Medicare Home Services (CPT® codes 99341-99350) are Being Audited

(June 20, 2017): As the Department of Health and Human Services (HHS), Office of Inspector General (OIG), signaled in both its ***2016*** and ***2017 Work Plans*****,** the government is concerned about the rapid growth they are seeing in the number of physician home services billed to the Medicare program. In order to qualify for coverage and payment, physicians providing this type of care are required to document why it is medically necessary to conduct a home visit of a patient in lieu of an office or outpatient visit. In light of the restrictive nature of these services, the OIG is in the process of conducting assessments of health care organizations that bill the Medicare program for Evaluation & Management (E/M) services provided at a beneficiary's home, sometimes colloquially referred to as ***"house calls."***

I. CPT Codes Used to Bill E/M Home Services in a Patient's Residence:

Only a limited set of codes may be used to report E/M services rendered to a patient living in their own home or apartment. CPT® codes 99341 through 99350 are used to code for Home Services. In order to qualify for coverage and payment under the Medicare program, the documentation must show that the E/M guidelines have been met and, in the case of a nonphysician practitioner (NPP), that the home service provided fits within the scope of practice authorized in that state. A description of these codes is outlined below. Please note, the time estimates indicated are only included in the AMA CPT Codebook descriptions. They are not included in either the **1995** or **1997** E/M Guidelines.

Home Visit Codes – New Patient:

99341 Low severity problem, 20 min.

99342 Moderate severity problem, 30 min.

99343 Moderate to high severity problem, 45 min.

99344 High severity problem, 60 min.

99345 Patient unstable or significant new problem requiring immediate physician attention, 75 min.

Home Visit Codes – Established Patient:

93347 Self-limited or minor problem, 15 min.

99348 Low to moderate problem, 25 min.

99349 Moderate to high problem, 40 min.

99350 Patient unstable or significant new problem requiring immediate physician attention, 60 min.

These codes cannot be used if the patient resides in a shared living facility or group home. In order for a home visit to be billed by a physician, the physician must have actually been present in the beneficiary's home. These codes only apply in care settings that can be properly coded as Place of Service (POS) 12 (Patient's Home).

II. Does a Patient Have to be "Homebound" in Order to Qualify for Home Services?

The homebound requirements of Medicare's home health benefit are not applicable to the provision of home services (as billed under CPT codes 99341 through 99350). In other words, a Medicare beneficiary does not necessarily have to be "***confined to the home***" in order for a physician to provide a covered home visit. Nevertheless, the medical record must document why it was medically necessary for the physician or qualified NPP to conduct a home visit in lieu of seeing the patient in the physician's office or in an outpatient clinic.

III. CMS Contractors are Actively Auditing E/M Services Conducted in a Patient's Home:

It is important to note that in addition to OIG, several CMS contractors are also actively auditing providers that have billed Medicare for E/M services conducted in a patient's home. As with their law enforcement counterparts, these administrative contractors are focusing their audits on whether the home visit was, in fact, medically necessary. As you will recall, a fundamental Medicare requirement under **§ 1862(a)(1)(A) of the Social Security Act** is that:

> ***". . . no payment may be made under part A or part B for any expenses incurred for items or services —***
>
> ***(1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. . ."***

With only limited exceptions,[1] the services provided by a physician or an NPP cannot be services that could be provided by a visiting nurse or home health agency under Medicare's home health benefits program.

Additionally, the decision to provide home visit services must be based on the medical necessity of providing in-home care. Medicare auditors will review the patient's medical records carefully to determine if, in fact, the patient was unable to come to the physician's office or an outpatient clinic for care. Moreover, even if the documentation supports that the patient was unable to come the physician's office or outpatient clinic on a specific date due to physical or mental disabilities, if the documentation does not support additional in-home visits, they will be denied.

IV. Know the Coverage Rules and Check Your LCD Covering Home Services:

It is essential that you understand the coverage and billing requirements governing home services as set out in the Medicare Benefit Policy Manual (MBPM) and the Local Coverage Determination (LCD) issued by your Medicare Administrative Contractor (MAC). LCD requirements may slightly vary from one jurisdiction to another. Therefore, you need to ensure that your practices fully comply with the LCD requirements applicable to your claims.

When assessing whether one or more home services are medically necessary, Medicare auditors will carefully examine the documentation associated with ***each*** visit. The documentation of each beneficiary encounter must include:

1. ***Reason for the encounter and relevant history;***
2. ***Physical examination findings, and prior diagnostic test results, if applicable;***
3. ***Assessment, clinical impression, or diagnosis;***
4. ***Medical plan of care including how the visit will change/changed the care of the beneficiary.***

To be clear, a physician or NPP must also obtain a full range of the administrative information normally obtained in an office visit when visiting a new patient. For instance:

- ***Did you provide the patient with necessary HIPAA privacy information? Did the patient complete a "Notice of Privacy Practices" form***
- ***Have you obtained an executed "Consent for Treatment" form from the patient?***
- ***Did you obtain a completed intake form for use with new patients?***
- ***Did you have the patient complete a form outlining their prior medical, family and social history?***
- ***Did you provide a copy of the organization's financial policies to the patient?***

V. Risk Areas When Billing for Home Services:

If audited, the Medicare reviewer examining your claims will likely deny payment if one of the following reasons for denial is identified:

1. ***It appears that one or more of the home services were was conducted for the***

convenience of the patient, the patient's family, or the physician, AND the documentation does not reflect that the patient was unable to come to the physician's office or an outpatient clinic for care.

2. ***The medical record does not clearly demonstrate that the patient, his/her family or another clinician involved in the case sought the initial service. In other words, what was the source of this referral? Was the care solicited by a party representing the home visit organization?***
3. ***The home services are provided at a frequency that exceeds that which is typically provided in the office and acceptable standards of medical practice.***
4. ***The home services are not being personally performed by a physician. It is being performed by an NPP but the claim is being billed at the physician's rate.***
5. ***The home services are being solely performed by an NPP but only the physician, not the treating NPP, is credentialed with Medicare.***
6. ***The specific services provided during the home services could be provided by a visiting nurse or home health agency.***

VI. Conclusion:

Home services (CPT® codes 99341 through 99350) billed to Medicare are currently being audited by multiple CMS contractors around the country and by OIG. If you receive a request for medical records from a UPIC, ZPIC or MAC, we recommend that you contact a qualified health lawyer as soon as possible. Depending on the contractor, the records request you receive may be related to a probe audit OR it may require that you send in a larger sample of records, one that the contractor contends is a ***"statistically relevant sample."*** If that is the case, the contractor will likely seek to extrapolate the error rate found when it reviews your claims records. It is imperative that you understand the ramifications of such an audit – call your health lawyer immediately.

Robert W. Liles, J.D., M.B.A., M.S., serves as Managing Partner at the health law firm Liles Parker, PLLC. Liles Parker attorneys represent health care providers around the country in connection with Medicare, Medicaid and Private Payor audits. For a free consultation, please call: 1 (800) 475-1906.

[1] The Medicare Benefit Policy Manual (MBPM), **Sec. 60.4**, "*Services Incident to a Physician's Service to Homebound Patients Under General Physician Supervision*," outlines very limited circumstances when a physician can provide services that would normally be performed by a home

health agency. Should a UPIC, ZPIC or MAC conduct a postpayment audit of these services, their review will focus, in part, on whether a "*substantial number of the services provided under this coverage when they could otherwise have been performed by a home health agency*."