate coding. Some coding consultants may advocate "aggressive" or "creative" coding practices (18). For example, one firm advertises a seminar that "discusses secrets, legitimate loopholes and inside information that managed care organizations and Medicare would rather you didn't know. More specifically, it is solely designed to increase cardiology reimbursement." Some coding practices advocated by consultants may border on the inappropriate or unethical (7). Material presented by cardiology coding consultants at large conferences has in some cases been inaccurate. If a physician is audited by the federal government, inaccurate advice from a consultant does not excuse incorrect coding practices.

Ambiguities in the CPT coding system inevitably produce controversy over coding practices, and "honest mistakes." To help disseminate accurate coding information, the ACC contracted with a consulting firm to develop a coding seminar that has been presented many times around the country since 1994. Information provided in these seminars is reviewed by ACC staff to ensure accuracy. The American College of Cardiology seeks to reduce or eliminate coding advice or practices that are inappropriate, incorrect or unethical. Some of these practices are discussed below.

Avoid upcoding. Upcoding is the replacement of the most appropriate code for a service or procedure by a code for a more complex service. This practice is unethical when it is done intentionally to provide higher reimbursement to the physician. (Inadvertent occasional upcoding or downcoding is inevitable because of the complexity of the CPT coding system and its documentation guidelines. If done inadvertently this is not unethical.) However, while inadvertent upcoding may not be unethical, it could be questioned by the Office of the Inspector General, and physicians could be subject to accusations of fraud for incorrect coding.

> *Example:* Assigning an evaluation and management code to an established patient visit. If the service and accompanying documentation most accurately corresponded to a given level of service but the service were coded as a higher level service, it would be upcoding. If done intentionally to increase payment this would be inappropriate, unethical and possibly fraudulent.

Systematic upcoding involving Medicare could result in punitive fines and even prosecution for fraud. To avoid the chance of an audit detecting upcoding, some physicians routinely code all evaluation and management services at an average level, assuming that upcoded services average out downcoded services. However, this could lead to some patients paying inappropriately high fees, and the unusual coding pattern of the physician's Evaluation and Management services might trigger a HCFA audit.

Example: A physician codes *all* established patient outpatient visits with the intermediate level CPT code 99213, regardless of the true complexity and work involved with each visit. The physician never uses the lower level codes 99211 or 99212, or the higher level codes 99214 or 99215. This is unfair to patients who have a low complexity visit deserving of a 99212 code because their copayment with the 99213 code may be inappropriately high. The unusual coding pattern for this physician (many 99213 services, no 99211, 99212, 99214 or 99215 services) can trigger a HCFA audit.

Avoid unbundling. Unbundling is defined in the National Correct Coding Policy Manual as "the billing of multiple procedure codes for a group of procedures that are covered by a single comprehensive code" (11). Unintentional unbundling can result from misunderstanding of coding. However, unbundling done intentionally (e.g., to increase physician compensation) is inappropriate, and may be illegal. Several professional societies have condemned this practice (19,20). Two types of unbundling are most relevant to cardiologists:

1. Fragmenting one service into component parts and coding each component part as if it were a separate service.

   Example: A coronary intervention procedure on one lesion on one day might include rotational atherectomy followed by stenting followed by poststent angioplasty balloon dilation. The appropriate coding approach would be to use CPT code 92980 for coronary stenting. It would be unbundling to code for coronary atherectomy (92995), and coronary angioplasty (92982), and coronary stenting (92980).

2. Reporting separate codes for related services when one comprehensive code includes all related services.

   Example: Left and right heart catheterization performed together should be coded with CPT code 93526 (combined left and right heart catheterization). It would be unbundling to code 93501 (right heart catheterization) in addition to 93510 (left heart catheterization).

For many procedural codes there is ambiguity about what specific services are included in the codes. This ambiguity often leads to genuine disagreement for specific codes over what constitutes unbundling.

Example: A temporary transvenous pacemaker is placed (CPT code 33210) during coronary angioplasty. The HCFA considers temporary pacemaker placement to be an integral part of angioplasty and considers it unbundling to code the temporary pacemaker placement in addition to the angioplasty. The contrary viewpoint is that temporary pacemaker placement is *not* an integral part of angioplasty, is not performed routinely with angioplasty and requires work in addition to the angioplasty. If this were true (and if the HCFA agreed) then coding the temporary transvenous pacemaker code in addition to the angioplasty code would be appropriate and would *not* constitute unbundling.

Ambiguities in CPT codes led to so many questions about what constituted unbundling that the HCFA initiated the Correct Coding Initiative (CCI) in 1994. The HCFA contracted with a consulting firm to review all CPT codes to determine which pairs of codes represent unbundling when coded together. In 1996 the HCFA implemented Phase I of the CCI, naming 83,000 code pairs that would be rejected for payment if billed for the same patient on the same day. Altogether, in the first four phases of the CCI the HCFA has proposed 136,000 code pairs as representing inappropriate coding. Physicians have convinced the HCFA to delete thousands of these from the list of "forbidden" code pairs (Table 4). Many thousands more were challenged, but ultimately were retained by the HCFA, which makes final decisions about its own payment policies. Medicare carriers now screen for unbundling of services (as designated in the National Correct Coding Policy Manual) and refuse to pay for unbundled codes.

Seek advice about coding codeless procedures. Current Procedural Terminology codes are assigned by the AMA CPT Editorial Panel to services and procedures it determines to be clinically effective, widely dispersed and performed frequently. Services without a CPT code are often not reimbursed by local Medicare carriers. Strategies to use in this situation include the following:

1. Seek written instruction on coding from the American Medical Association Department of Coding and Nomenclature, the American College of Cardiology, the HCFA or the local Medicare carrier.
2. Use the unlisted cardiovascular procedures code (93799) and supply supporting documentation with the claim.
3. Propose a code for the procedure. Individuals can submit a proposal for a code to the American Medical Association Department of Coding and Nomenclature, or can request that the ACC submit a coding proposal. The process of obtaining a new code usually takes 2 years.
4. Finally, physicians sometimes describe their service or procedure by using a code for a different service. This is common when a new procedure without a CPT code includes components of an established (usually less complex) procedure with a CPT code. To obtain some reimbursement for the new procedure, physicians code for the old procedure. The appropriateness of this is not always clear, and should be discussed with the local Medicare carrier.

Table 4. The American College of Cardiology's Efforts to Influence Cardiovascular Code Listings in the National Correct Coding Policy

Date	Action
Phase I of the Correct Coding Initiative	
December 1994	Phase I of the CCI lists 94,000 "inappropriate" coding combinations, including 149 "inappropriate" cardiovascular code pairs.
March 1995	The American College of Cardiology (ACC) challenges 90 of the "inappropriate" cardiovascular code pairs, recommending they be deleted from the CCI forbidden code pairs list.
October 1995	The Health Care Financing Administration (HCFA) removes 5,711 code pairs from the CCI Phase I list including 42 of the 90 contested cardiovascular code pairs.
January 1, 1996	The HCFA implements the CCI as the National Correct Coding Policy, including 83,000 code pairs that were not contested.
April 1996	The ACC again challenges 28 of the remaining 48 cardiovascular code pairs.
October 1996	The HCFA removes eight of the 28 challenged code pairs from the CCI list.
December 1996	The ACC again challenges three of the remaining code pairs on the CCI list.
June 1997	The HCFA removes these three challenged code pairs from the CCI list.
Phase II of the Correct Coding Initiative	
May 1996	The HCFA releases Phase II of the CCI with 16,000 new "inappropriate" code pairs, including 97 cardiovascular code pairs.
August 1996	The ACC challenges 64 of the cardiovascular code pairs.
December 1996	The HCFA removes 17 of the contested 64 cardiovascular code pairs from the CCI Phase II list and allows 40 others to be used with the 59 modifier.
Phase III of the Correct Coding Initiative	
May 1997	The HCFA releases Phase III of the CCI with another 15,000 "inappropriate" code pairs. The list includes 704 cardiovascular code pairs (most are unimportant HCPCS codes).
June 1997	The ACC challenges 54 of the cardiovascular code pairs. Several of these are excluded from the 1998 version of the CCI.
Phase IV of the Correct Coding Initiative	
July 1998	The HCFA releases Phase IV of the CCI with another 12,754 "inappropriate" code pairs, including 2,132 cardiovascular code pairs.
October 1998	The ACC challenges 2,033 of the cardiovascular code pairs, recommending that they be removed from the CCI forbidden code pairs list.

Example: Transvenous intra-atrial cardioversion for atrial fibrillation is an effective and clinically useful procedure, but does not yet have a CPT code. Some cardiologists code it with the code for external cardioversion (92960), a less complex service. Their rationale is that since both transvenous atrial cardioversion and external cardioversion use electrical energy to convert atrial fibrillation to normal sinus rhythm, the transvenous procedure is just a variation of the external procedure. In this example, the physician is reimbursed for a simpler procedure than was actually performed. In contrast, it would seem unethical for a physician to perform a simpler procedure without a code and bill for a more complex and remunerative procedure with a code.

Seek advice about dealing with code ambiguities. Ambiguities in CPT codes can lead to coding practices that seem justifiable to the physician but appear to insurers to be efforts to systematically "game" the system. When the appropriate CPT code for a particular situation is unclear, the physician should be aware that "creative coding" may come under the scrutiny of auditors and lead to charges of overbilling. When such ambiguities arise, it is prudent to consult with the local Medicare carrier or the AMA Department of Coding and Nomenclature.

Example: A 2-day stress/rest single photon emission computed tomography myocardial perfusion imaging study is usually coded 78465 (multiple studies, at rest and/or stress). An alternative (and more remunerative) strategy is to code with 78464 (single study at rest or stress) each day. Cardiologists might justify the latter approach by citing the higher practice costs of a second visit and intravenous line placement. However, routine use of this strategy might lead to claims denial or even a HCFA or Department of Justice (DOJ) audit. It would be prudent to seek advice from the HCFA or the AMA before implementing such an aggressive coding strategy.

Use modifiers appropriately. Modifiers are two-digit numbers appended to five-digit CPT codes to indicate an unusual circumstance that will affect reimbursement for the service or procedure. The decision to use a modifier when coding a particular service or procedure may be a matter of judgment, and there is the potential for abuse of modifiers to influence reimbursement. Occasional inadvertent mis-

takes are inevitable; the intentional misuse of modifiers to increase reimbursement would be inappropriate, unethical and possibly illegal. Documentation should be included with claims to describe the unusual circumstances denoted by the modifier. A more complete discussion of modifiers is found in CPT '99 (21).

Example: Modifier −22: Unusual procedural services. This modifier suggests that additional reimbursement is appropriate because unusual additional services were provided. For example, complex multibranch coronary angioplasty is appropriately coded with the single-vessel angioplasty code (92982), but may involve twice the work, time, risk and difficulty of conventional angioplasty. A claim including code 92982-22 with appropriate documentation may result in increased reimbursement from some Medicare carriers.

Example: Modifier −59: This modifier is used whenever a pair of codes is submitted that represent unbundled codes according to the HCFA's Correct Coding Initiative. The modifier indicates that the services or procedures were provided separately and are therefore not unbundled and are both reimbursable. This modifier is also used when several procedures are performed on different anatomic sites, or by different incisions, or at different sessions, or at separate lesions, on the same day for the same patient. This modifier signals Medicare claims personnel that there is a special circumstance making it legitimate to list the codes together. For example, several hours after angioplasty is performed the patient develops complete heart block and requires placement of a temporary pacemaker. The HCFA considers temporary pacemaker placement to be part of angioplasty and would reject a claim containing codes for both procedures on the same day, incorrectly assuming they were performed as part of one procedure. The −59 modifier prevents outright rejection of the claim by Medicare and triggers special review. Documentation must be attached to the claim to justify the need for temporary pacing separate from the angioplasty procedure.

Avoid unnecessary services. Services or procedures always entail some risk, inconvenience or cost. If there is no overall benefit that outweighs these negative factors, the service or procedure is medically unnecessary. It is inappropriate and unethical to knowingly provide such a service or procedure for financial or other gain (7,10,22,23). The American College of Cardiology has published guidelines for many cardiac procedures and services. They specifically designate as class III indications those conditions "for which there is evidence and/or general agreement that a procedure/treatment is not useful/effective and in some cases may be harmful" (24). For such a condition, the procedure or service would be unnecessary.

The medical necessity of services or procedures is often uncertain. In such cases the physician is ethically obligated to act in the patient's best interests and to help the patient decide whether it is in her/his best interest to undergo the service or procedure (1,2,7,25). Second opinions should be obtained when appropriate (23).

Document medical necessity of procedures. According to the Office of the Inspector General of the Department of Health and Human Services, audits found $23 billion in improper Medicare payments in 1996 (26). Of this, 37% was for "medically unnecessary" services. However, this estimate of the volume of medically unnecessary services may be grossly inflated for two reasons:

1. Documentation of the indication for a service or procedure is inadequate.

   Example: If a cardiologist obtained electrocardiograms on clinic patients for appropriate clinical reasons but did not document those reasons in the chart, a HCFA auditor might flag them as "medically unnecessary." Health Care Financing Administration guidelines require documentation of the indication for services and procedures (e.g., electrocardiogram performed to rule out silent interval myocardial infarction).

2. Some Medicare criteria for medical necessity are unreasonable.

   Example: Some Medicare carriers pay for echocardiography only if the claim includes ICD-9 codes for diseases the carrier accepts as appropriate for diagnosis with echocardiography. Claims without the "correct" ICD-9 codes are rejected with the rationale that echocardiography was medically unnecessary. Some local Medicare carriers will not reimburse for echocardiograms ordered to diagnose patients with ICD-9 codes for chest pain or syncope.

Unreasonable criteria for "medical necessity" defined by the HCFA should not preempt physicians' determination of what is medically necessary for the best care of their patients. To avoid problems with medical necessity issues, physicians should document why tests are ordered, and use appropriate ICD-9-CM codes in conjunction with CPT codes. Where Medicare carriers are using unreasonable criteria for medical necessity, physicians should work with local ACC chapters and local Medicare carrier advisory committees to change local Medicare policy.

CODING FOR SERVICES IN A TEACHING SETTING

The HCFA's 1969 Intermediary Letter 372 (IL-372) provided guidelines for attending physician involvement in services provided by residents to Medicare patients. However, these guidelines were ambiguous, and for 28 years evaluation and management services performed by residents were sometimes attributed to the attending physician even when the attending physician was not present at the time the service was provided (15,16). In other instances, the attending physician's presence was not documented, despite his or her countersignature on the resident's note.

To clarify its expectations for documentation of attending physician services, the HCFA published new rules on billing for teaching physicians that went into effect July 1, 1996 (27). These standards require the attending physician to be physically present during the *key* portion of a proce-

dure to bill for it. For evaluation and management services the attending physician must personally evaluate and examine the patient and discuss findings and management with residents/fellows, and must personally document his or her involvement for each encounter. Coding ramifications of these new standards include the following:

- It is now unlawful to code services or procedures as being provided by attending physicians if the above standards are not met.
- The attending physician does not have to perform all the work for the service that is being coded.

> *Example:* A resident performs and documents a very complex admission evaluation that meets CPT criteria for a level 5 service (CPT code 99223). The attending physician does not have to repeat the entire history and physical. To code and bill for the admission service, the attending physician must interview and examine the patient, review the resident's findings, discuss management with the resident and document this activity in the medical record.

However, if a level of service is determined by the time expended, such as discharge planning, only the time expended by the teaching physician without including time spent by the resident may be considered in coding the service (28).

> *Example:* An attending physician and resident spend 20 minutes reviewing a patient's hospital chart and discussing discharge procedures and follow-up with the patient. Subsequently the resident spends another 20 minutes answering further questions from the patient and dictating a discharge summary. The service should be coded as "hospital discharge, 30 minutes or less" (CPT code 99238) and cannot be coded as "hospital discharge, more than 30 minutes" (CPT code 99239).

In 1995 the Office of the Inspector General (OIG) of the Department of Health and Human Services introduced the Physicians at Teaching Hospitals (PATH) initiative to audit billing practices at teaching hospitals. These audits used vague standards from the HCFA's 1969 Intermediary Letter-372 and Medicare statutes (17). These audits also retroactively applied documentation guidelines implemented in 1995 to services performed years earlier (15). The first audits, at Thomas Jefferson University Hospital and the University of Pennsylvania, resulted in large fines. Consternation spread through the academic community as other teaching institutions considered their potential liability. Subsequently the OIG suspended audits in some states, but continued audits in other states. On October 29, 1997 the American Association of Medical Colleges and the American Medical Association filed suit against the federal government to stop audits from evaluating billing practices based on the vague rules of IL-372 and retroactive application of the AMA's evaluation and management guidelines. However, the suit was dismissed, and audits have continued.

LEGAL IMPLICATIONS OF INCORRECT CODING

Accurate coding is not only an ethical responsibility of the physician, but also necessary to comply with federal law (29). It is illegal to knowingly submit claims to Medicare that are false or fraudulent, or that materially misrepresent a material fact with regard to the physician's right to payment. The Federal False Claims Act provides fines of $5,000 to $10,000 for every false claim filed. The Health Insurance Portability and Accountability Act of 1996 allows a physician (or other person) to be subject to fines of up to $10,000 per item or service that the physician knows or should have known was not provided as billed, was upcoded or was part of a pattern of billing for services that were not medically necessary. A physician found liable under either of these provisions may also be excluded from Medicare and Medicaid.

The federal government has increased efforts to detect Medicare fraud. In 1995 the U.S. Department of Justice established a Special Health Care Fraud Task Force. The Office of the Inspector General of the Department of Health and Human Services is expanding its staff from 700 to 2,000, at least in part to investigate alleged Medicare fraud and abuse. The Health Insurance Portability and Accountability Act of 1996 created a Healthcare Fraud and Abuse Program to combat fraud and abuse in Medicare, Medicaid and private insurance programs. The budget for this program increases annually to $240 million in 2004 (30). More recently the Department of Health and Human Services began training senior citizens to recognize and report alleged fraud and abuse in Medicare (31). It seems clear the government is willing to take additional measures to reduce the cost of the Medicare program by targeting alleged fraud and abuse. The federal government's intentions are clear: United States Attorney General Janet Reno stated, "We have made health care fraud a priority and we will pursue it as vigorously as we can." Private insurers are also increasing efforts to detect fraudulent billing practices, including those involving inappropriate procedural coding. New York's Empire Blue Cross and Blue Shield sent 3,100 cases to criminal prosecutors in 1996 (32) and saved $38.5 million by detecting alleged fraud in 1997 (33).

Few physicians commit intentional Medicare fraud, but any physician who allows office personnel to consistently code services incorrectly risks prosecution for Medicare fraud. A physician is responsible for incorrect or fraudulent coding practices by office personnel even if the physician is completely ignorant of those coding practices. Physicians can minimize their legal risk by following the practices outlined above. For example, even if a physician is audited and found to have coded incorrectly, demonstrating that an office program is in place to comply with HCFA policy and that efforts were made to ascertain correct coding policy from the HCFA may prevent prosecution under the False Claims Act. The American Medical Association has re-

Table 5. Ethical Billing Practices

1. Help patients to understand their bill, their financial responsibilities and opportunities for financial counseling. When possible, do this before medical services are provided.
2. Use billing practices that in no way mislead patients or insurers about their responsibilities for payment of charges.
3. If a billing error is discovered, rectify the mistake as soon as possible. Pay back money received due to payment errors.
4. Bill consistently across all types of patients and insurers. Do not vary charges for particular patients or insurers from standard charges, or mislead them about standard charges.
5. Charge the usual copayment mandated by Medicare. Failure to do so may be unethical according to the American Medical Association (AMA) (10). Under Medicare law it is a felony to knowingly offer remuneration or anything of value to a patient in exchange for that patient's purchasing a service. Medicare may consider waiving a copayment to be remuneration offered to the patient in exchange for the patient's purchasing the physician's services. In addition to criminal penalties, a physician may also be subject to civil monetary penalties for waiving a Medicare patient's copayment obligation if the physician knows or should know that such a waiver is likely to influence that patient's selection of physician services. (A physician may waive a copayment when it is not part of an advertisement or solicitation, it is not a routine practice and either the patient is in financial need or the copayment is not collectible after a reasonable collection effort.)
6. Frequently physicians provide charity care. The AMA recognizes this as an ethical responsibility of the physician (10). Forgiving part or all of usual charges for patients without financial resources is consistent with this responsibility.

cently developed a model "Federal Fraud Enforcement Physician Compliance" plan for physicians to use as a guide for ensuring compliance with HCFA regulations governing Medicare coding and billing.

PROPER RESPONSE TO INCORRECT CODING/BILLING PRACTICES

Occasionally cardiologists may become aware of unethical or inappropriate coding/billing practices of other physicians or their employees. When a continued pattern of these practices is observed, it may be the ethical duty of the cardiologist to take action (10). The ACC does not have a mechanism for sanctioning cardiologists who practice inappropriate coding/billing procedures. If talking with the colleague is not possible or appropriate, improper coding/billing practices may be reported to county or state medical societies, state medical boards or the Office of the Inspector General. Some hospitals and health care organizations are establishing compliance or integrity programs that offer additional guidelines for reporting questionable practices.

If a physician identifies incorrect coding practices in his or her own practice, a compliance program should be implemented immediately to correct the problem. All efforts to resolve the problem should be carefully documented. If there is any coding practice that could be construed as fraudulent, the physician should inform legal counsel and seek advice about other appropriate action. If incorrect coding practices led to overcharging patients or insurers it may be appropriate for physicians to pay back the excess fees with interest.

ETHICAL BILLING PROCEDURES

The format of bills and claims is most important in fee-for-service systems, particularly when the patient is responsible for part or all of the bill. Bills should be clear and understandable to patients and insurers. They should include the date, charge and name of provider for each service, and an itemized description of the services provided, in language that the patient and insurance personnel can understand. Ideally this should use an accepted coding system (e.g., HCPCS, CPT and ICD-9-CM), and should include a short description of the service in language that patients can understand. Other recommendations for ethical billing practices for cardiologists and their office personnel are included in Table 5.

SHARING OR SPLITTING OF FEES

Fee splitting or sharing does not directly involve coding or billing practices and is beyond the scope of this document. This practice has been widely condemned as unethical (7,10,23). When Medicare funds are involved, this practice may be illegal as well.

ETHICS OF CODING AND BILLING FOR INSURANCE CARRIERS

Whereas physicians acknowledge their ethical obligation to serve the best interests of their patients (1,7,10,16), health care insurers have not articulated their ethical responsibility to pay in a timely manner. The 29th Bethesda Conference on Ethics in Cardiovascular Medicine criticized the medical business community for its lack of an ethical framework (2). The Conference concluded that the medical business community uses financial interests to justify policies that, in the framework of medical ethics, are unethical. This contrast between physicians' attempts to develop principles of medical ethics and the medical business community's apathy for them extends to the arena of coding and reimbursement. Whereas physicians have advocated ethical coding and billing procedures (5,6,8,10,15), insurers have not acknowledged a responsibility to minimize unnecessary complexity, delays and inappropriate denials of claims. In fact, Medicare and other insurance carriers have done the opposite by applying restrictive coding policies and increasing denials of claims. For example, Medicare carriers often deny claims

just because a modifier is appended to a CPT code, ignoring the fact that modifiers were developed for legitimate reasons and are an accepted part of the CPT coding system. As noted above, claims with CPT codes not linked to an arbitrarily defined "appropriate" ICD-9-CM code are routinely rejected without regard to the true clinical necessity of the service. Many physicians perceive that Medicare carriers and private insurers routinely delay and deny even valid claims for services for their patients.

We believe that it is an ethical obligation of insurance carriers to promptly pay for services to their patients when those services are rendered appropriately and reported with accurate coding and billing mechanisms. Insurers should accept this responsibility. Cardiologists should work with local ACC chapters, specialty societies, Medicare carrier advisory committees, state insurance commissioners and state agencies regulating managed care organizations to convince insurers to articulate and comply with this responsibility.

Insurers, including the federal government, should not prosecute physicians for fraud because of occasional or "innocent" coding mistakes. Recently the Department of Justice and the Department of Health and Human Services addressed this concern by issuing guidelines for how the False Claims Act would be applied to health care providers. However, physicians remain justifiably concerned that the government's approach to PATH audits will be extended to individual physicians. Cardiologists should continue to pressure the HCFA and the DOJ to avoid prosecution of physicians unless intentional fraud is demonstrable.

The HCFA must work to fulfill another obligation: consistency among its local Medicare carriers. Where ambiguities exist in interpretation of CPT codes or HCFA payment policies, local Medicare carriers have considerable latitude in interpreting them. This often leads to different coding and payment policies in adjacent Medicare regions for the same service.

> *Example:* CPT coding: Coronary angioplasty performed on a major coronary artery and/or its branches is coded as "92982, percutaneous transluminal coronary balloon angioplasty; single vessel." Angioplasty performed on a separate major vessel is coded with "92984, percutaneous transluminal coronary balloon angioplasty; each additional vessel." However, neither the AMA nor the HCFA have ever stated precisely what arteries qualify as "an additional vessel." If angioplasty is performed on the left anterior descending coronary artery (coded with 92982) and then on the left main coronary artery or ramus intermedius artery, it is up to the local carrier to determine if the left main or ramus qualify as an additional vessel (justifying the additional code 92984), or whether they are considered to be part of the same major vessel as the left anterior descending coronary artery. Some local Medicare carriers have stated policies on how to deal with this problem, but most offer no guidelines for coding or insight into how these decisions will be made by the carrier.
>
> *Example:* Payment policy: CPT codes must be accompanied by an ICD-9 code to be reimbursed. However, which ICD-9 codes can be used to justify a particular CPT code vary from one carrier to another. Some carriers allow the ICD-9 code for chest pain (786.5) to justify echocardiography (93307); others will disallow and refuse to reimburse echocardiography if it is coupled with the chest pain ICD-9 code.

The result of the HCFA's giving so much latitude to local Medicare carriers is that nationwide coding and payment policy disputes must be settled locally with each carrier. In regions where physicians are not well organized or knowledgeable about CPT coding and payment policy, physicians are at a disadvantage in negotiating with the local Medicare carrier. Variations in interpretation of coding and payment policy among Medicare carriers make it difficult for coding experts or specialty societies to dispense coding advice on a national basis. The medical community should work with the HCFA and local Medicare carriers to develop and adopt a common set of coding and payment policy guidelines.

SUMMARY

The federal government and many third party payers employ the CPT coding system. The underlying complexity and ambiguity of this system and yearly changes in CPT codes and coding policy make correct coding for services extremely difficult. Physicians, faced with decreasing reimbursements, are focusing more on coding for their services. Despite all of these factors, it is the ethical responsibility of physicians to code for their services accurately. Accurate coding has the additional benefit of minimizing exposure to allegations of Medicare fraud. Physicians should hold the federal government and insurance carriers to their ethical obligation to reimburse for appropriate services quickly and efficiently.

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