

Little Mistakes Can Still Be Fraud

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What is Fraud?

- Fraud is the intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person.
 - Findlaw.com

What is Fraud?

- Making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist.
 - These acts may be committed either for the person's own benefit or for the benefit of some other party.
 - In other words, fraud includes the obtaining of something of value through misrepresentation or concealment of material facts.
- Medlearn

Typical Medicare Fraud

- Phantom Billing for
 - Unnecessary procedures, or procedures that are never performed
 - Unnecessary medical tests or tests never performed
 - For unnecessary equipment; or equipment that is billed as new but is, in fact, used.
- Patient Billing
 - The patient involved provides his or her Medicare number in exchange for kickbacks.
 - The provider bills Medicare for any reason and the patient is told to admit that he or she indeed received the medical treatment.
- Up-coding and unbundling

Medicare's Take on Fraud

- Most frequently
 - Arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program.
- Violator
 - Physician or other practitioner
 - Hospital or other institutional provider
 - Clinical laboratory or other supplier
 - Employee of any provider
 - Billing service
 - Beneficiary
 - Medicare carrier employee
 - Any person in a position to file a claim for Medicare benefits.
 - Medlearn

Medicare's Take on Fraud

- Other violations, including:
 - The offering or acceptance of kickbacks
- Schemes range from
 - Individuals acting alone to broad-based activities by institutions or groups of individuals
 - Employ sophisticated telemarketing and other promotional techniques
 - Target and defraud several insurers
 - Not just Medicare
- Medlearn

Abuse

- Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program.
- Includes
 - Practices not consistent with goals of patient care that are
 - Medically necessary,
 - Meet professionally recognized standards
 - Are fairly priced
- Medlearn

Abuse

- Examples of Medicare abuse **may include:**
 - Misusing codes on a claim
 - Charging excessively for services or supplies
 - Billing for services that were not medically necessary.
- Both fraud and abuse can expose providers to criminal and civil liability
 - Medlearn

Medicare Fraud & Abuse Laws

- Used to address fraud and abuse
 - False Claims Act
 - Anti-Kickback Statute
 - Physician Self-Referral Law (Stark Law)
 - Social Security Act
 - U.S. Criminal Code
- Violations of these laws may result in
 - Nonpayment of claims
 - Civil Monetary Penalties (CMPs),
 - Exclusion from the Medicare Program,
 - Criminal and civil liability.

Medicare Part A-D)

1993 Survey - Health Insurance Association of America

- Overall health care fraud activity broke down as follows:
 - 43% Fraudulent diagnosis
 - 34% Billing for services not rendered
 - 21% Waiver of patient deductibles and co-payments
 - 2% Other

- Last Updated February 19, 1998

1993 Survey - Health Insurance Association of America

- Medicare's most common forms of fraud includes:
 - Billing for services not furnished
 - Misrepresenting the diagnosis to justify payment
 - Soliciting, offering, or receiving a kickback
 - Unbundling or "exploding" charges
 - Falsifying certificates of medical necessity, plans of treatment, and medical records to justify payment
 - Billing for a service not furnished as billed; i.e., upcoding
- Last Updated February 19, 1998

False Claims Act (FCA)

- The FCA protects the Government from being overcharged or sold substandard goods or services. The FCA imposes civil liability on any person who knowingly submits, or causes to be submitted, a false or fraudulent claim to the Federal Government.

False Claims Act (FCA)

- The “knowing” standard includes acting in **deliberate ignorance or reckless disregard** of the truth related to the claim.
- An example may be a physician who submits claims to Medicare for medical services he or she knows were not provided.
- Civil penalties
 - Fines
 - Up to 3 times the amount of damages sustained by the Government as a result of the false claims.
- There also is a criminal FCA .
- Criminal penalties
 - Fines
 - Imprisonment or both.

Anti-Kickback Statute

- Makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program.
- Statute is violated if
 - Remuneration is paid, received, offered, or solicited
 - To induce or reward referrals of items or services payable by a Federal health care program

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

- Created - May 2009
- Created by
 - Department of Health and Human Services (HHS) and
 - Department of Justice (DOJ)
- Cabinet-level priority
- Directed by
 - HHS Secretary Kathleen Sebelius
 - Attorney General Eric Holder.

HEAT's Mission

- To gather resources across the government to help prevent waste, fraud, and abuse in the Medicare and Medicaid programs.
- To crack down on the people and organizations who abuse the system and cost Americans billions of dollars each year.
- To highlight best practices by providers and organizations dedicated to ending waste, fraud, and abuse in Medicare.

HEAT's Mission

- To reduce health care costs and improve quality of care by preventing fraudsters from preying on people with Medicare and Medicaid. Learn more about [protecting yourself against Medicare fraud](#).
- To build upon the existing partnerships between HHS and DOJ to reduce fraud and recover taxpayer dollars.

HEAT Successes

- Between 2008 and 2011, HEAT actions led to a 75% increase in individuals charged with criminal health care fraud.
- Since 2007, HEAT's Medicare Fraud Strike Force, a multi-agency group of investigators designed to fight Medicare fraud, has charged more than 1,400 defendants who collectively falsely billed the Medicare program more than \$4.8 billion.
- In 2011, HEAT coordinated the largest-ever federal health care fraud takedown involving \$530 million in fraudulent billing.

Physician Self-Referral Law (Stark Law)

- Physician cannot refer certain designated health services if they
 - Have an ownership/investment interest (or immediate family member)
 - Have a compensation arrangement, unless an exception applies.
- Penalties include
 - Fines
 - Exclusion from participation in all Federal health care programs.

The Criminal Health Care Fraud Statute

- Prohibits knowingly and willfully attempting or executing a scheme or artifice
 - To defraud any health care benefit program;
 - To obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program
- Proof of actual knowledge or specific intent to violate the law is not required.
- Penalties for violating the Criminal Health Care Fraud Statute may include
 - Fines
 - Imprisonment
 - Both

Civil Monetary Penalties (CMP)

- Imposed for a variety of conducts
- Differing amounts of penalties and assessments
 - Based on the type of violation at issue
 - Range from up to \$10,000 to \$50,000 per violation.
- Can also include assessment of
 - 3 times the amount claimed for each item or service,
 - 3 times the amount of remuneration offered, paid, solicited, or received.

Civil Monetary Penalties (CMP)

- Violations include presenting claims that the person knows or should know:
 - Is for an item or service that was not provided as claimed or is false and fraudulent
 - Is for an item or service for which payment may not be made
 - Violating the Anti-Kickback Statute.

CAUTION – Hospital Employed NPP's

- After it self-disclosed conduct to the OIG, Inova Health Care Services d/b/a Inova Fairfax Hospital (Inova), Virginia, agreed to pay \$528,158 for allegedly violating the Civil Monetary Penalties Law provisions applicable to kickbacks and physician self-referrals.

CAUTION – Hospital Employed NPP's

- The OIG alleged that Inova paid remuneration to Arrhythmia Associates (AA) in the form of services provided by certain physician assistants (PA) within the office of AA. Specifically, Inova provided PA services to AA without written contracts in place and failed to bill and collect for those PA services.

Aetna Fraud

- Filing claims as out of network provider .
Increased charges
 - From \$1,400 to \$16,380 for the first 30 to 74 of critical care
 - From \$3,000 to \$30,000.00 for C-section delivery
- Charged \$56,000.00 for a \$74.00 ultrasound
- One physician was overpaid by \$4.4 million over 15 months
- 6 physicians reimbursed \$8.3 million up from \$4.1 million previous year

Are There Little Frauds?

- Does the breadth of the act determine the fraud?
- Is it like business ethics?
- Should you have known better?
- Were you “not given any choice”?

HIPAA

- Unintentional Violations
 - Simple non-compliance
 - Civil penalties
 - Carry less severe penalties.
 - Penalties as low as \$100.00
- Intentional Violations
 - Done with malice or for personal gain
 - Criminal matters
 - Carry severe penalties
 - \$250,000.00
 - 10 year imprisonment
 - Penalties may include
 - Loss of accreditations
 - Loss of medical license
 - Other sanctions

So ask the question

Unintentional fraud ?

- Non compliance

Intentional Fraud ?

- Personal gain

GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

- **1995 Guidelines**

1. The medical record should be complete and legible.
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

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Diagnosis Issues

- Specificity
 - Controlled vs uncontrolled
- Hierarchal
 - Not alphabetical
- Signs & symptoms
- Payable diagnoses

Documentation of History

- The levels of E/M services are based on four types of history
 - Each type of history includes some or all of the following elements:
 - Chief complaint (CC)
 - History of present illness (HPI)
 - Review of systems (ROS)
 - Past, family and/or social history (PFSH).
- 1995 E&M Guidelines

Chief Complaint

- The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.
- *DG: The medical record should clearly reflect the chief complaint.*
 - *1995 E&M Guidelines*

Differing Rules

- 2 plausible differential diagnoses, comorbidities or complications (not counted as separate problems) clearly stated and supported by information in record: requiring diagnostic evaluation or confirmation

• **Trailblazers**

Differing Rules

- Drug management, per problem. Includes “same” therapy or “no change” in therapy if specified therapy is described (i.e., record documents what the current therapy is and that the physician reviewed it). Dose changes for current medications are not required; however, the record must reflect conscious decision-making to make no dose changes in order to count for coding purposes.
- Do not count as treatment option’s notations such as: Continue “same” therapy or “no change” in therapy (including drug management) if specified therapy is not described (record does not document what the current therapy is nor that the physician reviewed it).

99211 & Lab Testing

- An Evaluation & Management (E/M) service is not medically necessary when the test is the main reason for the patient encounter. We see this situation with many different types of blood tests, including a prothrombin time (CPT Code 85610).
- Services billed to Medicare must be reasonable and necessary for the diagnosis and treatment of an illness or injury. A face-to-face encounter with a patient consisting of elements of both evaluation and management is required. The record substantiates the Evaluation portion when the record includes documentation of a clinically relevant and necessary exchange of information between the provider and patient.

99211 & Lab Testing

- Here are some examples of documentation that does not support the use of CPT 99211:
 - The documentation shows the PT/INR test results, but no additional patient complaint or any action by the nurse.
 - There is missing documentation to support the use of code 99211. Examples are vital signs, weight, patient recent history, etc.
 - There is no documentation to show the patient's condition required any level of E/M service for this date.
 - There is insufficient documentation to indicate the provider performed any E/M service.
 - The documentation shows the reason for the encounter was exclusively for the purpose of venipuncture.
 - There is no documentation of any face-to-face encounter.

Modifier -59 : OIG findings

- 40% error rate!
- Services were not distinct (53%)
- Service not adequately documented (25%)
- Documentation unclear or no documentation provided (28%)
- <http://oig.hhs.gov/oei/reports/oei-03-02-00771.pdf>

Modifier 59

Distinct Procedural Service

- Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under circumstances.
- Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion or separate injury (or area of injury in extensive injuries). However, when another already established modifier is appropriate it should be used rather than modifier 59

Modifier 59

Distinct Procedural Service

- Only if no more descriptive modifier is available and the use of modifier 59 best explains the circumstances should modifier 59 be used.
- NOTES: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, use modifier 25.

Modifier 59 Services Fraud or Not?

- Pulmonary Function Studies
 - Flow Loop
- Cardiac Stress Test
 - EKG
- Multiple endoscopic techniques

Modifier 52 or 53

Fraud or Not?

- 52 Reduced services
 - Accomplished some result but less than expected
 - Partially reduced or eliminated at physician discretion
 - Anesthesia not introduced (usually)
 - Medicare does not accept on E&M
- 53 Discontinued
 - Service started but could not be completed
 - Anesthesia started
 - Extenuating circumstances
 - Threatened well being of patient

Modifier 25

- \$1.96 billion allowed for modifier 25 claims
 - 29 million claims – 9% all E&M services
 - Used a 500 chart sample
 - 35% did not meet requirements
 - Overpayments of \$538 million
 - Significant numbers of claims had modifier 25 attached without need
 - 27% services
- OIG Study 2005

Modifier 25

- Documentation of E/M services and/or procedures missing
 - 27 percent of the sampled claims
 - 28% of all providers in the sample population
 - Used modifier 25 on more than 50 percent of their claims
- OIG report 2005

Modifier 25 – Significant Separately Identifiable E&M Service Provided by the Same Physician on the Same Day as the Procedure or Other Service

- It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significantly, separate....

Modifier 25

Fraud or Not?

- Office visit and
 - Pulmonary function testing
 - Ear wax removal
 - Nasopharyngoscopy
 - Infusion of medication
 - Arthrocentesis

Electronic Health Record Issues

- Ownership of input device
- Cut and paste portions of record
- Pull forward
- Pre-population of data based on type of service or chief complaint



Electronic Health Record Issues

- Templates checking all things
 - Conflicting information
 - No logic to assessment and plan
-
- Is the work documented being done?



BCBSM

- The documentation of each Patient Encounter must include:
 - Chief complaint and relevant history, including all pertinent health risks
 - Pertinent physical examination findings and prior diagnostic test results
 - Patient's progress, response to and changes in treatment, and revision of diagnosis
 - Assessment, clinical impression or diagnosis
 - Plan for care

Other Audit Problem Areas

- Office X-rays
- Office Procedures
- Office Injections
- Office Ultrasound guidance

BCBSM

- For nonsurgical diagnostic or therapeutic services requiring written interpretation, documentation in the patient's medical record must include, when relevant, the following:
 - Medications administered, including dose and route of administration
 - Nature, location and depth of injections, and use of imaging when required
 - Instruments and equipment used
 - Clinical findings (normal and abnormal) during the procedure
 - Patient's condition at the end of the procedure
 - Instructions for post-procedure care

BCBSM

- The physician's written interpretation must contain at least the following:
 - A specific description of all findings, both negative and positive, both normal and abnormal, both anatomic and physiologic for each procedure
 - Note: For imaging services, the number of views taken and the body areas viewed must be included.
 - An impression or diagnosis — and, for therapeutic services, the result of the therapeutic intervention
 - A plan for future patient management

Written Report

- IOM Chapter 13 Section 20.1
 - The interpretation of a diagnostic procedure includes a written report.
- IOM Chapter 13 Section 100.1
 - Carriers generally distinguish between an “interpretation and report” of an x-ray or an EKG procedure and a “review” of the procedure.
 - A professional component billing based on a review of the findings of these procedures, without a complete, written report similar to that which would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service.

X- Ray and EKG Interpretations

- IOM Chapter 13 Section - 100.1 (cont'd)
 - For example, a notation in the medical records saying “fx-tibia” or EKG-normal would not suffice as a separately payable interpretation and report of the procedure and should be considered a review of the findings payable through the E/M code. An “interpretation and report” should address the findings, relevant clinical issues, and comparative data (when available).

WPS Medicare

- **Missing/Insufficient Documentation for Injections**
- Documentation for injections must reflect the drug, dosage, frequency, method, and site of administration.
- Providers need be cognizant that dollars paid in error, whether small or large, can adversely impact the paid claims error rate.
- We recommend that providers consider performing periodic self audits if they provide these services.

BCBSM

- For surgical diagnostic and therapeutic services, the physician's operative report must contain at least the following:
 - Date of operation
 - Anesthesia or sedation used, and start and end times of anesthesia service
 - Operative approach used, and a summary of the procedures performed and the techniques used
 - Detailed operative findings, as well as any complications
 - Reference to specimens removed and appliances, hardware, etc., left in place

BCBSM

- For surgical diagnostic and therapeutic services, the physician's operative report must contain at least the following: *cont'd)*
 - Pre- and post-operative diagnoses
 - Name and signature of primary surgeon, and names and credentials of any surgical assistants
 - Note: If the operative report is dictated, the date of the dictation and transcription must be recorded in the patient's medical record.

Supervision of Diagnostic Tests

- NP/PA may perform diagnostic tests, but may not supervise someone else (tech/nurse) performing the diagnostic test
- "“Physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives who do not meet the definition of ‘physician’ may not function as supervisory physicians for the purposes of diagnostic tests,”
 - 2010 Hospital Outpatient Prospective Payment System (OPPS) Final Rule (*Federal Register* Nov. 20, 2009).

More Info

- Nurse practitioners, clinical nurse specialists, and physician assistants are not defined as physicians under §1861(r) of the Act. Therefore, they may not function as supervisory physicians under the diagnostic tests benefit (§1861(s)(3) of the Act).
- However, when these practitioners personally perform diagnostic tests as provided under §1861(s)(2)(K) of the Act, §1861(s)(3) does not apply and they may perform diagnostic tests pursuant to State scope of practice laws and under the applicable State requirements for **physician supervision (“S) or collaboration**.

Direct Supervision Therapeutic Service

- 2009 OPPS Final Rule
 - CMS determined the supervising physician or non-physician practitioner can be anywhere on the hospital campus, including
 - Physician's office
 - On-campus skilled nursing facility
 - Rural health clinic
 - Other non-hospital space

Direct Supervision Therapeutic Service

- 2012 OPPS Final Rule
 - Off-campus Physician Based Departments (PBD) of hospitals
 - CMS continued to require that the physician or NPP must be present in the off-campus PBD

Supervision of Therapeutic Services

- NPP's can directly supervise
 - Any service they can personally furnish
 - State scope of license
 - Hospital-granted privileges
- Which NPP's
 - Clinical psychologists
 - Nurse practitioners
 - Physician assistants
 - Clinical nurse specialists
 - Certified nurse-midwives
 - Licensed clinical social workers

FAQ from WPS Medicare



Intentional Fraud or Unintentional Fraud

Diagnostic Service

- **We perform a diagnostic service in the office; the physician reviews the test, and makes notes in the patient's chart. Is this documentation sufficient to submit a charge for the professional component?**
- No. CMS IOM Publication 100-04, Chapter 13, Section 100.1 shows Carriers generally distinguish between an "interpretation and report" of an x-ray or an EKG procedure and a "review" of the procedure. A professional component billing based on a review of the findings of these procedures, without a complete, written report similar to what would be prepared by a specialist in the field, does not meet the conditions for separate payment of the service.

Procedures

- **Is there a restriction on the level of procedure codes allowed under the incident to or shared/split guidelines?**
- There is no restriction on the level of service as long as the situation meets the requirements and the person providing the services can legally perform the services

History

- **Where does it state that ancillary staff can record the chief complaint (CC)? In addition, can you confirm that ancillary staff can obtain the review of systems (ROS) and past, family and social history (PFSH?)**
- The 1995 and 1997 Documentation Guidelines (DG) do not address who can record the chief complaint. WPS Medicare will allow the CC when recorded by ancillary staff. However, the physician must validate the CC in the documentation. The 1995 and the 1997 Documentation guidelines indicate ancillary staff may obtain the ROS and PFSH but they do not indicate the ancillary staff can obtain the History of Present illness

Who Can Document History

- **DG:** *The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.*

– 1995 E&M Guidelines

History

- **This question pertains to an Electronic Medical Record (EMR.) We have always been taught that the progress note "stands alone." When we are auditing physician's notes to determine if they are billing the appropriate level of service, what parts of the EMR can be used toward their levels without requiring them to reference it? We are referring specially to Growth charts, Past, Family, & Social History, Medication Listings, Allergies, etc.**
- If the physician were not referencing previous material in the EMR, then the information would not be used in choosing the level of E/M service.

History of Present Illness

- **If the nurse takes the HPI, can the physician then state, "HPI as above by the nurse" or just "HPI as above in the documentation"?**
- **No. The physician billing the service must document the HPI.**

History

- **When a medical assistant (MA) takes and records the vital signs in the chart of a flow sheet, does the physician need to include the information in his/her note or reference them in his note in order to receive credit under the "constitutional section" for E/M coding?**
- Yes, the vital signs need to be referenced. If the MA wrote them in the flow chart, it would not be apparent the physician saw the vitals unless the physician actually referenced them or re-dictated them in his/her note.
- In a physician's handwritten note for a visit, the MA will usually write the vitals at the beginning. In that case, it would be a fair assumption that the physician saw and was aware of the vitals and agreed with the findings. In the case of a dictated note, it is assumed that the physician saw the vitals taken by the MA before he/she dictated them. In both of those scenarios, as long as it could be easily inferred from the physician's notes that the physician was aware of the vitals, nothing further would be necessary

Examination

- **Can we count, in the exam element, performing a procedure and commenting on test results to choose level of Evaluation and Management (E/M?)**
- These actions are not part of the exam.

Medical Decision Making

- **Define self-limited or minor problem in the medical decision making grid under minimal level of risk. At times, it is difficult to determine whether a problem is self-limited or minor or whether it is a new problem with no additional work-up planned.**
- Determine whether the documentation shows you are treating the problem. If you are not treating the problem and the nature of the problem does not affect your MDM for the chief complaint of today's encounter, then you would not calculate that into your assessment of the patient's risk. The 1995 and 1997 DGs indicate the determination of risk is complex and not readily quantifiable and includes some examples in each of the categories.

Medical Decision Making

- **Can we use a referral or a decision for surgery in documenting the amount and complexity of data reviewed?**
- A referral or a decision for surgery is part of the "risk of significant complications, morbidity, and/or mortality" portion of the MDM.

New vs Established Patient

- **Doctor A is new to our group. If a former patient sees Doctor A under our group, is this patient new or established? If the former patient has a visit with Doctor B, in our group with the same specialty as Doctor A, is the patient new or established?**
- If Doctor A sees his/her former patient, the service is an established patient visit. Doctor A's NPI shows the provider has seen the patient within the previous three years. If the patient sees Doctor B under the new group with the same specialty without seeing the Doctor A first under the new group, then the patient is considered a new patient because the Tax ID is different.

Incident To

- **We schedule patients for injections, blood draws and other minor visits before the physician comes into the office. Can we bill for these services under the incident to guidelines?**
- Medicare pays for services and supplies (including drugs and biologicals) furnished incident to a physician's or other NPP's services, which are commonly included in the physician's bills, and for which payment is not made under a separate benefit category listed in §1861(s) of the Act. One of the requirements of incident to billing is that the physician must provide direct supervision - the physician must be in the office suite. For more information, see the [CMS IOM Publication 100-02Adobe Portable Document Format](#), Chapter 15, Section 60.
- Laboratory tests have their own benefit category as listed in §1861(s) of the act and as such are not subject to the incident to guidelines. Medicare considers a blood draw as part of the Clinical Laboratory services and as such is not subject to the incident to guidelines.

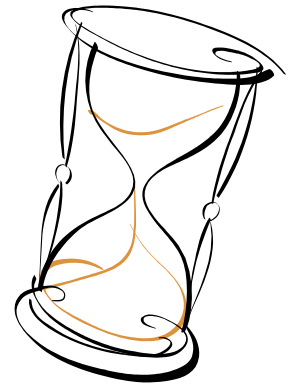
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Time

- **Can I use a check box indicating 30-74 minutes instead of saying I spent 51 minutes in critical care? In addition, the doctor was in and out of critical care for the patient all day. Is it ok at the end of the day to document "45 minutes today?"**
- Document the total time spent each time you visit the patient. CMS IOM Publication 100-04, Chapter 12, Section 30.6.12.E states, "Critical care is a time-based service, and for each date and encounter entry, the physician's progress note(s) shall document the total time that critical care services were provided"

Time



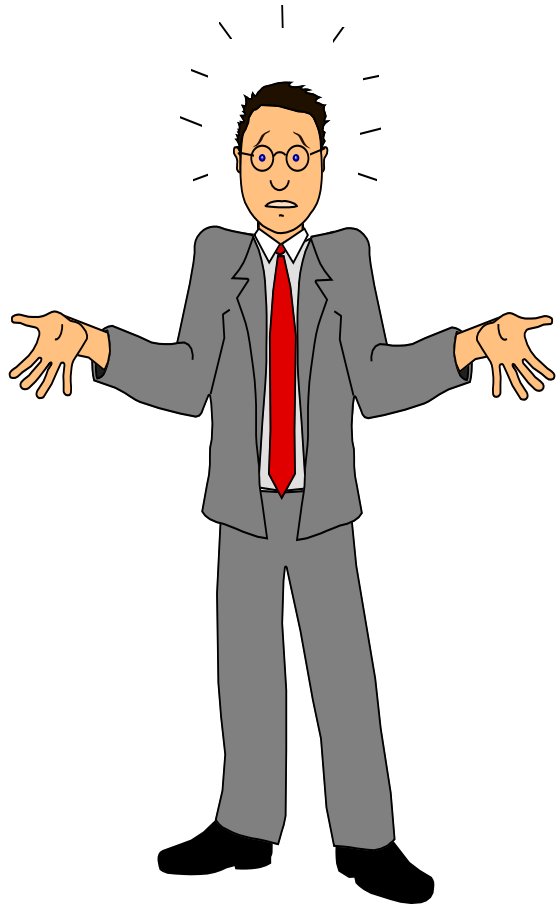
- The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded when time is used for the selection of the level of a service that involves predominantly coordination of care or counseling.

• MCM Ch. 12:30.6.1.B

Time

- **How must we document the start and stop time of the prolonged care service?**
- The services are time-based code so the time must be documented. Chapter 12, Section 30.6.15.1D of the Medicare Claims Processing Manual, Publication 100-04, also states that *"The start and end times of the visit shall be documented in the medical record along with the date of service."*

THANK YOU!!



QUESTIONS???

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