

## Medicare Zeroes In On E&M Coding As Key Source Of Payment Mistakes

If physicians are able to gain a better understanding of one of Medicare's most frustrating administrative requirements, there may be hundreds of millions of dollars in it for them.

Confusion about which codes to use for services contributed to estimated overpayments of more than \$20 billion to various program participants.

But nearly \$1 billion stayed in the federal coffers when it should have gone to medical professionals, and the agency suspects that the same coding confusion could be largely to blame. A special investigation of underpayments found that the vast majority of the reimbursement shortfalls to physicians alone could be linked to a familiar administrative headache: the evaluation and management code. Studies from past years had focused only on overpayments.

In part because of this discovery, CMS is asking the AMA to collaborate on a new effort to give physicians and carriers better guidance on E&M codes, which have been used since 1992 for some of the most common services that doctors provide. The agency last updated its written set of guidelines for the Association-owned system in 1997.

The AMA Current Procedural Terminology Editorial Panel, which is responsible for drafting changes to the coding structure, welcomed the chance to take another swing at improving a system that has left so many doctors perplexed and dissatisfied.

Federal officials have not established a final goal for the new initiative beyond reducing the amount of overpayments and making sure that doctors are fairly compensated for their services.

The solution that Medicare officials seek could involve making a better differentiation between the intensity score, measured using either three or five levels, that the system assigns to each E&M service.

One of the most common upcoding and downcoding mistakes that physicians made last year involved a one-level error, such as billing for a full, level-five office visit when they should have billed instead for a level-four service.

But fixing this problem is easier said than done, according to CMS. "Published studies suggest that under



certain circumstances, experienced reviewers may disagree on the most appropriate code to describe a particular service," the study says. "This may explain some of the incorrect coding errors in this report."

### A Familiar Effort

So if the overpayments and underpayments attributable to physicians are largely due not to errors but to honest differences in clinical judgment, is there any set of guidelines that could solve the problem?

The AMA, medical specialty societies and Medicare officials have been attempting to make the system work better for more than a decade.

Levels of physician frustration with the current CMS guidance led the Dept. of Health and Human Services' own regulatory reform advisory panel to recommend in 2002 that the agency drop the instructions altogether.

At the AMA Interim Meeting in Atlanta last month, delegates approved a resolution renewing Association support for CMS pilot studies to determine whether adoption of new real-world clinical examples would enable doctors to understand what codes to use in particular situations.

"CMS will encourage carriers to remind physicians about the importance of billing correctly to avoid upcoding and undercoding," the study says.

While CMS started to investigate the likely causes of underpayments for the first time in the fiscal year 2004 error rate report, the agency is still focused mainly on the cases in which Medicare participants are being paid too much.

### Focus on the Overpayments

Lawmakers also continue to exert pressure on CMS to stamp out more of the overage that is due in part to purposeful upcoding and other attempts to defraud the Medicare system. Senate Finance Committee Chair Charles Grassley (R, Iowa), one of Capitol Hill's most prominent watchdogs on this issue, said, "Improper payments jeopardize Medicare's ability to treat a growing population of beneficiaries. They have to stop." ▲

*(Excerpted from American Medical News, January 3/10, 2005)*

# The "Welcome To Medicare" Visit



Effective for dates of service on or after January 1, 2005, Section 611 of the Medicare Modernization Act provides for coverage under Part B of an initial preventive physical examination (IPPE), including a screening electrocardiogram (EKG), for new Medicare beneficiaries.

This physical examination is a once-a-lifetime benefit for a beneficiary and it must be performed within six months after the effective date of the beneficiary's first Part B coverage, but only if such Part B coverage begins on or after January 1, 2005. A physical examination given on January 10, 2005, for example, to a beneficiary whose Medicare Part B was effective initially on December 1, 2004 would not be covered under this benefit. If a beneficiary is first covered by Part B on January 1, 2005, then a physical provided on January 10, 2005 would be covered by this new benefit.

## Services Included in the IPPE

The initial examination means all of the following services:

1) Review of an individual's medical and social history, with attention to modifiable risk factors for disease detection, including past medical and surgical history, such as experiences with illnesses, hospital stays, operations, allergies, injuries and treatments, current medication and supplements, family history (including diseases that may be hereditary or place the individual at risk), history of alcohol, tobacco, and illicit drug use, diet, and physical activities;

2) Review of an individual's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the physician or other qualified non-physician practitioner (NPP) may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations;

3) Review of the individual's functional ability and level of safety based on the use of appropriate screening questions or a screening questionnaire, which the physician or other qualified NPP may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations, including, at a minimum, a review of hearing impairment, activities of daily living, falls risk, and home safety;

4) An examination to include measurement of the individual's height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the physician or qualified NPP, based on the individual's medical and social history (refer to 1 above) and current clinical standards;

5) Performance and interpretation of an EKG;

6) Education, counseling, and referral as deemed appropriate by the physician or qualified NPP, based on the results of the review and evaluation services described in the previous five elements;

7) Education, counseling, and referral, including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining the appropriate screening and other preventive services, which are covered separately under Medicare Part B. These include: (1) pneumococcal, influenza, and hepatitis B vaccines and their administration; (2) screening mammography; (3) screening pap smear and screening pelvic examinations; (4) prostate cancer screening tests; (5) colorectal cancer screening tests; (6) diabetes outpatient self-management training services; (7) bone mass measurements; (8) screening for glaucoma; (9) medical nutrition therapy for individuals with diabetes or renal disease; (10) cardiovascular screening blood tests; and (11) diabetes screening tests.

A new Healthcare Common Procedure Coding System (HCPCS) code, G0344 (IPPE; face-to-face visit, services limited to new beneficiary during the first six months of Medicare enrollment), will be used for billing the IPPE. As required by statute, this benefit always includes a screening EKG, which should be billed appropriately using new HCPCS codes G0366 (Electrocardiogram, routine ECG with 12 leads; performed as a component of the initial preventive examination with interpretation and report) for the full EKG service; G0367 (tracing only, without interpretation and report; performed as a component of the initial preventive examination) when only the tracing is performed; and G0368 (interpretation and report only, performed as a component of the initial preventive examination) when only the interpretation and report are performed. These three codes reflect the global, technical, and professional components of the screening EKG, respectively.

If the primary physician or qualified NPP does not perform the EKG during the IPPE visit, another physician or entity may perform and/or interpret the EKG. But, the referring provider must ensure that the performing provider bills the appropriate G code for the screening EKG and not a CPT code in the 93000 series.

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Physicians and qualified NPPs should bill G0366 for the full EKG service (tracing, interpretation, and report), or G0367 when only the tracing is performed, or G0368 when only the interpretation or reporting is performed. Hospitals can only perform the EKG tracing, so they should bill G0367 when they perform the tracing component of the EKG.

While some components for a medically necessary evaluation and management (E/M) service will be reflected in the new HCPCS code of G0344, Medicare will, when it is clinically appropriate, allow payment for a medically necessary E/M service (CPT codes 99201-99215) at the same visit as the IPPE. That portion of the visit must be medically necessary to treat the patient's illness or injury or to improve the function of a malformed body member and

will be reported with modifier -25.

A physician or qualified NPP, in various provider settings, may bill for the screening and other preventive services currently covered and paid by Medicare Part B under separate provisions of section 1861 of the Act, if provided during this IPPE.

The Medicare Modernization Act did not make any provision for the waiver of Medicare coinsurance and Part B deductible for the IPPE. Payment for this service would be applied to the required deductible, which is \$110 for calendar year 2005, if the deductible has not been met, with the exception of Federally Qualified Health Centers (FQHCs), and the usual coinsurance provisions would apply. ▲

### ***Same portions of one visit cannot be counted toward both “Welcome to Medicare” visit and separate E&M visit.***

**Y**ou can bill an E/M visit and the new “Welcome to Medicare” visit for the same patient on the same date of service, but the history and exam you collect and perform for the preventive visit cannot be counted toward the E/M service level you choose for the sick visit.

Some components of a medically necessary E/M service, such as a portion of the history or the physical exam, may also be part of the “Welcome to Medicare” visit. If that is the case, the components should go toward “Welcome to Medicare,” not the E/M service.

That would make it very difficult to bill for high-level E/M services on the same date as the “Welcome to Medicare” visit - and virtually impossible for new patients.

New patient E/M visit codes 99204 (\$137.19, par, national, in-office) and 99205 (\$173.57, par, national, in-office) each require you to document all three elements - history, exam and medical decision-making. That's hard to do when some of the documentation would count toward the preventive visit billed as G0344 (\$97.40, par, national, in-office). It is a little easier to document the E/M for an existing patient because you need only two out of three of history, exam and medical decision-making.

A patient with enough problems to merit a high-

level E/M service - whether new or existing - probably shouldn't be getting the preventive visit on the same date anyway. If the patient has a systemic condition such as diabetes, it would be hard to justify doing the preventive visit because the patient regularly needs full system reviews.

The physical exam portion of the “Welcome to Medicare” visit must include the patient's “height, weight, blood pressure, a visual acuity screen and other factors as deemed appropriate” by the doctor, based on clinical standards and the social and medical history.

If you routinely measure patient factors beyond those required as part of the preventive visit, it may be hard to count those factors toward an E/M visit instead. You should measure as much as you need for the preventive visit, but be conservative if you're putting together a checklist of factors to measure for the preventive visit.

Tip: Document a medically necessary same-day 99214 (\$82.62, par, national, in-office) by documenting a detailed exam with 12 bulleted elements not including height, weight or blood pressure. If you can document moderate complexity medical decision-making, then you can bill the 99214 without the history - but remember the service must be medically necessary. ▲

Sources: Part B News, Vol. 19 No. 1 January 3, 2005; [www.empiremedicare.com/news/nynews05/010305init.htm](http://www.empiremedicare.com/news/nynews05/010305init.htm)

# Medicare Preventive/Problem Visit Carve-Outs

## A Step by Step Approach

How often does a patient present for his “annual checkup” and once in the exam room, say to his physician, “Oh, by the way, I’ve been having this pain...” Do you politely tell your patients, “I’m sorry, but I can’t address your pain during an annual preventive visit”? Not usually. Good patient care generally means providing both the preventive and the problem-focused “sick visit” services at the same time.

But good coding and billing requires you to bill Medicare only for covered screenings or services (such as a problem-focused E/M). You must properly “carve out” the rest - the non-covered and/or preventive services to bill to the patient.

**The carve-out should show that you’ve subtracted the Medicare allowable(s) from your full fee for the preventive service.** Medicare Carriers Manual (MCM) section 15501 spells out that when you perform both preventive and problem-focused services during the same patient visit, you can’t collect more than what the charge for the preventive exam alone would have been. Let’s walk through Medicare’s rules for coding and billing a split preventive/problem-focused visit.

### Step #1

Determine which portion of the visit was preventive in nature, and which portion was illness- or injury-driven. While physicians don’t have to document two separate notes, it often helps if they separate the “problem” from the “preventive” in their documentation.

For example, document “patient here for annual exam” and document the annual exam elements, then note “patient also complains of...” and document the history, exam and medical decision-making for the problem. Or write something such as, “Patient presenting for annual well-woman exam, but she also complains of...” followed by what they address during the visit.

### Step #2

Choose the correct preventive E/M code (99381-99397) based on the documentation. Keep in mind that codes 99381-99397 don’t require a chief complaint or HPI because there’s not supposed to be a problem.

Preventive services do include a comprehensive history and exam, anticipatory guidance, risk factor reduction/counseling, ordering of lab or diagnostic procedures and treatment of insignificant abnormalities. (Remember that the term “comprehensive” here isn’t synonymous with the term as it’s used in the E/M documentation guidelines. Specialty societies and other groups have drawn up preventive history and exam guidelines appropriate to the patient’s age, gender and identified risks.)

Remember that a preventive medicine visit (codes 99381-99397) is a non-covered service for Medicare. But it still needs to be reported and “carved out.”

### Step #3

Select the right problem-focused (or “sick visit”) E/M code based on that part of the documentation that attends to the illness, injury or complaint. The level of service chosen must be consistent with the work done just for the additional problem. A covered E/M should be for the care of abnormalities or pre-existing problems and requires a significant, separately identifiable E/M to which you’ll add modifier -25. Insignificant or trivial problems that do not require performance of the key components should not be separately reported.

### Step #4

Check to see if the patient received any Medicare-covered screening services during the visit. A few you might want to be on the lookout for: colon/rectal cancer screening (G0104-G0107, G0120-G0122); prostate cancer screening (G0102, G0103); screening breast cancer mammography (76092, G0202, G0203); glaucoma screening exam (G0117, G0118); Pap smear (Q0091); pelvic and breast exam (G0101); or flu, pneumonia and hepatitis B vaccines (G0008, G0009 and G0010).

In the case of well-woman exams, remember that Medicare pays only for some of the screening exams such as the Q0091 Pap smear and the G0101 pelvic/breast exam. Most other services rendered during a well-woman exam (eg, history, exam, counseling) are considered uncovered preventive services as described in Step #2.

One final note: Be sure you’re familiar with the Medicare policies for each of the screening services you provide. There may be some catches. For example, digital rectal exam code G0102 is covered by Medicare, but it’s only paid separately if it’s not performed with any other E/M service on the same day (which isn’t too likely). Otherwise, it’s bundled into the E/M code.

## Using ‘Noncontributory’ in E/M Documentation

Officials from the Centers for Medicare and Medicaid Services (CMS) have confirmed that you *can* use the word “noncontributory” during a review of systems and get credit for an organ system, if you use certain language and ask the patient about the system.

If you begin a review of systems and find that a particular system does not contribute to the presenting problem, you can get credit for that system if you properly document the review.

### Documenting a noncontributory system

The following questions and answers apply nationally, according to CMS.

**Q.** *Under limited circumstances, can you use “noncontributory” to support the review of systems (ROS) and family history components of an evaluation and management service (E/M)? If the only thing holding down the level of service that you want to bill is documentation stating: “Family History: noncontributory,” is this acceptable?*

**A.** It is understood that there are circumstances where the term is appropriate. Under the 1995 E&M guidelines we are instructed that the patient’s positive responses and pertinent negatives for the system(s) related to the problem should be documented. Where the system(s) is not related to the problem “noncontributory” may be utilized. Likewise, if a family history is pertinent to the patient’s condition and treatment it should be properly solicited and documented. However, if it is not pertinent, “noncontributory” will be accepted.

**Q.** *Will you get credit for a complete ROS if you document several pertinent systems and then state: “All others reviewed and noncontributory” (as “all others reviewed and negative” is acceptable)?*

**A.** Yes. This language is correct, but be cautioned against using other language when documenting E/M services. A statement in a medical record that

reads ‘ROS negative or unremarkable’ with no other information is insufficient documentation for a complete review of systems. A complete ROS should cover at least 10 organ systems. You should include all the positive and pertinent negatives that are applicable to the current complaint(s) by the patient. A summary statement that says ‘all other systems or X number of systems are negative’ (or ‘unremarkable’) is permissible. Without such a summary statement all systems need to be individually documented.

**Q.** *Does saying for instance “cardiovascular system noncontributory” satisfy the guideline’s definition of documented?*

**A.** The answer is yes. The same is true for the past/family/social history component of history taking: The P/F/S history is only one part of history taking. Generally one to three facts (for a new patient) need to be recorded depending on the level of history sought. Where there is no P/F/S history information recorded nothing can be counted. A statement that ‘family history is noncontributory’ would be acceptable. This indicates that you *did* ask the patient if any family illnesses/genetics/social issues etc. have an impact on the problem(s) presented by the patient.

Writing “discussed with patient and noncontributory,” indicates that you have spoken with the patient about the problem and should be a clear sign to an auditor that the system has been reviewed. ▲

## OIG Warning for Physicians:



### *“Do Not Charge ‘Added Fees’ for Medicare Services”*

OIG is sending a clear message to physicians that they may not charge beneficiaries additional fees for services covered by Medicare. Charges beyond Medicare’s coinsurance and deductible could violate the assignment agreement and result in civil money penalties and exclusion, the agency warns in a March 31 OIG Alert.

“Charging extra fees for already covered services abuses the trust of Medicare patients by making them pay again for service already paid for by Medicare,” HHS Acting Principal Deputy Inspector General Dara Corrigan said in the Alert. OIG cited a recent case involving a physician who gave his patients a “Personal Health Care Medical Care Contract” and asked them to pay an annual fee of \$600 for services that included the following:

- Coordination of care with other providers
- Comprehensive assessment and a plan for optimum health
- Extra time spent on patient care

The agency argued that some of the services included in the contract already were covered by Medicare, so the fee constituted a request for payment above the appropriate co-pay and deductible. To settle the matter, the physician agreed to pay an undisclosed amount to OIG and stop offering the contracts.

The agency states that providers may charge Medicare patients extra for items and services that are not covered by Medicare, but the Alert illustrates that providers should think carefully about collecting any boutique or concierge care payments from beneficiaries. Providers who want more guidance on this issue should request an advisory opinion from OIG. ▲

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## Compliance Review

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This publication has not been reviewed and approved by CMS or any other agency and does not guarantee how such agencies will interpret Medicare regulations in any specific case. Refer to Medicare regulations for greater specificity and guidance.

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