Beware Pitfalls Lurking in Medicare Changes, Definitions and Standards

Updates on related services, split vs. incident-to billing and E/M times

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On February 5, 2014, CMS issued Transmittal 505, to Publication 100-08, Medicare Program Integrity Manual. On March 19, 2014, CMS rescinded the transmittal. The transmittal addressed the concept of related services for auditing purposes, particularly the recovery auditors, MACs and ZPICs.

Defining what is meant by related services is a bit challenging. A simple example is a situation in which a physician admitted a patient to the hospital, the physician made several subsequent visits, and then the patient was discharged. Several weeks later the hospital determined the inpatient admission was improper. The physician services are related, and, at least in theory, the physician should not be paid for the hospital services because the inpatient admission was inappropriate or otherwise denied.

So, did the recovery auditors have the right to recoup the physician's inpatient payments because the inpatient admission was improper?

On August 8, 2014, Transmittal 534 was issued and then rescinded. Then on September 4, 2014, Transmittal 540 was issued and later rescinded. On September 12, 2014, Transmittal 541 was issued. Whether this latter transmittal will be withdrawn is yet to be seen.

Auditing staff should carefully compare Transmittal 505 to Transmittal 541. CMS has become more focused on when and how recoupments can be demanded relative to related services. Note that Transmittal 541 is really just a start at delineating and clarifying when and how recoupments for related services should occur. Be watching for further events in this area.

Shared/split billing vs. incident-to billing

With the increasing availability and use of nonphysician practitioners (NPPs), joint encounters by a physician and midlevel practitioner (e.g., Nurse Practitioner, Physician's Assistant, Clinical Nurse Specialist) are becoming more common. Care should be taken to have coding, billing and documentation policies in place to properly code, bill and be reimbursed for these shared/joint services.

Shared/split billing is for services provided in almost any location when both the physician and an NPP provide, document and sign the work they each performed. Face-to-face encounters with the patient by both the physician and NPP are required. The physician can bill the service to Medicare.

Incident-to billing by a physician for services provided by an NPP or other ancillary staff can occur only in a physician office setting, that is, a freestanding clinic.[1]

There are a number of criteria, all of which must be attained, for the physician to bill for the services of the NPP or other ancillary staff. The criteria include that the physician must provide direct supervision, the service must be of a type typically performed in a physician's office and there must be an appropriate employment relationship.

From a compliance and auditing perspective, both the shared/split visits and the incident-to billing represent

[1] See 42 CFR §413.65 for a definition of freestanding clinic.

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challenges, and there are many questions that can arise. Thus, policies and implementing procedures must be carefully established so that everyone understands what is permissible and what is not.

A small example is the question of whether an NPP can see a new patient and then have the physician bill for the services on an incident-to basis. The general answer is "no." If the NPP is developing the plan of care, the billing should be with the NPP's National Provider Identifier (NPI). Of course, the physician might also see the patient, so that the visit becomes a shared/joint encounter.[2]

Typical time for E/M services

For physician E/M (Evaluation and Management) coding, the CPT Manual lists the typical time for certain sequences of codes. For instance:

- 99203 – Level 3 New Patient – 30 Minutes
- 99214 – Level 4 Established Patient – 25 Minutes
- 99231 – Level 1 Subsequent Hospital Care – 15 Minutes

Depending upon the type of service, these typical times are for face-to-face services or, in the hospital, for time at the bedside or on the hospital floor.[3]

These typical times for certain types of E/M codes were developed to assist physicians and staff in coding cases by time instead of using the level of history, examination and medical decision making.

"When counseling and/or coordination of care dominates (more than 50%) the encounter with the patient and/or family (face-to-face time in office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time shall be considered the key or controlling factor to qualify for a particular level of E/M services."[4]

While the phrase "typical time" is used, CPT also indicates that "the specific times expressed in the visit descriptors are averages and therefore represent a range of times…"[5]

The use of the word "average" tends to cause federal auditors to conclude that given a list of encounters for a physician, the total time for providing a sequence of services can be statistically determined. For instance, consider the following E/M codes for a given physician on a given date of service.

- 99203 (30 Minutes) – 5 Patients
- 99211 (5 Minutes) – 18 Patients
- 99213 (15 Minutes) – 6 Patients
- 99214 (25 Minutes) – 4 Patients
- 99244 (60 Minutes) – 8 Patients

If we multiply the number of encounters times the average time, the total time is 910 minutes or a little over 15 hours. The auditors would then point out that the physician was only in the office for 7 hours so that there must be some sort of fraudulent behavior.

While this is not why the typical times were developed, you should be prepared to address this approach that may be used by external auditing entities. **NP**

[2] For instance, see MLN Matters Number SE0441.
[3] See Professional Edition 2014 CPT Manual, pages 7-8.
[4] See Professional Edition 2014 CPT Manual, page 10.
[5] See Professional Edition 2014 CPT Manual, page 7.

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