

**Try This for Medicare Fraud
(Well, At Least Abuse)
Part II
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Introduction

In Part I we reviewed fraudulent/abusive practices as they applied to surgical coding. There are also many questionable coding practices applicable to office visits and consultations as well as diagnostic tests.

Office Visits/Consultations

Office visits. There has been an increase in Medicare audits accompanied by refund requests when two providers in the same practice billed for office visits. You can bill for an office visit and a consultation on the same day by two different providers in the same practice, but not two office visits. You must bill one service, combining the appropriate efforts of both physicians in the practice.

Medicare Carriers Manual Section 15501.1 H

H. Physicians In Group Practice. –Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level. (Refer to §15511, Prolonged Services, when the duration of the direct face-to-face contact between the physician and the patient exceeds the typical time of the visit code billed.) Physicians in the same group practice but who are in different specialties may be and be paid without regard to their membership in the same group.

CPT code 99211 and Technician Services. Code 99211 is defined in CPT (Current Procedural Terminology) as follows:
99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

Physicians have access to all codes in CPT; however, the use of code 99211 does not require the presence of a physician. Usually this code is used when a technician or nurse provides a minor service such as taking blood pressure or changing a dressing. Ophthalmic technicians work under Medicare's "Incident To" rules when employed by physicians. Work performed by them is included in the service billed by the physician. There are certain types of services that are medically necessary and may be performed by a physician extender that does not require the services of a physician, such as an injection. Code 99211 is usually used when these services are performed and there is no physician participation in the service. However, the service still must be medically necessary.

When a patient returns for a special ophthalmologic diagnostic test - such as visual fields, ultrasonography, fundus photography - most often there is not a medically necessary reason for billing code 99211. If your chart notes reflect that the patient is to return for a diagnostic test but not a medically necessary office visit with the physician you cannot bill 99211 for the technician.

The abuse of code 99211 in such situations is the reason that the bundles of all diagnostic tests and office visits occurred originally and is currently implemented in the National Correct Coding Initiative. If a patient is to be scheduled or is scheduled for cataract surgery and is instructed to return for an A scan with intraocular lens power calculations, there is no medical necessity for a technician visit, and billing such is perpetuating fraud. The same is true for other diagnostic tests. However, in the case of visual fields, for example, if a scheduled office visit with the physician is planned for glaucoma follow up, then it would be permissible to bill for both the office visit and the test.

Some other common errors include billing an office visit for an optometric visit when the purpose for the visit was a refraction or low vision evaluation (not visual rehabilitation), and using CPT code 95060 (Ophthalmic mucous membrane tests) for billing Schirmer Tear Tests that are included in the office visit and not billable separately.

Consultations. Note: Medicare's consultation policy was revised in December of 2005 and clarified in 2006. See article on Consultations under E/M Coding section.

Eye Codes (CPT Codes 92004/92014/92002/92012)

In CPT there are extensive definitions for the Ophthalmological Services, commonly referred to as the Eye Codes or Ophthalmology Codes. Many practitioners have not paid particular attention to the definitions in the CPT, let alone adhere to their individual contractor's policies. Beware! Audits of eye codes are increasing. The definitions in CPT admittedly are broken and not well crafted, but they are there and are incorporated into almost all contractor policies. Audits are being conducted based on them. Here are some key points to remember:

- Make sure you have medical necessity for all the individual examination elements for the level you chose to bill.
- Technicians frequently forget to do confrontation fields, and to a lesser extent, basic sensorimotor examination. The physician needs to fill those in if the comprehensive codes are to be billed (92004/92014).
- Contractors may have screens for the frequency of the comprehensive eye codes. Usually, more than 2 services per year will be denied or downcoded.
- The comprehensive eye code audits (CPT codes 92004, 92014) often focus on the phrase "It always includes initiation of diagnostic and treatment programs." This usually is interpreted to mean that if you do not initiate a diagnosis or treatment program, even if it is a nonbillable (to Medicare) service, such as a refraction, then under audit the comprehensive eye code will be downcoded to 92002, 92012 or a lower level E/M code.

Evaluation and Management (E/M) Codes

Level 5 Office Visits/Consultations. Many practices still have not mastered the basic requirements of Evaluation and Management Coding. The Documentation Guidelines issued in 1997 by HCFA(now CMS) and the AMA (American Medical Association) are still the ones that you need to be in compliance with for E/M codes and many carriers have local coverage determinations (LCD) and coding guidelines for the ophthalmology (eye) codes. The E/M codes are going to be in effect for some time since the last attempted revision was voted down last year.

A great deal of legal compliance work is being generated by practices under audit for various problems associated with both sets of codes. The E/M level 5 codes are often a trigger for audits.

CPT defines the various level 5 codes as follows:

99245 Office consultation for a new or established patient, which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:

- a comprehensive history;
- a comprehensive examination; and
- medical decision making of high complexity.

99215 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:

- a comprehensive history;
- a comprehensive examination;
- medical decision making of high complexity

In Medicare's auditing procedures, a practitioner will seldom have met the requirements for 99245 - basically due to a conflict of interpretation of high risk. In the majority of cases it is prudent to use 99244. Be sure you know your contractor's regulations.

Some coding courses have advocated using 99215 rationalizing this by stating that you can use your previously taken comprehensive history and you can then perform a comprehensive examination thus meeting the 2/3 requirement. Billing 99215 using a brief notation that a previously taken history was reviewed, accompanied by a comprehensive examination that may or may not be medically necessary, will surely lead to serious problems. The 1997 Documentation Guidelines state, "Because the level of E/M service is dependent on two or three key components, performance and documentation of one component (eg, examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service."

Many well-intentioned practices have been audited and penalized by Medicare by using aforementioned faulty reasoning. When billing for

follow-up patients who are being followed at frequent intervals, there is only occasionally enough severity to warrant using code 99215.

Conclusion

In the final and third part of this series we will examine the fraudulent/abusive practices associated with Diagnostic Tests.

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