PROVIDER Bulletin

KERN HEALTH SYSTEMS

May 8, 2023

Proper Claims Submission Updated 05/08/2023

Dear Provider,

Kern Health Systems (KHS) periodically conducts retrospective claim reviews and has identified some billing patterns that could result in a medical record request, audit, or claim payment recoupment. Some key examples of incorrect billing are listed below:

Advance Practice Practitioner

The individual performing/rendering the medical service **must** be reported in box 24J on a CMS1500 claims form. Supervising physician should not bill on behalf of the rendering provider.

Telehealth Services

Any services performed via telephonic, or telehealth must be billed with the CPT code representing the nature of the visit along with the Place of Service (POS) 02 and modifier 95. Although Medicare has different billing requirements, Medi-Cal requires the correct CPT code to be billed with the above POS and modifier.

For example, if an established patient is seen via telehealth CPT code 99212-99215 (level billed will vary based on documentation) would be billed with the modifier 95 and POS would be equal to 02. As with in-office E&M, telehealth visits must be medically necessary and performed by a medical provider. A call to a member to inform them of a negative lab result will not justify billing an E&M when performed by support staff and/or if the encounter is not medically necessary (above and beyond the visit where the lab was ordered). The lab read is implied and counted toward the E&M level when ordered per AMA guidelines. A positive result requiring additional work-up, medications, or other MDM should be documented and again, the visit must be performed by a medical provider just as an in-office E&M visit.

Abnormal amount of evaluation and management codes

The deviation of the standard quantity of visits billed based on established time frames for the codes billed.

For example, a provider bills 20 unique visits on a given day using CPT code 99215. CPT code 99215 equates to extensive medical decision making or a 40–54-minute visit. 20 visits x 40 minutes = over 13 hours in one workday (just for KHS members).

Billing appropriate level of care for each new or established visit: 99202-99205 or 99212-99215

Please ensure you are billing the appropriate level of care for each visit based on time spent with patient or complexity of the visit and supported in medical record documentation of the visit.

For reference, the 2023 CPT timeframe and MDM levels are indicated below:

99202: 15-29 min; straightforward	99212: 10-19 min; straightforward
99203: 30-44 min; low	99213: 20-29 min; low
99204: 45-59 min; moderate	99214: 30-39 min; moderate
99205: 60-74 min; high	99215: 40-54 min; high

****Please ensure your medical record documents support all diagnoses and all services billed.**

For additional resources, please reference links below. The AAPC/Codify website will assist you with information regarding Encounter Data, Medical Decision Making, Time-Based Coding, and Final Code Level. The AMA website will outline any Evaluation and Management (E/M) Code and Guideline changes.

AAPC/Codify: https://www.aapc.com/codes/em-calculator-2023

AMA website: https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

- The table on pages 8-13 breaks down medical decision-making levels and explains that 2 of 3 elements must be met to select the level. Pages 14-19 that follow the table explain each category in more detail.
    - Example: A chronic condition that is stable falls under lower MDM than one documented as uncontrolled or with a documented exacerbation or progression

If you identify any claims billed incorrectly, please contact your Provider Relations Representative at 1-800-391-2000 to discuss corrective action.

KHS posts all bulletins on the KHS website, www.kernfamilyhealthcare.com, choose Provider, then Bulletins.

Sincerely,

Melissa McGuire
Deputy Director of Provider Network
Kern Health Systems