

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance



Office of the Senior Deputy Director

Transmittal #15-08

To: DC Medicaid Physicians and Non-physician Practitioners (NPPs)

From: Claudia Schlosberg, JD 
Interim Senior Director and Medicaid Director

Date: **MAR 17 2015**

Subject: The Medicaid Recovery Audit Contractor (RAC) Program; Clarification of DHCF's Coding Requirements for Certain Hospital Claims by Physician and Non-Physician Practitioners; and Resumption of Audit Activity.

The purpose of this transmittal is to provide guidance to providers regarding the Department of Health Care Finance's (DHCF) Medicaid Recovery Audit Contractor (RAC) program and to clarify DHCF's coding requirements for claims submitted by physicians and non-physician practitioners (NPPs) for services provided to fee-for service and managed care Medicaid beneficiaries during a hospital visit. Specifically, this transmittal clarifies correct coding of Initial Hospital Care as well as Comprehensive and Consultative levels of services as defined in Current Procedural Terminology (CPT). The submission of claims using these codes has been the subject of recent reviews conducted as part of the District of Columbia's Medicaid Recovery Audit Contractor (RAC) program approved audit plan for physicians. Due to concerns raised by providers, DHCF temporarily suspended recoveries under these audits. This Transmittal also provides notice that, effective on the date of this transmittal, DHCF will resume RAC audit activity associated with these reviews.

1. Purpose of RAC Program

The Centers for Medicare & Medicaid Services (CMS) established the Medicaid Recovery Audit Contractor (RAC) program as a requirement for States to promote the integrity of the Medicaid program, pursuant to a requirement of the *2010 Patient Protection and Affordable Care Act* (PPACA). Medicaid RACs are mandated to review claims for which Medicaid payment has been made to identify underpayments and overpayments and recoup overpayments for the states. [42 CFR 455.506(a)]. Further, States must coordinate the recovery audit efforts of their RACs with other auditing entities, and make referrals of suspected fraud and/or abuse, as defined in 42 CFR 455.2, to the Medicaid Fraud Control Unit or other appropriate law enforcement agency.

The CMS Medicaid RAC final rule includes a number of provisions that respond to key industry concerns, including but not limited to:

- Medicaid RACs are limited to a three-year look-back period.
- Medicaid RACs must coordinate their RAC efforts with other auditor programs.
- Medicaid RACs are prohibited from auditing claims that other State agencies or contractors have already audited for the same issue.
- Medicaid RACs are required to notify providers of overpayment findings within 60 days.
- States are required to set limits on medical record requests.
- Medicaid RACs must employ at least one medical director.

2. DHCF's Coding Standards

Audits and reviews conducted by the Medicaid RAC program evaluate billing and medical record documentation using CMS' Health Care Common Procedure Coding System (HCPCS). Level I of the HCPCS are CPT codes, maintained by the American Medical Association, that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) when used outside the physician's office.

In calendar year 2010, CMS published the Medicare Physician Fee Schedule Final Rule with comment period (CMS-1413-FC) eliminating the use of all consultation codes for Medicare claims (inpatient and office/outpatient codes) for various places of service except for telehealth consultation G-codes.

Publication 100-04 Medicare Claims Processing Transmittal 1875 Revisions to Consultation Services Payment Policy section 30.6.10 - Consultation Services (Codes 99241 - 99255) states:

All physicians and qualified non-physician practitioners shall follow the E/M documentation guidelines for all E/M services. These rules are applicable for Medicare secondary payer claims as well as for claims in which Medicare is the primary payer.

The official instruction, CR6740, issued to Medicare MACs and carriers regarding this change may be viewed at <http://www.cms.hhs.gov/transmittals/downloads/R1875CP.pdf> on the CMS website.

Significantly, DHCF did not adopt these rules for District Medicaid claims, and DHCF has continued to recognize consultation codes. The DC Medicaid fee schedule reflects that consultation codes (99241-99245) and (99251-99255) are still payable under DC Medicaid.

Policy Clarifications/Reminders

Physicians and qualified NPPs should be aware that the District of Columbia MMIS Provider Billing Manual Version 3.03 Section 12.5.2 Program Limitations states that DHCF also endorses the “guidelines” and “notes” published in the CPT Manual. In some cases, specific disclaimers or re-definitions are documented to providers to explain the differences that are required by program limitations. Following is a list of these re-definitions specific to the use of the following CPT codes1. The Minimal Level of Service Category (99201, 99211, 99241, and 99251) as defined by CPT guidelines may not be claimed or reimbursed unless, at the visit, there is actually a face-to-face consultation between the physician and the patient which is annotated in the medical record. Services performed by assistants, nurses and other non-physician practitioners may only be claimed if there is a code accurately describing the services and a rate of reimbursement established other than the minimal level.

2. The Consultation Category of Service (99241-99245) (99251-99255) as described in CPT guidelines may not be claimed or reimbursed unless a comprehensive written report is prepared and forwarded to the referring physician or agency. A copy of the report must be available for review by DHCF.

3. The Comprehensive (99204, 99205, 99215, 99221, 99222, and 99223) and Consultative (99241-99245) (99251-99255) levels of services as defined by CPT guidelines will only be reimbursed at DHCF’s comprehensive rate of reimbursement for non-hospital patients to the same physician once within a twelve-month period.

4. The Initial Hospital Care (99221-99223) as defined in CPT may only be reimbursed once per hospitalization and should only be billed by the admitting physician, Subsequent hospital visits should be billed with the appropriate code for follow up visits. The physician receiving reimbursement for initial hospital care may not receive reimbursement at the comprehensive rate for subsequent hospital care services without supplying written justification.

5. The New Patient Visit (99201-99205) as defined by CPT guidelines may only be reimbursed one time every 1095 days to any participating physician or group for the same recipient.

CPT defines a new patient as: *One who has not received any professional services 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 years.* The 2014 CPT® manual defines professional services as those face-to-face services provided by physicians or other qualified health care professionals who may report an E/M service by a specific CPT code.

Remember, the new patient code group (99201-99205) requires all three elements (history, physical, Medical Decision Making) to meet the minimum level of service as opposed to the outpatient established code group (99211-99215) which has the two out of three requirements.

Providers are also advised to retain documentation for discretionary Medicaid review in the event that claims are questioned. The retained documentation must support the level of physician services billed and reimbursed by Medicaid.

Response to Concerns Regarding Current Audits

In response to concerns raised about the RAC Program by various providers, on October 8, 2014, DHCF temporarily suspended RAC program activity and consulted with the Centers for Medicare and Medicaid Services (CMS). In addition, DHCF's RAC contractor hosted three webinars to provide additional training and guidance to providers on correct coding of claims. DHCF's RAC contractor also extended opportunities for one on one consultation. Ultimately, DHCF was unable to identify any authority that would authorize us to terminate or change the scope of audits already in progress. Accordingly, effective with the date of this document, DHCF has directed the District's RAC Contractor to resume processing of these audits. However, for providers who disagree with the draft audit findings, we have directed the RAC Contractor to extend the time for submission of additional documentation to April 17, 2015.

Going forward, DHCF will make reasonable efforts to evaluate the impact of proposed audit plans on provider populations and adjust the audit plan to mitigate administrative impact on the provider as it relates specifically to the request for documentation to support billing and claims reimbursement where the look back period exceeds a one (1) year timeframe.

Additional Information

For additional information about this transmittal, please contact Donald Shearer at 202-698-2007, or email at Donald.Shearer@dc.gov

For additional information regarding HCPCS code set, please visit the CMS website at <http://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/>

For additional information about the ICD-9-CM, please visit the World Health Organization website at <http://www.who.int/classifications/icd/en/>

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Appendix A

Frequently Used Evaluation and Management (E/M) Code Descriptions

When the physician sees the patient for the first time in the hospital, use hospital admission codes (99221-99223). Documentation must meet three of three key components:

CPT 99221as: *Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making of straightforward or low complexity. Counseling and/or 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 problem(s) requiring admission are of low severity. Physicians typically spend 30 minutes at the bedside and on the patient's hospital floor or unit.*

CPT 99222: *Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or 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 problem(s) requiring admission are of moderate severity. Physicians typically spend 50 minutes at the bedside and on the patient's hospital floor or unit.*

CPT 99223: *Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or 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 problem(s) requiring admission are of high severity. Physicians typically spend 70 minutes at the bedside and on the patient's hospital floor or unit.*

Follow up visits in the hospital, use hospital subsequent day codes (99231-99233). Documentation must meet two of three key components:

CPT 99231: *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or 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 patient is stable, recovering or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.*

CPT 99232: *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or 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 patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.*

CPT 99233: *Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high*

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complexity. Counseling and/or 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 patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

New patient office or other outpatient visit codes (99201-99205)

CPT 99201: Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision-making. Counseling and/or 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 problems are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family.

CPT 99202: Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision-making. Counseling and/or 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 low to moderate severity. Physicians typically spend 20 minutes face-to-face with the patient and/or family.

CPT 99203: Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity. Counseling and/or 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 moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

CPT 99204: 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 moderate complexity. Counseling and/or 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 moderate to high severity. Physicians typically spend 45 minutes face-to-face with the patient and/or family.

CPT 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. Counseling and/or 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 moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

Established office or other outpatient visit codes (99211-99215)

CPT 99211: Office or other outpatient visits 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.

CPT 99212: Office or other outpatient visit for the evaluation and management of an established patient that requires at least two of these three key components: a problem focused history -a problem focused examination -straightforward medical decision making. Counseling and/or 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 self-limited or minor. Medical practitioners typically spend 10 minutes face-to-face with the patient and /or family.

CPT 99213: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three components: an expanded problem focused history-and expanded problem focused examination - medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified

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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. Medical practitioners typically spend 15 minutes face-to-face with the patient and/or family.

CPT 99214: 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 detailed history -a detailed examination -medical decision making of moderate complexity. Counseling and/or 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 moderate to high severity. Medical practitioners typically spend 25 minutes face -to-face with the patient and/or family.

CPT 99215: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the three key components: a comprehensive history-a comprehensive examination medical decision making of high complexity. Counseling and/or 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 moderate to high severity. Medical practitioners typically spend 40 minutes face-to-face with the patient and/or family.

Office Consultation Codes (99241-99245)

CPT 99241: Office consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision-making. Counseling and/or 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 self-limited or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

CPT 99242: Office consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision-making. Counseling and/or 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 severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family.

CPT 99243: Office consultation for a new or established patient, which requires these three key components: Inpatient consultation for a new or established patient, which requires these three key components: a detailed problem focused history; a detailed problem focused examination; and medical decision making of low complexity. Counseling and/or 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 moderate severity. Physicians typically spend 40 minutes face-to-face with the patient and/or family.

CPT 99244: Office consultation for a new or established patient, which requires these three key components: A comprehensive problem focused history; a comprehensive problem focused examination; and medical decision making of moderate complexity. Counseling and/or 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 moderate to high severity. Physicians typically spend 60 minutes face-to-face with the patient and/or family.

CPT 99245: Office consultation for a new or established patient, which requires these three key components: A comprehensive problem focused history; a comprehensive problem focused examination; and medical decision making of high complexity. Counseling and/or 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 moderate to high severity. Physicians typically spend 80 minutes face-to-face with the patient and/or family.

Hospital Consultation Codes (99251-99255)

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CPT 99251: *Inpatient consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision-making. Counseling and/or 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 self-limited or minor. Physicians typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.*

CPT 99252: *Inpatient consultation for a new or established patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision-making. Counseling and/or 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 severity. Physicians typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.*

CPT 99253: *Inpatient consultation for a new or established patient, which requires these three key components: a detailed problem focused history; a detailed problem focused examination; and medical decision making of low complexity. Counseling and/or 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 moderate severity. Physicians typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.*

CPT 99254: *Inpatient consultation for a new or established patient, which requires these three key components: a comprehensive problem focused history; a comprehensive problem focused examination; and medical decision making of moderate complexity. Counseling and/or 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 moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.*

CPT 99255: *Inpatient consultation for a new or established patient, which requires these three key components: a comprehensive problem focused history; a comprehensive problem focused examination; and medical decision making of high complexity. Counseling and/or 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 moderate to high severity. Physicians typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.*