THOUGHTFUL APPROACH TO WHETHER AND HOW TO USE BILLING EXPERTS

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The use of billing experts has seen an energetic increase over the past few years by defense bars across the country in an attempt to tackle the various ways that medical providers are inflating their bills. Whether done by providers intentionally or due to a misunderstanding of medical coding guidelines, use of medical coding experts can help those involved in personal injury litigation (specifically, the jury) understand what procedures were actually performed on a patient, and whether the CPT (Current Procedural Terminology) codes billed were proper and the associated charges reasonable. While a majority of cases could probably stand to use a billing expert to help assess the reasonable value of a case, it is the combination of certain facts and certain providers which make a case prime for designating a billing expert for trial. This author will discuss the ways in which doctors and medical facilities routinely overbill, usually in hopes of a big recovery, and will make some observations about the types of cases best suited to combat the problem. For the sake of acknowledging a growing trend in Georgia with certain providers, this author will assume the provider has intentionally inflated the bills.

The most common ways that medical providers inflate the bills are by upcoding, unbundling, duplicate billing, and improper use of coding modifiers.

Upcoding is when a provider uses a higher-level procedure code than what was performed on the patient, in an attempt to inflate the total bill. For example, a CPT code of 99213 can easily be inflated to a CPT code of 99214, if the reader of the records and bill doesn't know any better. CPT 99213 is the code for "office or other outpatient visit." This level of service involves an "expanded" history and exam, a "low" level of decision making, and a "low to moderate" level of severity of the presenting problem. CPT 99214, however, is a level up from CPT 99213; this level of service involves a "detailed" history and exam, a "moderate" level of decision making, and a "moderate to high" level of severity of the presenting problem. The difference between using a lower code versus a higher code all depends on the amount of time spent face-to-face with a patient, the number of problems presented, the complexity of the problems presented, the amount of data and labs involved

in the decision making, the risk of complications of the suggested treatment, among other factors. Imagine an in-office consultation being billed as a thirty (30) to sixty (60) minute face-to-face consultation, when in fact the patient merely stopped by for a medication check/refill. The average non-medically trained person (i.e. a juror), typically won't know about the difference between one code or another. A billing expert, however, can audit the patients records and compare the service(s) rendered with CPT codes use and explain to a jury how a service may have been upcoded. https://www.cgsmedicare.com/partb/mr/pdf/99213.pdf

Unbundling is when a provider literally "unbundles" an all-encompassing procedure code into smaller separate procedure codesvin an attempt to inflate the cost of the procedure. This can sometimes inflate the bill by thousands of dollars. For example, CPT code 64490 is a code used for facet joint injection(s) and includes image guidance (fluoroscopy or CT). CPT code 77003 is the code used for "fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)." CPT 77003 should not be used with CPT 64490, because a facet joint injection (CPT 64490) necessarily includes the use of fluoroscopic guidance (CPT 77003). When there is a single code available that captures payment for the component parts of a procedure, that is what should be used.

In explaining unbundling to a jury, it can be helpful to use the analogy of going to a restaurant expecting a price-fixed dinner including an appetizer, entree, two sides, and a dessert, but receiving the bill showing each item billed separately for a higher total charge. Some surgery centers, especially those treating car accident patients referred by an attorney, are notorious for unbundling the cost of a procedure. The average layman wouldn't know what to look for or why it matters. A billing expert, however, can audit the patients records and compare the service(s) rendered with CPT codes used, and explain to a jury how a service may have been unbundled in an attempt to inflate the bills. https://www.americanmedicalcoding.com/code-cpt-code-77003/ http://www.radiologybillingcoding.com/2016/09/fluoroscopic-guidance-cpt-code-77001.html

Duplicate billing and coding modifiers are used similarly by providers to inflate the bills. While duplicate billing is just that—billing twice (or more) for the same item or procedure—modifiers allow for additional billing for a service or procedure, but at a lower rate. A blatant duplicate billing example is when the assistant surgeon, working along-side the primary surgeon, bills for the exact same code as the primary surgeon. Most laymen can see that there may be duplicate billing, but it may take an expert to explain why that is not reasonable, or why a modifier must be used to account for the assistant surgeon's service, if he or she was necessary

during the surgery. Regarding modifiers, sometimes providers bill the second part of a bilateral procedure with a modifier when the primary procedure code already includes the bilateral service.

In an effort to combat upcoding, unbundling, duplicate billing, and improper use of coding modifiers, defendants/insurers have turned to medical billing experts to analyze the charges of past medical services rendered to a plaintiff to determine the reasonable marketplace value for the same service, in the same year, in the same community and surrounding areas. This is done by reviewing standard fee references, such as Wasserman's Physicians' Fee Reference, PMIC's Medical Fees, OptumInsight National Fee Analyzer, and online resources such as Find A Code, among others. Think of these sources like legal treatises an attorney might reference to better understand the elements of a claim; they are usually paid-for databases that professionals can and should access in order to practice fairly and reasonably. In the context of the medical services world, the above databases typically contain a cost range for a particular a medical procedure, which should give guidance to a medical practitioner of the reasonable value of the service he or she is providing to a patient (i.e. charging a patient). It is when the practitioner's charge for a procedure is way outside of the database range that defendants/insurers become alarmed and find it necessary to hire an expert to help understand the reasonable value of a medical procedure. These experts have access to the same databases to which the practitioner should have access, and they know how to interpret the data and apply the geographic modifier to account for the area/community in which a plaintiff treats. A billing expert is important for trial in order to show the jury that while Dr. So-and-so charged a plaintiff $X amount for a specific procedure, many doctors in the same community charge a fraction of that amount. While it is true that some doctors can and do charge car accident patients whatever they want in order to maximize their own recovery for medical treatment should the plaintiff succeed at trial, it is not fair for doctors to take advantage of defendants/insurance companies and/or their own patients (the plaintiff), should the defense succeed at trial.

In deciding whether to designate a billing expert for trial, it is important to consider the negligence and causation elements of a case, as well the skill and talent of opposing counsel, the tendencies of the jury pool, and the likeability of the parties. Not every "over-billed" case is a good candidate for a billing expert at trial. Sometimes "over-billing" will be obvious to a jury, especially if other aspects of the case allow the defense to argue the entire claim is "manufactured." But sometimes negligence and causation of injury are clear, and the defense simply wants to ask the jury to return a reasonable verdict based on the reasonable value of the plaintiff's medical treatment. This should be done with an eye toward avoiding looking "nit-picky," but rather asking a jury to not award "a penny less or a penny more" than what is

reasonable for a plaintiff's medical care. After all, the defendant should only be held accountable for what is reasonable, not for whatever Dr. So-and-so felt like charging the plaintiff, which can sometimes top fives times what others might charge for the same procedure.

Keep in mind that a billing expert can also be used for settlement purposes and mediation, without being designated for trial. Even if the time has passed to designate an expert, or use of an expert at trial might come across as "nit-picky" to a jury, there may still be merit to having an expert to review the bills in order to let the plaintiff know that you are happy to discuss settlement for a reasonable sum. And if the case doesn't settle, if you are lucky, the plaintiff's attorney will pre-emptively tell the jury you will argue "reasonableness of bills" in your closing argument, allowing you to simply tell the jury you agree with counsel and ask them to award a "reasonable sum." It is always good to have opposing counsel tell a jury what you might argue and make your case for you. Every time opposing counsel says "reasonable" is one less time you have to say it, and one more time you can agree with him or her.