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Check Trends on E/M Services

Medicare has released a report that indicates in 2016 there were $1.1 billion in payments for undercoded claims. This represents services that were billed at a lower level than was supported by the medical record documentation. The new and established office visit codes were major contributors to that loss of revenue, representing more than $342 million of the loss.

In addition to the loss of revenue these claims can be considered as an offer of a discount or an inducement for referrals or services which is prohibited under the Medicare fraud and abuse laws.

One step that practices can take to prevent this is to train providers on the basic documentation guidelines for E/M services. In addition, your coding patterns should be compared to benchmarks for your specialty. If you would like to analyze your E/M coding, please contact your consultant or phone us at 1-800-572-5275.

New Prolonged Service Codes Now Payable in 2017

CMS has added two new codes for services which formerly were considered non-covered. CPT codes 99358 and 99359 are reimbursed at $112.20 and $53.97 respectively. These are for prolonged physician services without direct patient contact. These do not include any services provided by staff, however, these codes may be billed by any eligible billing practitioner. Code 99358 requires at least one hour of time either prior to or subsequent to a patient encounter. CPT 99359 is an add on code to 99358 for each additional 30 minutes of time. While these prolonged care codes are billed in conjunction with a companion E/M code, the prolonged services do not have to occur on the same day that the companion code service is delivered. The only requirement is that the prolonged services must relate directly to the services that were or will be furnished in the face to face encounter with the patient.

These prolonged services may not be billed in conjunction with complex chronic care management services, nor may they be billed with transitional care management services. However, the restriction on TCM is on the practitioner and not the patient. So a patient could receive TCM services and prolonged services in the same month as long as they were not billed by the same practitioner. Finally, the prolonged service codes may also be used in conjunction with G0505 which is a new code used for cognitive and functional assessment with the development of a care plan for cognitively impaired individuals.

It is important to be as specific as possible in documenting in the medical record the time devoted to these services.

If you have any questions or want additional information, please contact Bryan Burke at 1-800-572-5275 or bburke@hci-ebs.com.

"Incident to" Billing

Medicare allows for 100% reimbursement for services performed by PAs, NPs, and CNSs when they are delivered in compliance with the "incident to" rules. The major components of these rules include:

1. The service must take place in a non-institutional setting which excludes hospitals and SNFs.
2. A Medicare credentialed physician must initiate the patient's care and establish a treatment plan.
3. Subsequent care must be provided under a physician's direct supervision which in the office setting means in the office suite and immediately available.
4. The physician is expected to continue to actively participate and manage the patient's course of treatment.
5. Both the physician and the mid-level provider must be employed, leased or contracted by the entity that bills for the services.
6. The services must be the type of service normally delivered in the office setting.

If all of these guidelines are followed, then the services can be billed under the physician's NPI and are paid at 100% of the physician fee schedule rather than the reduced rate of 85% if billed under the mid-level provider's NPI.

These requirements do not apply to services with their own benefit category. So lab tests, vaccines, EKGs, some x-rays and ultrasounds only require general supervision and are not considered incident to services. While these services may be furnished incident to, they have their own statutory benefit categories with their own supervisory requirements and they override any incident to supervision requirements.

Hospital Fined $3.2 Million

The OCR has announced that Children's Medical Center of Dallas was fined $3.2 million as a result of multiple HIPAA breaches. The initial incident occurred in 2009 with the loss of a Blackberry device containing ePHI of 3800 individuals. The device was not password protected or encrypted. In 2013 there was another incident involving the loss of a laptop with ePHI of 2462 individuals. In the interim the hospital continued to provide its staff with unencrypted devices, despite its knowledge of the risk they posed and external recommendations to correct it. The fine resulted from non-compliance with HIPAA rules and a failure to implement a risk management plan.

If you have any questions or want additional information, please contact your consultant:
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