Teaching Physician Compliance ALERT
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Time-Based Evaluation and Management Services

The National Government Services (NGS) Medicare Medical Review Department is currently performing service-specific prepayment audits on several families of evaluation and management (E&M) services as well as prolonged services.

Medical review results show two main problems when time-based codes are billed:

- **the amount of time involved is not documented**
- **the records lack documentation detailing what was actually done during that time.**

It is essential that the documentation specifically state the amount of time involved in the service. Simply stating, for example, that you had a "lengthy discussion with the patient" is imprecise and subjective. For E&M services where more than 50% of the time is spent counseling or coordination of care, **the *total time of the visit is required* as well as the *amount of time spent counseling***. Only the actual face-to-face time spent by the provider billing for the service can be considered in determining the level of E&M service. Time spent with the patient by other staff such as nurses and office assistants cannot be included in the face-to-face time.

Face-to-face time for office and other outpatient visits includes the physician performance of such tasks as:

- obtaining a history
- physically examining the patient
- counseling the patient.

Non-face-to-face time includes such tasks as:

- reviewing records and tests
- arranging for further services
- communicating with other professionals and the patient through written reports or telephone contact
- discussing the patient with the family without the patient present.

When billing time-based codes for outpatient services, do not include non-face-to-face time in the total time for the service.

Documentation in support of counseling includes the following:

- total duration of face-to-face or floor time
- the duration of counseling or coordination of care and medical decision making
- a detailed description of the coordination of care or counseling provided.

The documentation needs to provide sufficient information on what was coordinated, what was discussed, or advice provided during counseling. Simple references such as "chart reviewed, RN consulted, reviewed Rx, etc." is not sufficient. Bear in mind that auditors may review the number of services billed by a provider on a day-by-day basis and add up the time spent on counseling to ensure that it is reasonable.

The physician need not complete a history and physical examination in order to select the level of service. Time spent in counseling/coordination of care and medical decision-making will determine the level of service billed.

Source: National Government Services, Medicare Part B, Clinical Education, Time Based Evaluation and Management Services May 2012.

Who can obtain the history of present illness (HPI)?
According to a NGS FAQ, only the physician can obtain the patient's HPI. The FAQ stated:

Q25 Can office staff record the HPI and have the physician sign or initial as acknowledgement of his review?
A. No, the physician must personally document the HPI.

Office staff would include but not be limited to medical assistants, LPNs, RNs, and technicians.

Source: National Government Services 4/7/11 FAQ

Upward Trending of E/M Levels Worries OIG

The U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) says that physicians are reporting high-level evaluation and management (E/M) codes more frequently for all types of E/M services. Medicare payments for E/M services increased 48 percent in the decade ending 2010, from $22.7 billion to $33.5 billion.

The OIG analyzed E/M services to determine coding trends from 2001-2010 and identified 1,700 physicians "who consistently billed higher-level E/M codes," despite treating similar patients to other physicians in the review. These "outlier" physicians billed the two highest codes within a visit type at least 95 percent of the time and are, the OIG implies, ripe for audit. The OIG has already shared with CMS its list of the approximately 1,700 physicians it identified as "consistently billing higher level E/M codes in 2010," and "will also consider these physicians for further review in our continuing series of evaluations of E/M services."

The OIG concurred that the upward trending of E/M services is due, at least in part, to abusive or fraudulent activity. In response, OIG proposed three recommendations to the Centers for Medicare & Medicaid Services (CMS):

- Continue to educate physicians on proper billing for E/M services.
- Encourage Medicare contractors to review physicians' billing for E/M services.
- Review physicians who bill higher-level E/M codes for appropriate action.

Next, the OIG plans to issue a report that will assess the extent of documentation vulnerabilities in E/M services using electronic health record (EHR) systems. The bottom line: Providers can expect greater scrutiny of E/M services in the months and years ahead.

Beware of E&M Revenue Enhancement Scams

An Ocala osteopathic doctor, Adam Alpers, M.D. was featured on NBC's "Rock Center" news magazine recently as an example of how some physicians try to manipulate the Medicare and Medicaid systems by stretching the reimbursement payment limits. The news program referenced Alpers' video series, "Medical Coding Cash Secrets," which promises health care professionals thousands of dollars in additional earnings if they follow his guidance on pushing their billing practices to maximum financial effect. The video, which Alpers sells for $349, not only included advice that may be suggestive of upcoding but also a list of glowing testimonials from providers who said

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they'd never used the program. Dr Alper's defended his course materials as "teaching providers how to use the proper billing codes for things they are already doing"; however, his website was reportedly taken down "for maintenance" shortly after the NBC probe.

As stated in our Yale Physicians Medical Billing Compliance Manual, Departments or Sections should advise the Director of the YMG prior to engaging any outside billing consultant and should provide a copy of any reports prepared by such consultants.
Source Ocala.com & MSNBC

In The News

Lawsuit Claims 24 Million in Medicaid Fraud by CT Dentists

The state has lodged civil fraud charges against a half-dozen individuals and 22 dental corporations asserting that they schemed to illegally collect more than 24 million dollars from Medicaid in Connecticut over two years. The alleged mastermind of the scheme, Gary Anusavice, was a former dentist in Massachusetts and was convicted of a felony for submitting false health care claims. As a result of this conviction, Anusavice was excluded from participating in any state or federal health care programs. The exclusion specifically banned him from submitting or causing to submit claims for payment. Anusavice created a series of corporations to set up dental practices in Connecticut and failed to disclose on Medicaid enrollment forms that he was an excluded provider.
Source: Meriden Record Journal

Southeastern Connecticut Pediatrician Pleads Guilty to Federal Child Pornography Charge

The United States Attorney's Office for the District of Connecticut, announced that Todd Parrilla, 48, of Stonington, plead guilty to one count of receipt and distribution of child pornography. In pleading guilty, Todd Parrilla, a medical doctor who had a pediatric practice in southeastern Connecticut, admitted that he possessed more than 100,000 images and videos of child pornography. At the time of his arrest, Parrilla was employed as a pediatrician in Pawcatuck, Connecticut. Dr. Parrilla faces five to 20 years in prison.
Source: U.S. Attorney's Office, District of Connecticut

Billing for Services Not Rendered

The United States Attorney's Office for the District of Connecticut, announced that Alan Emmett Bradley, 56, of Norwalk, Connecticut and Ocoee, Florida, was arrested in Florida on a federal criminal complaint charging him with one count of health care fraud. The criminal complaint alleges that Bradley billed the state of Connecticut Medicaid program for hundreds of services that he did not render.

As alleged in the criminal complaint, Bradley, a certified alcohol and drug abuse counselor, obtained the Medicaid cards of various Medicaid clients and used the cards to submit hundreds of claims to Connecticut's Department of Social Services. The claims alleged that Bradley performed 75- to 80-minute individual psychotherapy sessions to these Medicaid clients at his office in Norwalk. Hundreds of these counseling sessions did not occur and, for many of them, Bradley was actually living and attending school in Florida.
Source: U.S. Attorney's Office, District of Connecticut

Aetna Sues Surgery Centers Over Billing Practices

In a bold and unusual move, Aetna recently sued several California surgery centers for an alleged "fraudulent billing scheme". The lawsuit alleges that the surgery centers induced physicians to refer patients to the surgery centers with promises that the patients would not have any financial responsibility for their coinsurance and deductibles. Aetna claims that the surgery centers then turned around and submitted charges for reimbursement that were artificially inflated, driving up the cost of health insurance coverage.

Aetna's lawsuit alleges that providers are liable for engaging in a fraudulent and illegal kickback scheme when they waive a patient's coinsurance and deductible amounts, even if the provider bills the patient but ultimately does not collect from the patient. Aetna is asking the court to require the surgery centers to pay damages, to surrender their profits, and pay Aetna's attorney fees. Aetna is also asking the court to issue an injunction preventing such "fee-forgiving" practices in the future.
Source Duane Morris Health Law

Aetna Deselecting Physicians Based on E&M Coding Patterns

Aetna has notified 130 Texas physicians it will terminate them from its networks as of July 1, 2012. Aetna says it told the physicians a year ago it was concerned about their billing patterns. Evaluation and management (E&M) codes were the only ones Aetna examined, and its concern primarily involves level 4 and 5 E&M codes. The Texas Medical Association learned that Aetna sent letters to the deselected physicians that stated their billing data and coding practices caused them to be more costly than their peers. At least one physician in New Jersey was also dropped from Aetna's network for the same issues. At the time of this article, it is unclear if this is a national initiative or if certain states were targeted.
Source: Texas Medical Association & Hartford Courant

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