Weekly Auditing and Compliance Tip

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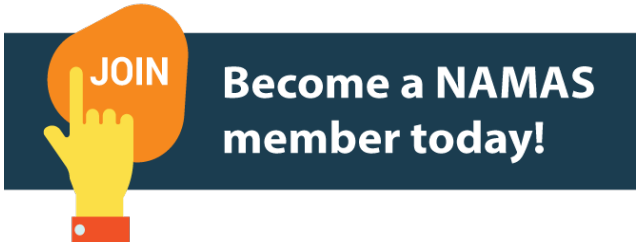
Auditing Evaluation & Management Services: Is it the Same for Everyone Everywhere?

Click Here to Listen to This Week's Audit Tip

The short answer is no but there is quite a bit of clarification necessary to fully qualify the point. There are various differences that need to be well understood while auditing E&M services performed and reported by Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC). Let's begin with establishing what is indeed consistently the case with E&M services, regardless of any place of service.

CPT codes are defined by the American Medical Association (AMA) and are updated annually from an editorial perspective. The specific evaluation and management (E&M) definitions within the CPT manual are consistent throughout the healthcare industry. For example, CPT code 99213 is defined as an "*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2*



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of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family" in any place of service. The levels of history, examination and medical decision making and estimation of time necessary to sustain this level of service would be indistinguishable in a provider's office (POS #11), Rural Health Clinic (POS #72) or a Federally Qualified Health Center (POS #50). In other words, the definitions within CPT are consistent across the board. So, possessing a strong understanding of the quantitative values of the various "levels" or history, physical examination and medical decision making (MDM) is paramount, regardless of where the site of service actually is. Over the years, we have heard folks say that the level of service reported in certain locations doesn't really matter because the method of reimbursement (e.g., all-inclusive rate [AIRR] or the Prospective Payment System [PPS] rate) does not directly impact the amount reimbursed. This is simply not true in the long run because the coding data is used throughout the insurance industry to provide benchmarks and trends. If providers code higher than documentation supports, it could make a patient population appear to be less "well" than they really are. Conversely, if providers routinely under-code (e.g., selecting CPT code 99213 when CPT code 99214 is substantiated), it would appear that the population served is less "ill" than they really are. This will definitely have long terms impacts on reimbursement rates.

We have established that the actual definitions of the CPT codes are universal. So, now let's delve into the aspects of auditing E&M services that may differ in one place as opposed to another. We can start with how one defines a new and an established patient. According to CPT, a new patient is *"one who has not received any professional services*

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January 23 & 24: Knoxville, TN
February 6 & 7: Atlanta, GA
February 13, 15, 20 & 22: Online Evenings (6pm - 9pm EST each session)
March 6 & 7: Kansas City, MO

*from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three (3) years."* However, if you are auditing professional services for providers in a Federally Qualified Health Center (FQHC), this definition is not compatible with the AMA's definition outlined above. Rather, according to CMS (and specifically for FQHCs), *"A **new patient** is one who has not received any professional medical or mental health services from any practitioner within the **FQHC** organization or from any sites within the **FQHC** organization within the past three years prior to the date of service"*. This pertains to Medicare covered service only. For example, if an FQHC patient gets a dental cleaning which is NOT covered by Medicare - then they are still eligible to be a new patient upon their next visit. For more information, use the following link: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf

Also in an FQHC, there is a need to understand something that does not pertain to non-FQHC settings called the Qualifying Visit List (QVL). There are a number of E&M codes that are not reflected within the QVL and, as such, may not qualify for reimbursement. For example, CPT code 99211 *(Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services)* does not qualify for reimbursement for the encounter (e.g., AIRR or PPS) in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). This is a level of service that is reported often in private practice for the likes of "nurse only visits" but CPT code does NOT reflect a billable "encounter" in the RHC or FQHC settings. Another aspect to consider about reporting the proper level of E&M service is that for RHCs, the patient's coinsurance is based on the charge. And the level of service in an FQHC affects the total

March 20, 21, 22: Online (1pm - 5pm EST)
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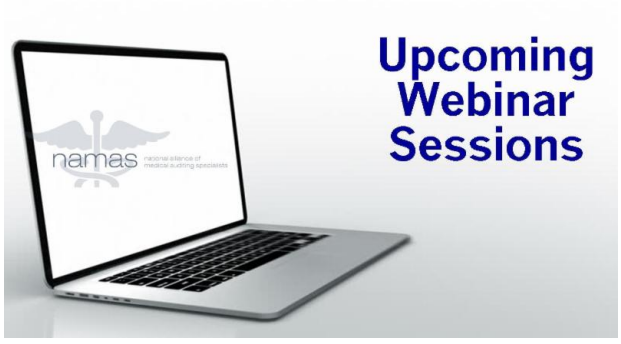

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MIPS Changes for 2018: What You Need to Know
(What You Need to Know Webinar Series)
Speaker: Grant Huang, CPC, CPMA
January 16, 2018
2pm EST

Benchmarking for Audit Risk

charges for the date of service and *"under the FQHC PPS, Medicare pays FQHCs based on the lesser of their actual charges or the PPS rate for all FQHC services furnished to a beneficiary on the same day when a medically necessary face-to-face FQHC visit is furnished to a Medicare beneficiary."* So, the level of E&M service selected may impact whether the FQHC gets their actual charges or the PPS payment rate.

This Week's Audit Tip Written By:

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John is the Vice President of Audit and Compliance Services for Association for Rural & Community Health Professional Coding

NAMAS Calendar of Events

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(Compliance Webinar Series)
Speaker: Frank Cohen, MPA, MBB
January 23, 2018
2pm EST

History of the E&M Encounter
(Hands-on Webinar Series)
Speaker: Stephanie Allard, CPC, CEMA, RHIT
January 30, 2018
2pm EST

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