Discussion of Medical Review Issues

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My Role as an LPET Specialist

- Provide one-on-one education to providers via telephone contacts and follow-up educational letters
- Writer articles for UMD Web site and quarterly Medicare B Bulletins
- Perform specialty Group Mailings of educational flyers to specific specialty groups
- Conduct Seminars to specialty groups
- Participate in inter-departmental education to UMD employees
- Attend conference calls sponsored by PET Department to serve as a representative from the Medical Review Department.

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Objectives

- To understand documentation requirements of billing an E&M service in addition to a prothrombin time.
- To understand that prolonged care represents a service above and beyond the usual E&M service.
- To understand the proper billing of preventive care
- To have a clear understanding of "Incident to" guidelines.

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Topics

- Office visit (99211) with Prothrombin Time (85610)
- Prolonged services (99354)
- Preventive visit (99391-99397) and a evaluation & management service
- "Incident to" Services

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Medical Review Issues - October 2004

- The seminar content presented in this Power Point Presentation is dated October 2004 to reflect that the information is accurate at this time, but is always subject to revision or change.
- We encourage you to periodically refer to our Web site to insure that you are utilizing the most accurate versions of any LMRP/LCD referenced in this Seminar.
- We also encourage that you periodically access the CMS Internet Only Manual (IOM) for National Coverage Determination (NCD) guidelines referenced during this Seminar.

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Questions will be answered at the end of this Seminar

I will answer as many questions as time will allow at the completion of the Seminar.

Office Visit and Prothrombin

- To meet Medicare guidelines for payment of procedure code (PC) 99211 along with a protime, documentation must substantiate a separately identifiable service.
- No modifier is necessary.
- Documentation must define a stated reason for concern that requires medical management by the practitioner.
- When PC 99211 is billed in a repetitive pattern each time a prothrombin time is billed, the question of medical necessity becomes apparent.

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Office Visit and Prothrombin

- The Medical Review Department conducted a Service-Specific Review (SSR) of PC 99211 when billed on the same day as a prothrombin time.
- This SSR resulted in an error rate of 62 percent, since documentation did not substantiate the E&M service.
- As a result of the 62 percent error rate, claims for PC 99211 along with a protime are being reviewed at random.
- In the majority of the claims reviewed, PC 99211 is denied as not medically necessary in addition to the protime.

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References

- An article titled "Billing Code 99211 and Prothrombin Time" was posted on our Web site (posted 11/26/03) and was printed in our Medicare B Bulletin (printed December 2003).
- An article written by our Medical Director titled "Prothrombin Time" was printed in our September 2003 Medicare B Bulletin.

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Prolonged Services

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Definition of Prolonged Care (per CPT Manual)

"Codes 99354-99357 are used when a physician provides prolonged service involving direct (face-to-face) patient contact that is beyond the usual service in either the inpatient or outpatient setting. This service is reported in addition to other physician services, including evaluation and management services at any level."

- Prolonged care is used to report the total duration of the physician's face-to-face time, even if the time spent by the physician is not continuous time.

- Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the E&M codes.

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Prolonged Services

- Medical Review conducted a service-specific review (SSR) of procedure code 99354 (prolonged physician service in the office or outpatient setting requiring direct face-to-face patient contact beyond the usual service).
- This SSR resulted in an error rate of 100 percent, since documentation did not substantiate payment of a prolonged service in addition to and E&M code.

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SSR Results

- Documentation reviewed did not support medical necessity and payment of prolonged care since an outstanding event or situation over and above an E&M service was not substantiated in the record.
- Documentation did not provide the length of time spent during the office encounter.
- The rendering provider who billed the service was not identified in the record.
- Handwriting was not legible.
- In review of one record, the patient was asked to remain the the waiting room for two hours.

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Internet Only Manual Guidelines for Prolonged Care

- Prolonged care guidelines can be found in the CMS Internet Only Manual (IOM), PUB 100-04, Chapter 12, Section 30.6.15.1.
- In these guidelines, it specifically states:
  - The physician may only count the duration of direct face-to-face contact with the patient (whether continuous or not) beyond the typical time of the visit code billed.
  - Time spent by the office staff with the patient, or time the patient remains unaccompanied cannot be billed.

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Internet Only Manual Guidelines for Prolonged Care (continued)

- In these guidelines, it specifically states:
  - Documentation must state duration and content of the E&M code billed to substantiate that the physician personally furnished the time specified in the E&M code definition.
  - Prolonged services codes can be billed only if the total duration of all physician direct face-to-face service (including the visit) equals or exceeds the threshold time for the E&M service that the physician had provided (typical time plus 30 minutes).
  - If the total duration of face-to-face time does not equal or exceed the threshold time for the level of E&M service the physician provided, the physician may not bill for prolonged services.

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Illustration of Correct Reporting of Prolonged Codes (per CPT Manual)

Total Duration of Prolonged Services Beyond Usual Service	**Code(s)**
Less than 30 min.	Not reported separately
30-74 min. (1/2 hr.- 1 hr. 14 min)	99354 x 1
75-104 min. (1 hr. 15 min.- 1 hr. 44 min.)	99354 x 1 & 99355 x 1
105-134 min. (1 hr. 45 min.- 2 hr. 14 min.)	99354 x 1 & 99355 x 2
135-164 min. (2 hr. 15 min.- 2 hr. 44 min.)	99354 x 1 & 99355 x 3
165-194 min. (2 hr. 45 min.- 3 hr. 14 min.)	99354 x 1 & 99355 x 4

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Proper Billing for Prolonged Care

- If the total duration of the prolonged service lasts less than 30 minutes, beyond the usual service provided, prolonged care would not be reported separately.
- If a prolonged service lasts 30-74 minutes, beyond the usual service provided, prolonged care codes 99354 or 99356 may be reported once along with an E&M service.
- When time for counseling dominates 50% or more of visit, it is appropriate to bill higher level E&M rather than prolonged care.

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Proper Billing for Prolonged Care

- The CPT Manual provides the following example: prolonged care and treatment of an acute asthmatic patient.
- Other examples that are appropriate to bill:
  - crisis situations requiring physician's direct attendance
  - side effects of medication injections requiring management by the physician
  - hypoglycemic or hyperglycemic episodes treated in the office
  - fall in the physician's office requiring physician's medical attention

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Documentation Requirements for Prolonged Care

- Documentation must state that the patient presented with a situation that requires additional face-to-face time over and above the usual office visit.
- Documentation must include the direct one-on-one face-to-face time that the physician spent with the patient, and that amount of time must exceed the time of the E&M code billed beyond 30 minutes.

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SSR 100 % error rate

- Due to an error rate of 100%, claims for prolonged care (PC 99354) are being reviewed at random.
- In the majority of claims reviewed, code 99354 is denied as not medically necessary, since documentation does not support payment of a prolonged service.
- An article titled "Prolonged Care - Procedure Code 99354" was posted on our Web site (posted 5/7/04) and was printed in our June 2004 Medicare B Hotline Bulletin.

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Preventive Care Codes (99391-99397)

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Preventive Care Codes (99391-99397)

- Preventive care services are not a Medicare benefit.
- An Advance Beneficiary Notice (ABN) would not be necessary, however, you should advise the patient that the service is not a Medicare benefit.
- Preventive care codes may be used for a yearly physical exam in which no illness or injury is being managed by the practitioner or physician.

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Clinical Specialist Review

- Beneficiary complaints have been received in regard to the patient being charged for preventive care when they are being seen by the physician for chronic conditions, such as hypertension.
- Management of a chronic condition should not be billed under preventive care codes.

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Clinical Specialist Review (Continued)

- Review of documentation reflected that a portion of the visit was preventive in nature, but also a portion could have been coded as an E&M service.
- If a patient is being treating for a covered condition, whether chronic or not, the management of the condition, if documented properly may meet Medicare requirements of being medically necessary and should be coded with the appropriate level E&M code.

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Internet Only Manual Guidelines for Preventative Services

- Guidelines for Preventative Services can be found in the CMS Internet Only Manual (IOM), PUB 100-04, Chapter 12, Section 30.6.2.
- In these guidelines, it states:
  - When a physician furnishes a Medicare beneficiary a covered visit at the same place on the same occasion as a non-covered preventative medicine service, consider the covered visit to be provided in lieu of a part of the preventative medicine service of equal value to the visit.

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IOM Guidelines for Preventative Services (continued)

In these guidelines, it states:

- The physician may charge the patient, as a charge for the non-covered remainder of the service, the amount by which the physician's current established charge for preventative medicine exceeds his/her current established charge for the covered visit.
- The physician is not required to give the beneficiary written advance notice of non-coverage of the part of the visit that constitutes a routine visit. However, the physician is responsible for notifying the patient in advance of his/her liability for charges for services that are not medically necessary to treat the illness or injury.

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IOM Guidelines for Preventative Services (continued)

In these guidelines, it states:

- There could be covered and non-covered procedures performed during this encounter (eg, screening x-ray, EKG, lab tests). These are considered individually.
- Those procedures which are for screening for asymptomatic conditions are considered non-covered and, therefore, no payment is made.
- Those procedures ordered to diagnose or monitor a symptom, medical condition, or treatment are evaluated for medical necessity and, if covered, are paid.

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Preventative Care (cont)

- If a beneficiary is having her biannual (low risk) or annual (high-risk) pap smear and pelvic/breast exam, these are preventive services that are payable by Medicare. The appropriate screening code (G0101 and Q0091 should be billed.

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"Carve Out"

- Determine your usual fee for the non-covered, routine physical examination.
- Determine Medicare's fee for the covered portion of the exam.
- Bill the covered portion using the appropriate E&M visit code.
- Bill the preventive portion, which the patient would be responsible for.

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Remember

- It is not necessary to have the patient sign an ABN.
- As a courtesy, advise the patient the preventive service is not a Medicare covered benefit.
- Adequate documentation must be legible and available upon request.

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References

- Article on our Web site titled "Preventive Services" under Medical Review.
  - This article does provide additional direction in regard to billing annual/biannual gynecologic screening services.

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"Incident to" Services

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Definition *(Per Internet Only Manual)*

"Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness."

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Internet Only Manual Guidelines for "Incident To" Services

- Guidelines for billing services as "Incident To" can be found in the CMS IOM, PUB 100-02, Chapter 15, Section 60.1.
- In these guidelines, it states:
  - There must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the non-physician practitioner is an incidental part.

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Internet Only Manual Guidelines for "Incident To" Services

- In these guidelines, it states:
  - There must be subsequent services by the physician of a frequency that reflects the physician's continuing active participation in and management of the course of treatment.
  - There must be direct physician supervision, which means the physician must be present in the office suite and immediately available and able to provide assistance and direction throughout the time the service is performed. Direct supervision does not mean that the physician must be present in the same room.
  - Services and supplies are of the type that are commonly furnished in physicians' offices or clinics.

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Internet Only Manual Guidelines for "Incident To" Services

In these guidelines, it states:

- Auxiliary personnel means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. Likewise, the supervising physician may be an employee, leased employee, or independent contractor of the legal entity billing and receiving payment for the services and supplies.
- The patient's financial liability for "incident to" services is to the physician. Therefore, "incident to" services must represent an expense incurred by the physician billing for services.

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DO NOT BILL

- "Incident to" cannot be billed by non-physician practitioners or other auxiliary personnel in a hospital setting (inpatient, outpatient, emergency room).
- Physicians cannot bill "Incident to" another physician. If a physician needs to obtain a PIN from Medicare, he/she may contact the Provider Hotline.

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DO NOT BILL

- Mental health counselors cannot bill "incident to" under the Psychiatrist's provider number.
- Physical Therapists cannot bill "incident to" another physical therapist.

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Summary of Seminar (what was learned)

- For reimbursement of 99211 along with a protime, documentation must substantiate a separately identifiable service and must define a stated reason for concern that requires medical management and not just regulation of coumadin.
- For reimbursement of prolonged care, two requirements must be met:
  - The duration of the visit must have exceeded at least 30 minutes beyond the usual E&M service
  - The patient must present with a situation that requires additional face-to-face time over and above the usual office visit.

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Summary of Seminar (what was learned)

- Care and treatment of chronic conditions may not always be considered as preventative in nature and may meet Medicare guidelines for payment under an E&M service, if documentation is reflective of an evaluation and management service.
- For billing "incident to", there must have been a prior direct, personal professional service furnished by the physician whose PIN is being billed to Medicare for payment, and the physician must be physically present in the office suite

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Phone Numbers and Web Site Addresses

- Provider Hotline : (877) 567-7173
- Telephone Appeals: (866) 838-6070

Web site Addresses:

- www.umd.nycpic.com
- www.cms.hhs.gov

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Thank You for Coming

We hope this Seminar was educational and beneficial to you.