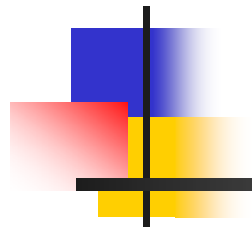


Non-Physician Providers Utilization and Risk for Physician Practices



PAHCOM
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Disclaimer

- This material is designed to offer basic information for coding and billing and is presented based on the experience, training and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the presenter does not accept any responsibility or liability with regards to errors, omissions, misuse, or misinterpretation. This presentation and handout is intended as an education guide only.



Outline

- Government Enforcement and Risk Areas
 - Recent OIG's report on Non Physician Practitioners
- Non Physician Practitioners
- “Incident-to”
- Shared/Split Visits
 - Documentation and Billing Requirements
 - Impact of the Elimination of Consultation Codes
- The Private Payer Difference
- Education tools to improve compliance



Handouts Included

1. Documentation Tips for Common Physician CPT Coding Issues
2. Checklists for:
 - “Incident-to”
 - Shared Visits
3. First Coast Service Option (FCSO) Medicare Carrier: “Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria”



Government Enforcement

- Many of the recent overpayment, audit, civil false claims act and even criminal cases instituted by the federal and state agencies overseeing the Medicare and Medicaid programs involve allegations of improper billing for “incident-to” services.
 - Because of this, “incident-to” was on the OIG work plan from 2007-2009, and prior to that in 2004, 2003 and 2001



OIG Report – August 2009

Objectives:

- Review days of service were Medicare allowed for more than 24 hours of services billed by a single physician.
- Assess the qualifications of non physician who performed these services.

Copy of Report: OEI-09-06-00430

<http://oig.hhs.gov/oei/reports/oei-09-06-00430.pdf>



OIG Report – Findings

- Quality of care
- Medical necessity
- Billing compliance:
 - 21 % of services not personally performed by physicians were done by unqualified non physicians
 - \$12.6M for approximately 210,000 services (1st qtr 2007)



CMS: “One Time Notification”

- On October 9, 2009, CMS: One Time Notification:

“Various OIG Reports that have Medical Review Implications”

- Medicare Part B Chemotherapy Administration: Payment and Policy
 - **Prevalence and Qualifications of Non Physicians Who Performed Medicare Physician Services (Released August 2009)**
 - Medicare Part B Billing for Ultrasound
- To read the one time notification:
 - <http://www.cms.hhs.gov/transmittals/downloads/R574OTN.pdf>



OIG's Recommendations

In March, 2011, OIG published:

"Compendium of Unimplemented Recommendations"
with the following recommendations to CMS:

1. Seek revisions to the "incident to" rule; and
2. Require physicians who bill services to Medicare that they do not perform to identify the services on their Medicare claims using a service code modifier

To read the OIG report:

<http://oig.hhs.gov/publications/docs/compendium/2011/index.asp>



Physician Audit Risk

- Incident-to and shared visits are transparent to the payer, because it looks just like a claim for physician services and it is very likely that the provider will be paid for the claim even if they have not complied with the requirements of incident-to or shared visits.
- Consider doing an internal review of
 - physicians using NPPs; and
 - physicians with high work RVUs compared to their peers



Review Considerations

- When performing coding audits on areas that use NPP it can be helpful to interview staff.
 - For example, if an ER visit note states dictated by NPP and is electronically signed by the physician you might want to ask the physician who performed the visit. If the NPP performed the visit, and all the physician did was sign the note, the “face-to-face” requirement needed for an outpatient hospital setting is not met for billing this under the physician as a shared visit.



Risk Areas:

- Failing to understand that the general supervision rule requirements for NPPs under some state law will not satisfy the direct supervision requirements for “incident-to” billing under either the Medicare or the state’s Medicaid program;
- Failing to ensure that NPPs practicing in a state are licensed and certified in the state they are practicing and not another state;
- Failing to ensure documentation link between the NPP and physician when a NPP provides “incident-to” services.



Risk Areas (cont.):

- Applying “incident-to” billing regulations to the institutional settings (i.e. hospitals or skilled nursing facilities);
- Billing “incident-to” for new patients, or established patients with new chief complaints; and
- Billing incident-to when services provided by unqualified staff



Non-Physician Practitioners (NPPs)

- Non-physician practitioners (NPPs) are health care professionals permitted by law to provide care and services within the scope of the individual's licensure and consistent with individually granted privileges by a facility's governing body.
 - Examples of NPPs:
 - certified nurse-midwives, clinical psychologists, clinical nurse specialist, physician assistants and nurse practitioners.
 - American Academy of Nurse Practitioners (AANP.org)
 - American Academy of Physician Assistants (AAPA.org)



NPP Coverage Restrictions

- The Balanced Budget Act (BBA) eliminated the coverage restrictions for Nurse Practitioners (NPs) and Physician Assistants (PAs), effective for all services furnished on and after January 1, 1998.
 - Therefore, services by the NPPs may be covered in ANY setting regardless of the designation of the area in which the services are furnished.



Eligibility Requirements for NPs

- NPs who qualify for Medicare billing number for the first time on or after January 1, 2003 must meet the requirements as follows:
 - Be a registered professional nurse who is authorized by the state in which the services are furnished to practice as a NP in accordance with state law;
 - Be certified as a NP by a recognized national certifying body that has established standards for NPs*; and
 - Possess a Master's degree in nursing.

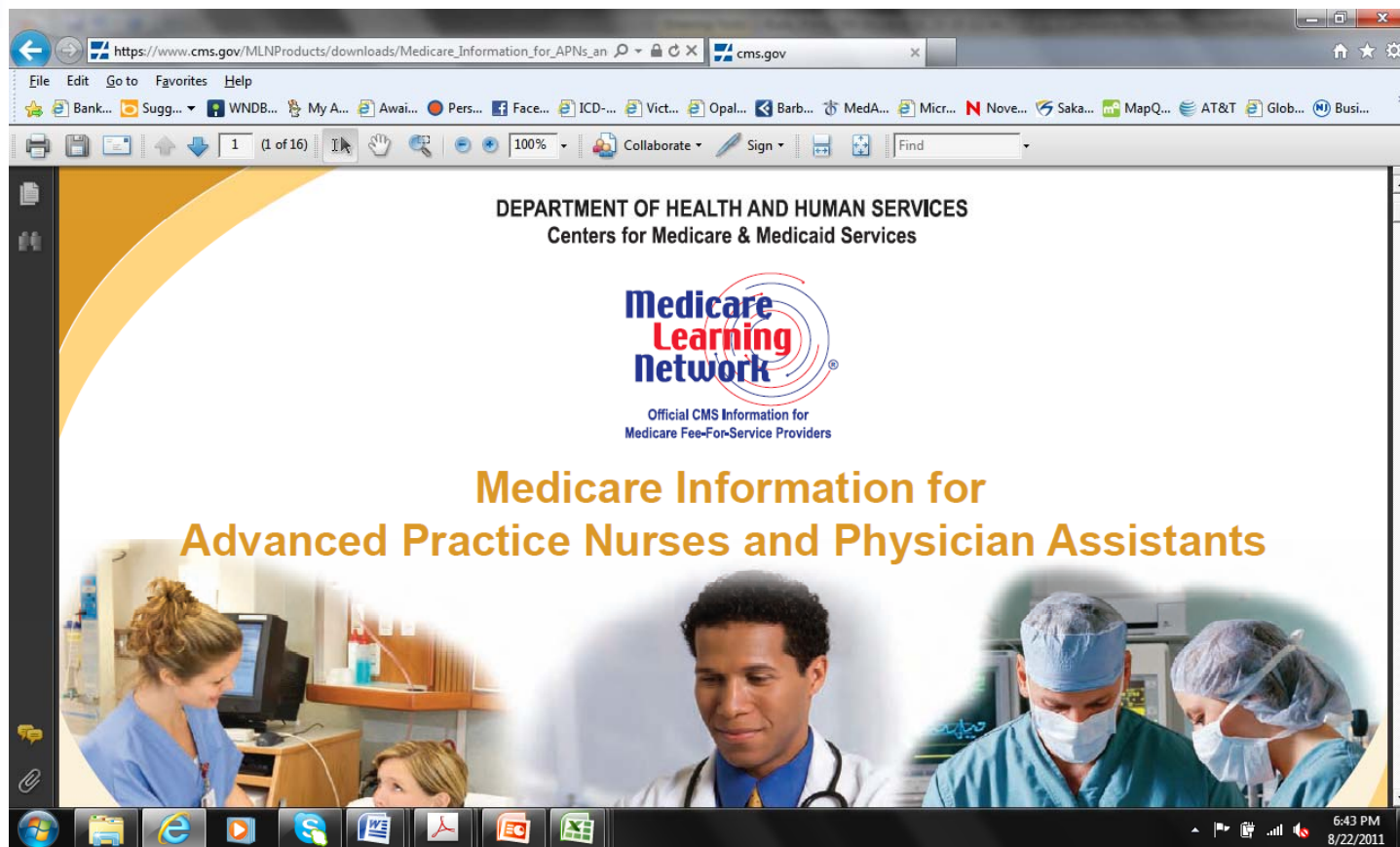


Eligibility Requirements for PAs

- To furnish covered PA services, the PA must meet the conditions as follows:
 - Must currently be certified by the National Commission on Certification of Physician Assistants (NCCPA) to assist primary care physicians; or
 - Have graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant; and
 - Be licensed by the state to practice as a physician assistant.

(*See handout for organizations that are recognized national certifying bodies)

CMS Booklet for APNs & Pas



https://www.cms.gov/mlnproducts/70_apnpa.asp



Billing Options for NPPs

1. NPPs own provider number receiving 85% of the MPFS
2. Incident-to the physician receiving 100% of the MPFS
3. Shared visits allow NPPs and physicians who work for the same employer/entity to share patient visits on the same day by billing the combined work under the physician's provider number for 100% of the Medicare physician fee schedule (MPFS) reimbursement- although the NPP might have done the majority of the work.

(MPFS= Medicare Physician Fee Schedule)



Incident-to

- "Incident-to" allows physicians to bill for services and supplies, commonly furnished in the physician office setting, which are provided by auxiliary staff or Non-Physician Practitioners (NPPs) and that are an integral, although incidental, to their professional services.
- "Incident-to" services are paid for by Medicare under the physician fee schedule as though the physician personally performed the services.



Auxiliary Personnel

Examples of incident-to services performed by auxiliary personnel such as nurses, technicians, and therapists:

- Anti-coagulation therapy
- Care related to diabetes
- Patient infusion therapy, and some types of cancer chemotherapy treatments
- Psychological services
- Some nursing home services
- Some home care based medical services



NPPs Services

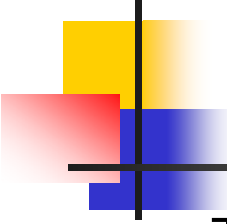
- NPPs unlike other auxiliary staff:
 - May render a much broader range of services under their scope of practice, including minor surgeries and Evaluation and Management (E/M) services.
 - May bill independently for their services when the “incident to” requirements are not met.
 - May have auxiliary staff that provide services “incident to” their services.



Incident-to Defined

- In order for the services to be covered as “incident to” the services of a physician, the services must meet all the requirements for coverage specified in the Medicare Benefit Policy Manual Pub. 100-02, Chapter 15 §60-60.3.
 - The service must be an integral, incidental part of the physician’s personal professional services, and it must be performed under the physician’s direct supervision.
 - This does not mean that each occasion of an incidental service performed must always be the occasion of a service actually rendered by the physician.

Physician Involvement/ Direct Supervision

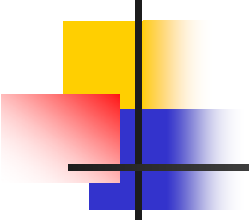
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- There must have been a direct personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed is an incidental part;
 - There must be subsequent services by the physician of a frequency that reflects the physician's continuing active participation in and management of the course of treatment; and
 - The physician must be physically present in the same office suite and immediately available to render assistance if necessary.



“Incident-to” Basic Requirements

- The service or supplies are an integral, although incidental, part of the physician's or practitioner's professional services;
- The services or supplies are of a type that are commonly furnished in a physician's/NPP's office or clinic;
- The services or supplies are furnished under the physician's/ practitioner's direct supervision and included in the physician's bill;
- The services or supplies are furnished by an individual who qualifies as an employee of the physician/NPP or professional association or group that furnishes the services or supplies;
- The service is part of the patient's normal course of treatment, during which a physician personally performs an initial service and remains actively involved in the course of treatment.

Documentation of Physician's Involvement

- 
- The physician must perform an initial service and must actively participate in and manage the course of treatment.
 - The physician does not need to see the patient on every visit, as long as the physician has prescribed the plan of care and is actively managing the plan of care.
 - When the NPP provides the "incident-to" service, the documentation should include a link between the NPP and the physician to show that the physician was actively involved in and delegated the service to the NPP.
 - "Dr. Smith was in the office suite while I saw this patient"
 - "The patient was also seen by Dr. Smith, who will write a separate note"



Subsequent Visits

- For each subsequent visit with the non-physician clinician, the physician should review the clinical assistant's documentation and denote the following:
 - Any input that the physician gave (i.e. agreeing that the current regimen is appropriate)
 - Notation and review of lab values.
 - Review of any adverse reactions.
- Documentation can take place after the patient has left and the physician is able to meet with staff to complete documentation requirements .



Time Records

- Auditable time records must be kept by NPP who acts interchangeably between hospital services (included in cost report) and physician services. So the independent cost can be removed from the cost report.
- Medical necessity for clinics that use an NPP to see the same patients as the physicians may inadvertently create over utilization and compromise medical necessity.



99211- Consider This Example

- A patient was seen in an office setting and CPT code 99211 was billed “incident to” the provider. The provider did not treat the patient on this visit; a medical assistant performed the procedure.
- The patient returned to the office in two weeks and was seen by the provider. This visit was billed as a new patient visit and was denied by Medicare.
 - Why was this encounter denied and should the office appeal it?



Established Patient -New Problem

- A Medicare patient seen in the office setting by the NPP and complaining of a new problem.
- How should this be billed?
 - The NPP may take care of the new problem and can bill incident-to the physician?
 - The NPP may take care of the new problem and bill using his/her own name and NPI?
 - The physician must see the patient and establish care?



Different Settings

- Medicare Part B covers items and services incident to a physician's professional services.
- However, according to the Medicare Benefit Policy Manual and the Code of Federal Regulations, **this applies only to non-institutionalized settings** (i.e., settings that are not hospitals or skilled nursing facilities [SNF]);



Hospital Setting- No Incident to

- Chapter 15 §60.1B of the Medicare Benefit Policy Manual states the following:
 - *“For hospital patients and for SNF patients who are in a Medicare covered stay, there is no Medicare Part B coverage of the services of physician-employed auxiliary personnel as services incident to physicians’ services under §1861(s)(2)(A) of the Act.*
 - *Such services can be covered only under the hospital or SNF benefit and payment for such services can be made to only the hospital or SNF by a Medicare intermediary.”*



What is a Shared Visit?

- A split/shared Evaluation and Management (E/M) visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified non-physician practitioner (NPP) each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service.
- The physician may bill the service when he or she performs a substantive portion of the service in a face-to-face encounter.
 - A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision- making key components of an E/M service.

(Medicare Claims Processing Manual, Pub.100-04, Ch.12,§30.6.13H)



Shared/Split Visit Clinic/Office Setting

Non-Hospital Based Outpatient Clinic/Office Setting:

- When a non-hospital outpatient clinic/office E/M encounter is shared/split between a physician and an NNP, the E/M encounter may be billed under the physician's name and provider number if:
 - The patient is an established patient; **and**
 - The "incident to" rules are met. (Note: Medicare has clarified that "incident to" billing is not allowed for new patient visits).

(Source: Medicare Claims Processing Manual Pub.100-04, Chapter 12 §30.6.1)



Shared/Split Visit Facility Setting

Inpatient/Hospital Outpatient / Emergency Department Setting:

- When a hospital inpatient/hospital outpatient/emergency department E/M encounter is shared/split between a physician and an NPP from the same group practice, the E/M encounter may be billed under the physician's name and provider number if:
 - The physician provides any **face-to-face** portion of the E/M encounter (even if later in the same day as the NPP's portion);
and
 - The physician **personally documents** in the patient's record the physician's face-to-face portion of the E/M encounter with the patient.
 - Co-signatures are NOT sufficient.

Shared Visits Apply to the Following E/M Codes:

- 
- Hospital setting:
 - **Hospital admissions (99221-99223)**
 - Subsequent hospital visits (99231-99233)
 - Discharge management (99238-99239)
 - Observation care (99217-99220, 99234-99236)
 - Emergency department visits (99281-99285)
 - Prolonged care (99354-99357)
 - Hospital provider based office visits (99201-99215)
 - Physician office setting:
 - Established office visits (99211-99215) with an established plan of treatment.



Consultations & Shared Visits

Split/shared visits do not apply to:

- Critical care services (99291-99292)
- Procedures
- Consultations (99241-99255) **Prior to 1/1/2010**
 - Provider can split/share a consultation-type service when using an applicable split/shared E/M code (such as hospital or office/outpatient E/M codes). (Physician ODF 4/14/10)
<http://medicare.fcso.com/EM/168518.asp>
 - Remember that split/shared in the office setting (non provider based) requires “incident-to” guidelines to be met, therefore shared visits cannot be used for new problems.



Examples of Shared Visit

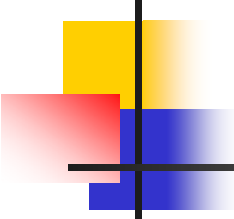
- Hospital rounds at different times of the day (must be same date of service).
- Office visits where NPP performs history and physical exam and physician performs medical decision-making, and incident to requirements are met.



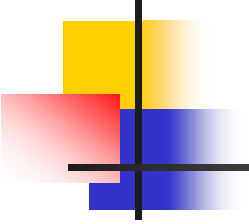
Documentation for Shared Visit

- Follow the Documentation Guidelines as for any E/M Service.
- Each physician/NPP should personally document in the medical record his/her portion of the E/M split/shared visit.
- Documentation must support the combined service level reported on the claim.
- Auxiliary staff may document the review of systems and past family and social history. The physician and NPP must personally review this documentation and confirm and/or supplement it in the medical record.

Physician Participation for Split/Shared Visits

- 
- Insufficient Physician Participation for Split/Shared Visits:
 - Physician did not personally perform and personally document his/her face-to-face portion of the E/M encounter with the patient.
 - Physician participated in the service by only reviewing the patient's medical record and co signing the note.

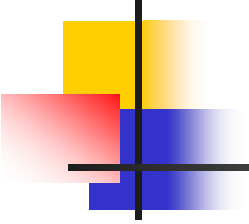
Examples of Acceptable Documentation



It appears that the situation of teaching physician services that involve residents is somewhat analogous to split/shared visits. Therefore these examples from the CMS material on teaching physician services, such as CMS Pub.100-4, Chapter 12, Section 100.1.1.A General Documentation Instruction and Common Scenarios, are helpful* when establishing documentation examples for split/shared visits.

- *"I saw and evaluated the patient. I reviewed the NPP's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."*
- *"I saw and evaluated the patient. Agree with NPP's note but lower extremities are weaker, now 3/5; MRI of L/S Spine today."*

Examples of Unacceptable Documentation:

- 
- *"Agree with above.", followed by legible countersignature or identity;*
 - *"Rounded, Reviewed, Agree.", followed by legible countersignature or identity;*
 - *"Discussed with NPP. Agree.", followed by legible countersignature or identity;*
 - *"Seen and agree.", followed by legible countersignature or identity;*
 - *"Patient seen and evaluated.", followed by legible countersignature or identity; and*
 - *A legible countersignature or identity alone.*

Such documentation is not acceptable because the documentation does not make it possible to determine whether the physician was present, evaluated the patient, and/or had any involvement with the plan of care.



Scribing

- If a nurse or NPP acts as a scribe for the physician, the individual writing the note (or history or discharge summary, or any entry in the record) should note “written by X, acting as scribe for Dr. Y.” Then, Dr. Y should co-sign, indicating that the note accurately reflects work and decisions made by him/her.
- Record entries made by a “scribe” should be made upon dictation by the physician, and should document clearly the level of service provided at that encounter. This requirement is no different from any other encounter documentation requirement.

*Source: First Coast Service Option, Part B Update Third Quarter 2006.
Check your carrier for specific instructions.*



Common Questions

- Do shared visits apply to procedures?
- Can the shared visit occur at different times?
- Can the physician share a visit with a hospital employed NPP?
- Can the physician share a visit with a medical student?
- Can the physician's nurse (RN) share the visit with the physician in the hospital setting?



Private Payer Differences

- Most private payers do not issue numbers to NPPs and request that billing occur under the supervising physician. For example, some payers might only ask that state law is followed when PAs deliver care.
 - Therefore it might be appropriate for the PA to provide care without a physician face-to-face encounter in an ED setting and bill under the physician's number.
- Some hospitals query private payers to see what their rules are. However, an alternative to querying the private payers is to send the private plans a certified letter advising the plan of the hospital's procedures for billing NPP service, unless the plan advises the hospital otherwise in writing.



Shared Visit Guidelines Met?

- NPP sees hospital inpatient in the morning while the physician is in surgery.
 - Documents history, exam & medical decision making & signs the note.
- Physician provides a face-to-face visit with the patient later in the day & reviews the labs
 - Documents “labs reviewed, agree with treatment” and co signs the note
- Does this meet the guidelines to bill under the physician’s NPI?



Medicaid (Florida)

- Services provided by a NPP under the direct supervision of a physician may be billed using the physician's provider number instead of the NPP's provider number. Direct supervision means the physician:
 - Is on the premises when the services are rendered, and
 - Reviews, signs and dates the medical record.
- Exceptions are deliveries, psychiatric services and child health check-up screenings.
 - The NPP must directly render these services and bill using his or her Medicaid ID number. Medicaid will not reimburse the physician and the NPP for the same service to the same recipient on the same day.
- Florida Medicaid reimburses NPPs using a separate fee schedule (reimbursed at 80% of physician fee).




CMS Regulation

- Non institutional or office incident to services"
 - 42 Code of Federal Regulation (CFR) §410.26
 - "66 Federal Register 55246,55267(November1,2001)
 - 42 CFR §410.32

- Institutional or hospital Incident to services
 - 42 CFR §410.27
 - 66 FR 18434,18524 (April7,2000)


CMS Policy

- 
- Medicare Benefit Policy Manual, Chapter 15 §60
 - Incident-to Services
 - Homebound patients

 - Medicare Claims Processing Manual, Chapter 12 §30
 - Evaluation & Management Services
 - Shared/Split visit

 - Education Material
 - CMS: Medicare Information for Advanced Practice Nurses and Physician Assistants (September 2010)
 - Trailblazer- Incident to Services Manual (November 2010)

Supervision of Diagnostic Tests

- 
- Supervision requirements for diagnostic tests are different than for office visits. The Centers of Medicare Medicaid Services (CMS) developed three levels of supervision requirements:
 - general,
 - direct and
 - personal.
 - The CPT code determines which level of supervision is required.
 - Download the Physician Fee Schedule Relative Value Files from the CMS website:
<http://www.cms.hhs.gov/PhysicianFeeSched/pfsrvf/list.asp>



General Supervision

- Services are under the general quality control of physicians
 - a physician does not need to be in the office, e.g., electrocardiogram (CPT 93000).
 - See Medicare Physician Fee Schedule Data Base (MPFSDB) file, CPT 93000, ("01" Supervision Value)
- The training of the non physician personnel who actually performs the diagnostic procedures and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

Supervision Requirement CPT 93000

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Clipboard Font Alignment Number Styles Cells Editing

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2009 National Physician Fee Schedule Relative Value File
 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply.
 Dental codes (D codes) are copyright 2002 American Dental Association. All Rights Reserved.

Revised 12/11/2008

10	HCPCS	MOD	DESCRIPTION	STATUS CODE	MP RVU	FULLY IMPLEMENTED		FULLY IMPLEMENTED		PCTC IND	GLOB DAYS	PRE OP	INTRA OP	POST OP	MULT PROC	BILAT SURG	ASST SURG	CO- SURG	TEAM SURG	ENDO BASE	CONV FACTOR	MAGNOSTIC PROCEDURES	CALC FLAC	
						NON-FACILIT TOTAL	NON-FACILIT TOTAL	FACILITY TOTAL	FACILITY TOTAL															
13792	92986		Revision of aortic valve	A	1.51	38.57	39.38	38.57	39.38	0	090	0.09	0.84	0.07	2	0	0	0	0	0	0	36.0666	09	0
13793	92987		Revision of mitral valve	A	1.59	39.93	40.77	39.93	40.77	0	090	0.09	0.84	0.07	2	0	0	0	0	0	0	36.0666	09	0
13794	92990		Revision of pulmonary valv	A	1.20	30.72	31.22	30.72	31.22	0	090	0.09	0.84	0.07	2	0	0	0	0	0	0	36.0666	09	0
13795	92992		Revision of heart chamber	C	0.00	0.00	0.00	0.00	0.00	0	090	0.09	0.84	0.07	2	0	2	0	0	0	0	36.0666	09	0
13796	92993		Revision of heart chamber	C	0.00	0.00	0.00	0.00	0.00	0	090	0.09	0.84	0.07	2	0	2	0	0	0	0	36.0666	09	0
13797	92995		Coronary atherectomy	A	0.84	19.21	19.63	19.21	19.63	0	000	0.00	0.00	0.00	2	0	0	0	0	0	0	36.0666	09	0
13798	92996		Coronary atherectomy adx	A	0.10	5.00	5.11	5.00	5.11	0	ZZZ	0.00	0.00	0.00	0	0	0	0	0	0	0	36.0666	09	0
13799	92997		Pul art balloon repr, percu	A	0.40	17.63	17.76	17.63	17.76	0	000	0.00	0.00	0.00	2	0	0	0	0	0	0	36.0666	09	0
13800	92998		Pul art balloon repr, percu	A	0.28	9.06	9.25	9.06	9.25	0	ZZZ	0.00	0.00	0.00	0	0	0	0	0	0	0	36.0666	09	0
13801	93000		Electrocardiogram, compl	A	0.03	0.58	0.53	0.58	0.53	4	XXX	0.00	0.00	0.00	0	0	0	0	0	0	0	36.0666	01	0
13802	93005		Electrocardiogram, tracing	A	0.02	0.33	0.28	0.33	0.28	3	XXX	0.00	0.00	0.00	0	0	0	0	0	0	0	36.0666	01	0
13803	93010		Electrocardiogram report	A	0.01	0.25	0.25	0.25	0.25	2	XXX	0.00	0.00	0.00	0	0	0	0	0	0	0	36.0666	09	0
13804	93012		Transmission of ecg	A	0.18	5.05	4.65	5.05	4.65	3	XXX	0.00	0.00	0.00	0	0	0	0	0	0	0	36.0666	01	0
13805	93014		Report on transmitted ecg	A	0.02	0.77	0.78	0.77	0.78	2	XXX	0.00	0.00	0.00	0	0	0	0	0	0	0	36.0666	09	0
13806	93015		Cardiovascular stress test	A	0.14	2.78	2.76	2.78	2.76	4	XXX	0.00	0.00	0.00	0	0	0	0	0	0	0	36.0666	02	0
13807	93016		Cardiovascular stress test	A	0.02	0.68	0.70	0.68	0.70	2	XXX	0.00	0.00	0.00	0	0	0	0	0	0	0	36.0666	02	0
13808	93017		Cardiovascular stress test	A	0.11	1.65	1.60	1.65	1.60	3	XXX	0.00	0.00	0.00	0	0	0	0	0	0	0	36.0666	02	0
13809	93018		Cardiovascular stress test	A	0.01	0.45	0.46	0.45	0.46	2	XXX	0.00	0.00	0.00	0	0	0	0	0	0	0	36.0666	09	0
13810	93024		Cardiac drug stress test	A	0.12	3.38	3.55	3.38	3.55	1	XXX	0.00	0.00	0.00	0	0	0	0	0	0	0	36.0666	09	0

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MPFSDB

Supervision Indicators



Procedure must be performed under the....

- 01 = General supervision of a physician.
- 02 = Direct supervision of a physician.
- 03 = Personal supervision of physician.
- 09 = Concept does not apply

(MPFSDB=Medicare Physician Fee Schedule Data Base)



Direct Supervision

- Services require that the physician is on the premises in the “office suite” and immediately available to furnish assistance and direction throughout the performance of the procedure, e.g., “incident-to” services.



Personal Supervision

- The physician must be in attendance in the room while the non-physician provider/technician is performing the service.
 - e.g., transesophageal echocardiogram (CPT 93312).



Conclusion

- Although transparent to the payer, non-compliance with the incident-to and split/shared visit policy could be an easy target for Recovery Audit Contractors (RACs).

- Now is a good time to review a few internal progress notes, you may discover:
 - Physicians are not aware of the face-to-face requirement for billing split/shared visits,
 - Physicians do not realize incident-to rules do not apply in emergency room and provider-based offices, or
 - Physicians are using the split/shared visits for critical care and consultations prior to 1/1/10.

Questions?



Additional Handouts Available:

<http://elinkunz.com/>

Thank you!

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Audit Checklist: Incident-to

AuditChecklist_Incident-to_032608 [Compatibility Mode] - Microsoft Wo... Table Tools

Home Insert Page Layout References Mailings Review View Acrobat Design Layout

Print Layout Full Screen Reading Web Layout Outline Draft Ruler Document Map Gridlines Thumbnails Message Bar Zoom 100% One Page Two Pages Page Width New Window Arrange All Split View Side by Side Synchronous Scrolling Reset Window Position Switch Windows Macros

Month:		Physician:		Met criteria:
Patient:		Reviewer:		Payer:

If the answer is "no" to any of the questions, it is not appropriate to bill the service incident-to the physician.

DOCUMENTATION TASK		YES	NO
Location	Does the place of service (POS) fall within the definition of an office or a physician directed clinic?		
	The service is not performed in the institutional setting (i.e. hospital or skilled nursing facility)? Incident-to services cannot be performed in the emergency room, hospital outpatient department or provider based physician office (POS 22).		
Employment relationship	Does the physician or group incur an expense and meet the employment requirements for the auxiliary staff? - OR -		
	Does the auxiliary staff include employees, leased employees, or independent contractors of the physician or the entity that employs or contracts with the physician?		
Supervision	Did the physician perform direct supervision ? (Present in the office suite to assist, if necessary. The physician does not need to be physically present in the patient's treatment room for these services.)		
	Is there a documentation link between auxiliary staff and the physician when the incident-to service was performed? (Archived records of when the supervising physician was in the office suite, i.e. physician schedules, etc or documentation in the		

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Example of Reference Tool:

- Florida –Distinguishing between ARNP/PA:

STATUTORY AUTHORITY	
ARNP	PA
Nurse Practice Act Florida Statutes, Chapter 464	Medical Practice Act Florida Statutes, Chapter 458
Medical Practice Act Florida Statutes, Chapter 458	Osteopathic Medicine Act Florida Statutes, Chapter 459
Florida Administrative Code Board of Medicine §64B8 Board of Nursing §64B9	Florida Administrative Code Board of Medicine §64B8
Pharmacy Act Florida Statutes, Chapter 465	Pharmacy Act Florida Statutes, Chapter 465

Example Reference Tool Cont.

SUPERVISION	
ARNP	PA
<p>General supervision by a Florida-licensed medical doctor, osteopathic physician or dentist. Degree and method of supervision to be determined by the ARNP and Physician and identified in written protocols.</p> <p>General supervision: Supervising physician authorizes procedure being carried out but need not be present when such procedures are performed. Must be available for consultation and advice either in person or by communication device.</p> <p>Protocol may or may not require on-site supervision, but is not required by statute.</p> <p>Restrictions placed on the number of off-site locations a physician may supervise, but no restriction on the number of ARNPs which may be supervised (not applicable to licensed hospitals, ASCs and other entities exempted by statute).</p> <p>No requirement for physician responsibility other than protocol rules.</p>	<p>Responsible supervision by Florida-licensed medical doctor or osteopathic physician.</p> <p>Responsible Supervision: The ability of the supervising physician to responsibly exercise control and provide direction over the services of the PA. It requires the easy availability or physical presence of the supervising physician to the PA.</p> <p>Unless specifically prohibited by rule (see Attachment A) PA can be supervised indirectly without his/her supervising physician on-site as long as the supervising physician is easily available to communicate with the PA.</p> <p>MD or DO may oversee up to four PAs.</p> <p>Supervising physician assumes legal liability for the acts and omissions of the PA.</p>

Additional Handouts:

1. Documentation Tips for Common Physician CPT Coding Issues
2. Checklists for:
 - “Incident-to”
 - Shared Visits
3. First Coast Service Options (FCSO) The Florida Medicare Bulletin, 3rd Quarter 2006: “Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria”

Questions?

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1

Documentation Tips: Common Physician Coding Issues

Issue	Codes Affected	Solution
<p><u>Under-documentation (Over Coding)</u> of Evaluation and Management (E/M) service when the nature of the presenting problems and severity of illness supports a higher level code.</p> <p>The nature of the presenting problem drives documentation in the same way that it evokes the medically-indicated examination and medical decision-making.</p>	All E/M codes that have multiple levels.	<p>Document the required history, exam and medical decision-making to support the nature of the presenting problem.</p> <p>Code selection is usually predictable within the first few moments and during the history taking of the patient encounter. Conditions posing an immediate threat to life or limb qualify for the highest level, whereas patients whose conditions reflect minor or well controlled problems are at the lowest.</p> <p>Review clinical examples from AMA’s CPT manual Appendix C.</p>
<p><u>Over-Documentation</u> of E/M service when the presenting problems, exam level, patient acuity or decision-making complexity supports a lower level code.</p>	All E/M codes that have multiple levels.	<p>Assign the appropriate code based on the level of each of the key components actually performed and documented which are: history, exam, medical decision-making; and in some cases: counseling, coordination of care and time.</p> <p><u>Medicare Claims Processing Manual, Pub.100-04, Chapter 12, §30.6.1.A:</u></p> <p><i>“Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed.”</i></p>
<p>Incorrectly documenting time when using time as the determining factor for E/M services.</p>	All E/M codes for which time could be a factor in code selection.	<p>Document total time, the content of the counseling or coordination of care, and document that more than half of the time was spent on counseling or coordination of care. (i.e. “20 minutes of the 30 minute visit spent counseling the patient on...”)</p>
<p>Code assigned for service not performed or not documented.</p>	All codes	<p>Do not submit a code for a service that has not been documented in the patient’s chart or not performed</p>
<p>Time not documented for time-based E/M codes.</p>	<p>99291, 99292 Critical Care Services 99356 Prolonged Services 99239 Hospital Discharge Service > 30 minutes</p>	<p>Document time spent at the bedside or with family members discussing the patient’s care.(i.e.”total critical care time is 35 minutes”) Documenting start and stop time is preferable to documenting duration.</p> <p>Critical care services without time documented should be billed using follow up visit CPT 99233.</p> <p>Critical care performed by a non-physician practitioner (NPP) cannot be billed by the physician.</p>

Documentation Tips: Common Physician Coding Issues

Issue	Codes Affected	Solution
<p>Medicare Prior to 1/1/10 and Non Medicare Payers: Documentation does not support requirements for consultation E/M service which are:</p> <ol style="list-style-type: none"> 1. opinion request by another physician; 2. performance of all required components of an E/M service; and 3. a report to the requesting physician. <p>Consultations are often confused with transfers of care, in which case another E/M code is appropriate, usually subsequent hospital visits or office visits.</p>	<p>99241-99245 Office Consultations 99251-99255 Inpatient Consultations (only one per specialty per inpatient admission)</p> <p>Note: CMS has eliminated Consultations codes as of 1/1/09, waiting for more guidance. Private payers may continue to use codes.</p>	<p>Use a Consultation code when the “intent of a service is that a physician is asking another physician or for advice, opinion, a recommendation, suggestion, direction, or counsel, etc. in evaluating or treating a patient because that individual has expertise in a specific medical area beyond the requesting professional’s knowledge”</p> <p>Use Subsequent Hospital Visits (99231-99233) or Office Visits (99201-99215) when a physician intends that another you take over the responsibility for managing the patients’ complete care for the condition and does not expect to continue treating or caring for the patient for that condition.</p> <p>If unsure of the requesting physician’s intent, call the physician and document the intent in the medical record.</p>
<p>Medicare Prior to 1/1/10 and Non Medicare Payers: Consultation report back to the requesting physician does not make it clear who requested the consult.</p>	<p>99241-99245 Office Consultations 99251-99255 Inpatient Consultations (only one per specialty per inpatient admission)</p>	<p>Clearly state who made the request: “I am seeing the patient at the request of Dr. Smith...”</p> <p>Document the nature of the opinion requested: “the purpose of which is to evaluate and provide recommendations for care of the (conditions)...”</p> <p>Plan of care should include the rendering physician’s opinion. “As you requested, I have evaluated the patient’s back pain and my recommendations are....”</p>
<p>Level 4 and 5 consultations, new patient office visits and Level 2 and 3 inpatient admissions and observations requirement not documented.</p>	<p>99244-99245 Office Consultations 99254-99255 Inpatient Consultations 99204-99205 New Patient Office Visit 99222-99223 Initial Hospital Visits (Admissions) 99219-99220 Initial Observations 99235-99236 Observation Same Day Adm/DC</p>	<p>All require documentation of <u>comprehensive exam and comprehensive history</u>. Without it, the service billed cannot be higher than level 3.</p>
<p>More than one discharge day E/M service submitted for a patient.</p>	<p>99238-99239 Hospital Discharge Services</p>	<p>Coordinate coding of the E/M discharge day service with other physicians on the case and seeing the patient on the day of discharge; code a subsequent hospital service if another physician is coding the discharge day service</p>

Documentation Tips: Common Physician Coding Issues

Issue	Codes Affected	Solution
Under-documenting comprehensive <u>exam</u> needed for level 4 and 5 consultations, new patient office visits and Level 2 and 3 inpatient admissions and observations.	99244-99245 Office Consultations 99254-99255 Inpatient Consultations 99204-99205 New Patient Office Visit 99222-99223 Initial Hospital Visits (Admissions) 99219-99220 Initial Observations 99235-99236 Observation Same Day Adm/DC	<ul style="list-style-type: none"> • ‘95 DG Multi-system exam: 8 or more organ systems. Cannot combine with body areas. • Organ systems include: Const., Eyes, ENT, Cardio, Resp, Gastro, GU, Musc, Skin, Neuro, Psych, Hematologic. • Body areas include: Head (including the face), neck, chest (including breasts and axillae), abdomen, genitalia (groin, buttocks), back (including spine) and each extremity. • ‘97 DG Multi-system exam: Perform all bullets from at least 9 systems/areas, and document at least 2 bullets from EACH of 9 systems /areas.
Under-documenting comprehensive <u>history</u> needed for level 4 and 5 consultations, new patient office visits and Level 2 and 3 inpatient admissions and observations.	99244-99245 Office Consultations 99254-99255 Inpatient Consultations 99204-99205 New Patient Office Visit 99222-99223 Initial Hospital Visits (Admissions) 99219-99220 Initial Observations 99235-99236 Observation Same Day Adm/DC	<ul style="list-style-type: none"> • HPI – 4 elements • PFSH- need 3 elements (Past, Social and Family History). Don’t use the term “unremarkable” or “not relevant”, as these can be flags that you skipped family history. Use: “Past family and social history reviewed; no family history of cardiovascular disease”. • ROS – complete review of system (at least 10) is reviewed. Our carrier, First Coast Service Option, still permits the “all other systems negative” shortcut: “At least ten organ systems must be reviewed. Those systems with positive or negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such notation, at least ten systems must be individually documented”.
“History Unobtainable” caveat	All EM codes that have multiple levels	<ol style="list-style-type: none"> 1. Document the information obtainable from other sources such as family, paramedics, nursing home staff etc. AND 2. Document why the patient was unable to personally provide the information.
Medicare Prior to 1/1/10 and Non Medicare Payers: More than one Initial Hospital Care Service coded for the day of admission. Only the admitting physician can code Initial Hospital Care. Only one admission code per hospital admission is allowed.	99221-99223 Initial Hospital Care	Coordinate coding of E/M admission service with other physicians on the case and seeing the patient on the day of admission; code a subsequent hospital service if another physician is coding the admission service.
E/M services coded for post-op follow-up during the global surgery period (usually 90 days post op).	99231-99233 Subsequent Hospital care 99211-99215 Office Visit – Established Patient	Use code 99024 to report a follow-op post-op visit for services performed within global period.

Documentation Tips: Common Physician Coding Issues

Issue	Codes Affected	Solution
Inpatient visit code used with a patient in outpatient observation status and vice versa.	99231-99233 Subsequent Hospital care 99217-99220 Initial Observation care	Verify the registration status of the patient and assign the codes appropriate to that status.
Wrong E/M code assigned when patient admitted and discharged on same day.	99234-99236	Use appropriate observation or inpatient care services codes (99234- 99236), not 99218 and 99220 when patient are placed in observation and discharged the same day, unless the patient is in observation for less than 8 hours.
Using NPPs for shared visits for critical care and consultations that cannot be reported as shared visits for Medicare.	99291-99292 Critical Care 99241-99255 Consultations Office and Hospital	Do not share visits with NPP for Critical Care services and Outpatient Consultations. If the NPP does the history and physical for a Consultation, this can only be reported under the NPP's number. Effective 1/1/10, Medicare inpatient consultation codes reported with 99221-99223 can be shared visits.
Incorrectly documenting shared visit with NPP in hospital setting. Shared visits between the physician and NPP may be reported as one visit, if each provider sees the patient separately and each documents separately. Each component of the visit must be medically necessary.	99231-99233 Subsequent Hospital Care 99221-99223 Initial Hospital Care 99238-99239 Discharge Services 99217-99220 & 99234-99236 Observation Care 99281-99285 Emergency Department Visits 99354-99357 Prolonged Care Services 99201-99215 Outpatient Office (Provider based)	Each physician/NPP should personally document in the medical record his/her portion of the E/M split/shared visit. Example: “I saw and evaluated the patient. Agree with NPP’s note but lower extremities are weaker, now 3/5; MRI of L/S Spine today.” If the physician participated in the service by only reviewing the patient medical record, the service may only be billed under the NPP’s provider number.
Incorrectly using shared visit with NPP in physician office setting for new patient visits.	99201-99205 New Office Visit 99211-99215 Established Office Visit (“incident-to” must be met)	Do not report new patients under the physician’s provider number in this setting if the visit is shared. When using shared visits in the physician office (not provider-based office/outpatient department) the “incident-to” requirements must be met. This means new patients cannot be shared in this setting, since “incident-to” requires an established treatment plan by the physician.
Reporting multiple codes when a single code exists that describe the services, referred to as unbundling.	Any code that describes a service included as a component of another code, either by definition, or by standards of medical practice.	Do not report a service that is a component of another service reported for the same encounter.

Documentation Tips: Common Physician Coding Issues

Issue	Codes Affected	Solution
Presenting Problems for Subsequent Hospital Visits:		
Subsequent Hospital Visit: CPT 99231	<ul style="list-style-type: none"> • stable, possible ready for discharge 	
Subsequent Hospital Visit: CPT 99232	<ul style="list-style-type: none"> • new, minor problem such as fever 	
Subsequent Hospital Visit: CPT 99233	<ul style="list-style-type: none"> • unstable, or developed a significant complication or new problem 	
(For clinical examples by specialty see American Medical Association's CPT Manual Appendix C)		

CMS Fact Sheet: CERT Signature Requirements	Source: ICN 905364 March 2011
Questions	Answers
What is required for a valid signature?	<p>In order for a signature to be valid, the following criteria must be met:</p> <ul style="list-style-type: none"> • Services that are provided or ordered must be authenticated by the ordering practitioner; • Signatures are handwritten or electronic (stamped signatures are not acceptable); and • Signatures are legible. <p>Reference: CMS "Medicare Program Integrity Manual" (Publication [Pub.]100-08), Chapter 3, Section 3.4.1.1.D</p>
What should I do if I haven't signed an order or medical record?	<p>You may not add late signatures to medical records (beyond the short delay that occurs during the transcription process). Medicare does not accept retroactive orders. If the practitioner's signature is missing from the medical record, submit an attestation statement from the author of the medical record.</p> <p>Your contractor may offer specific guidance regarding addenda to medical records. If the order is unsigned, you may submit progress notes showing intent to order the tests. The progress notes must specify what tests are being ordered. A note stating "Ordering Lab" is not sufficient. If the orders and the progress notes are unsigned, your facility or practice will be assessed an error, which may involve recoupment of an overpayment.</p>
What if the physician signs the order or progress note, but the signature is not legible?	<p>You may submit a signature log or attestation statement to support the identity of the illegible signature. If the original record contains a printed signature below the illegible signature, this may be accepted.</p> <p>Reference: CMS "Medicare Program Integrity Manual" (Pub. 100-08), Chapter 3, Section 3.4.1.1.D.1</p>
What is a signature log?	A signature log is a typed listing of the provider(s) identifying their name with a corresponding handwritten signature.

Documentation Tips: Common Physician Coding Issues

CMS Fact Sheet: CERT Signature Requirements	Source: ICN 905364 March 2011
Questions	Answers
	This may be an individual log or a group log. A signature log may be used to establish signature identity as needed throughout the medical record documentation. Reference: CMS “Medicare Program Integrity Manual” (Pub. 100-08),Chapter 3, Section 3.4.1.1.D.1.a
What if my provider does not have a signature log currently in place?	On behalf of a health care provider, you may create a signature log at anytime, and Medicare Contractors will accept all submitted signature logs regardless of the date on which they were created
Am I able to attest to my signature?	Yes, you may attest that a signature is yours. A signature attestation is a statement that must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. Guidance on how to word your attestation is provided in the CMS “Medicare Program Integrity Manual” (Pub. 100-08), Chapter 3,Section 3.4.1.1 at http://www.cms.gov/manuals/downloads/pim83c03.pdf
Can I avoid delays in the completion of claims review by sending a signature log or signature attestation with my documentation?	CMS encourages you to submit a complete medical record with appropriate signature documentation initially to avoid delays in the completion of the review. This would include a signature log or attestation if needed.
Do my signatures need to be dated?	Documentation must contain enough information to determine the date on which the service was performed/ordered. If the entry immediately above or below the entry is dated, medical review may reasonably assume the date of the entry in question. Reference: CMS “Medicare Program Integrity Manual” (Pub. 100-08),Chapter 3, Section 3.4.1.1.J
What are the guidelines for using an electronic signature?	The guidelines for using an electronic signature are: <ul style="list-style-type: none"> • Systems and software products must include protections against modification, and you should apply administrative safeguards that correspond to standards and laws; • The individual whose name is on the alternate signature method and the provider bears the responsibility for the authenticity of the information being attested to; • Physicians are encouraged to check with their attorneys and malpractice insurers in regard to the use of alternative signature methods; • Part B providers must use a qualified electronic prescribing(e-prescribing) system; and • Prescriptions for drugs incident to Durable Medical Equipment (DME) must be made via a qualified e-prescribing system. Reference: CMS “Medicare Program Integrity Manual” (Pub. 100-08),Chapter 3, Section 3.4.1.1
Example :Provider Attestation in Lieu of Timely Authentication	“I, _____[print full name of the physician/practitioner]____, hereby attest that the medical record entry for _____[date of service]____ accurately reflects signatures/notations that I made in my capacity as _____[insert provider credentials, e.g., M.D.]____ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.”

2



AUDIT CHECKLIST: INCIDENT-TO

Month:		Physician:		Met criteria:
Patient:		Reviewer:		Payer:

If the answer is “ no ” to any of the questions, it is not appropriate to bill the service incident-to the physician.			
DOCUMENTATION TASK		YES	NO
Location	Does the place of service (POS) fall within the definition of an office or a physician directed clinic?		
	The service is not performed in the institutional setting (i.e. hospital or skilled nursing facility)? Incident-to services cannot be performed in the emergency room, hospital outpatient department or provider based physician office (POS 22).		
Employment relationship	Does the physician or group incur an expense and meet the employment requirements for the auxiliary staff? – OR		
	Does the auxiliary staff include employees, leased employees, or independent contractors of the physician or the entity that employs or contracts with the physician?		
Supervision	Is there direct supervision by the physician? (Present in the office suite to assist, if necessary. The physician does not need to be physically present in the patient’s treatment room for these services.)		
	Is there a documentation link between auxiliary staff and the physician when the incident-to service was performed? (Records of when the supervising physician was in the office suite, i.e. physician schedules, etc or documentation in the medical record by the physician.)		
Services performed	Did the physician personally perform the initial service and develop the plan of care? (Non-physician practitioners (NPPs) cannot see new patients or established patients with new problems incident-to).		
	Is the service a part of the patient’s normal course of treatment?		
	Is the physician actively involved in the course of treatment?		
	Is the physician’s involvement documented in order to prove physician involvement on an “active” level?		
Auxiliary staff services	If service is performed by auxiliary staffs, who are not NPPs, is only a level 1 visit (CPT 99211) billed? (NPPs can bill for whatever established patient evaluation and management level that is documented)		
	If the review of systems (ROS) and past family and social history (PFSH)? were performed by auxiliary is there documentation to support that the physician and/or NPP personally reviewed this documentation by confirming and/or supplementing to it in the medical record?		
Qualified Staff	Are auxiliary personnel performing physician services qualified non-physician practitioners (NPP)? This includes Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists.		
	Is the NPP licensed and certified to practice in the state in which they are practicing?		
	The NPPs salary is excluded from the facility’s cost report?		
Scribing	If a scribe was used, did they only document what was dictated to them by the physician and is the scribe identified as such? (Scribes do not act on their own)		
Incident-to? 100% of feesch.	Yes or No? If “incident-to” requirements are not met , the services may be billed under the NPP’s own provider number and paid at 85% of the Medicare physician fee schedule.		



HALIFAX HEALTH

AUDIT CHECKLIST: SHARED/SPLIT VISIT

Month:	Physician:	Met criteria:	
Patient:	Reviewer:	Payer:	
If the answer is “ no ” to any of the questions, it is not appropriate to bill the service as a shared/split visit under the physician’s provider number.			
DOCUMENTATION TASK		YES	NO
Qualified Staff	Are auxiliary personnel performing physician services qualified non-physician practitioners (NPP)? This includes Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialist.		
	Is the NPP licensed and certified to practice in the state in which they are practicing?		
Employment relationship	Does the physician or group incur an expense and meet the employment requirements for the NPPs? – OR –		
	Are the NPPs employees, leased employees, or independent contractors of the physician or the entity that employs or contracts with the physician?		
NPPs licensing and services	Are collaboration agreements for NPs filed with the state and available?		
	Are services performed by NPP within the state’s Scope of Practice?		
	Is the NPPs salary excluded from the facility’s cost report? If the NPP performs both facility and professional services, are time sheets kept?		
Office setting (non-hospital based outpatient clinic)	Did the physician personally perform the initial service and develop the plan of care? NPPs cannot see new patients or established patients with new problems since incident-to regulations apply in this setting.		
	Is the service a part of the patient’s normal course of treatment?		
	Is the physician actively involved in the course of treatment?		
	Is the physician’s involvement documented in order to prove physician involvement on an “active” level?		
Hospital setting including ER and provider based clinics (POS 22).	Shared visits are only used for the following services? <ul style="list-style-type: none"> • Hospital admissions (99221-99223) and follow up visits p visits (99231-99233) • Discharge management (99238-99239) • Observation care (99217-99220, 99234-99236) • Emergency department visits (99281-99285) and Prolonged care (99354-99357) • New* (provider based only) or established patients (99201-99215). * New patients can only be shared in provider based hospital clinics or outpatient departments, not in the office setting.		
Cannot be shared	If the NPP performed consultations (99241-99255), critical care services (99291-99292) or procedures is the service billed under the NPP’s provider number for Medicare?		
Documentation	Did the physician and NPP from the same group practice both partly perform the service? (The physician has a face-to-face encounter with the patient.)		
	Did the physician have a face-to-face encounter with the patient on the same calendar date as the NPP?		
	Did the physician document his part of the service, history, exam or medical decision making? (i.e., “I saw and evaluated the patient. Agree with NPP’s note but lower extremities are weaker, now 3/5; MRI of L/S Spine today.”)		
Scribing	If a scribe was used did they only document what was dictated to them by the physician and the scribe is identified as such? (Scribes do not act on their own)		
Shared Visit	Can this service be billed under the physician’s provider number?		

3

A PHYSICIAN'S FOCUS

Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria



In addition to national and local coverage determinations (NCDs and LCDs), there are certain principles that apply to all Medicare claims. These are rooted in the Medicare laws and regulations. By drawing the attention of our provider community to these topics, we anticipate reducing the claim payment error rate and reimbursing for medically necessary services correctly and expeditiously. This is not an all-inclusive list, but it does represent frequent observations from our Medical Review and Medical Policy departments. The focus of this article is on professional services that are usually but not always billed to the carrier (Part B funds) as opposed to the fiscal intermediary (FI – Part A and B funds). However, the principles apply to FI services unless specific differences are noted in the Medicare manuals. We hope that this publication will be useful to our providers and their teams by facilitating the correct filing of claims and the submission of supportive information.

Documentation

General Information

Below are some key points:

- Medicare expects the documentation to be generated at the time of service or shortly thereafter. Delayed entries within a reasonable time frame (24-48 hrs.) are acceptable for purposes of clarification, error correction, the addition of information not initially available, and if certain unusual circumstances prevented the generation of the note at the time of service.
- The medical record cannot be altered. Errors must be legibly corrected so that the reviewer can draw an inference as to their origin. These corrections or additions must be dated, preferably timed, and legibly signed or initialed.
- Every note must stand alone, i.e., the performed services must be documented at the outset. Delayed written explanations will be considered. They serve for clarification only and cannot be used to add and authenticate services billed and not documented at the time of service or to retrospectively substantiate medical necessity. For that, the medical record must stand on its own with the original entry corroborating that the service was rendered and was medically necessary.
- If the provider elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter must be documented in the medical record. Generally, the time must be documented when billing for all time-based codes, such as critical care, prolonged services, hospital discharge services, and others.
- All entries must be legible to another reader to a degree that a meaningful review may be conducted. All notes should be dated, preferably timed, and signed by the author. In the office setting, initials are acceptable as long as they clearly identify the author. If the signature is not legible and does not identify the author, a printed version should be also recorded.

Responding to Additional Documentation Request Letters and Requests from the Comprehensive Error Rate Testing Contractor

Although the terminology of these letters may vary, it is important to send all information that will support the claim. For non-laboratory services, this is the billing provider's responsibility, regardless if she or he has created it. For example, when seeking reimbursement for a diagnostic test, the performing (billing) provider should not only submit the report but also the order and the referring provider's office notes that document the medical necessity for the study. If the information received fails to support the coverage or coding of the claim, in full or in part, the contractor must deny the claim, in full or in part (CMS Online Manual System, Pub. 100-8, Program Integrity Manual, Chapter 3, Section 3.4.1.2A).

There are situations where test reports or other elements of the documentation are housed at a different location from the performing provider's office, for instance an EKG or X-ray read in the hospital. Because it is the performing provider who is required to submit this documentation upon request, it would be best practice if providers kept a copy of this information in their records so that it is readily available. This is a very important issue, as it continues to generate a high error rate in CMS' CERT (comprehensive error rate testing) program and results in numerous recoupments of payments already made.

Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria (continued)**Cloning of Medical Notes**

Documentation is considered cloned when each entry in the medical record for a beneficiary is worded exactly like or similar to the previous entries. Cloning also occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment.

Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information. All documentation in the medical record must be specific to the patient and her/his situation at the time of the encounter. Cloning of documentation is considered a misrepresentation of the medical necessity requirement for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

Evaluation and Management Coding**Procedure Code/Diagnosis Code Linking**

It is not enough to link the procedure code to a correct, payable ICD-9-CM code. The diagnosis or clinical signs/symptoms must be present for the procedure to be paid.

Volume of Documentation vs. Medical Necessity

The Social Security Act, Section 1862 (a)(1)(A) states: “No payment will be made ... for items or services ... not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the functioning of a malformed body member.” This medical reasonableness and necessity standard is the overarching criterion for the payment for all services billed to Medicare. Providers frequently “over document” and consequently select and bill for a higher-level E/M code than medically reasonable and necessary. Word processing software, the electronic medical record, and formatted note systems facilitate the “carry over” and repetitive “fill in” of stored information. Even if a “complete” note is generated, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of an E/M service. Information that has no pertinence to the patient’s situation at that specific time cannot be counted.

Shared Visits

Shared visits with non-physician providers (NPPs) may be reported as one visit, if each provider sees the patient separately and each documents separately. Each component of the visit must be medically necessary.

In the office/clinic setting:

- Providers may bill under the physician’s provider identification number (PIN), if all “incident to” requirements are met (follow-up visit, direct supervision, etc.).
- The service must be billed under the non-physician provider’s PIN if any of the “incident to” requirements are not met (example: new patient and/or physician not in the office suite).

In the hospital inpatient/outpatient/ER setting:

- Providers may bill under the physician’s or NPP’s PIN if the physician provides any face-to-face portion of the E/M encounter with the patient.
- The services must be billed under the NPP’s PIN if there is no face-to-face encounter by the physician.

The medical necessity of a service is the overarching criterion of payment. All interventions must be aimed at benefiting the patient and not only satisfying a billing requirement. It must be apparent that the face-to-face encounter with the physician is medically necessary and benefits the patient (impacts evaluation, treatment, and outcome). Shared visits cannot be reported in the skilled nursing facility (SNF) or nursing facility (NF) settings.

Scribing

If a nurse or non-physician practitioner (PA, NP) acts as a scribe for the physician, the individual writing the note (or history or discharge summary, or any entry in the record) should note “written by xxxx, acting as scribe for Dr. yyyy.” Then, Dr. yyyy should co-sign, indicating that the note accurately reflects work and decisions made by him/her.

It is inappropriate for an employee of the physician to make rounds at one time and make entries in the record, and then for the physician to make rounds several hours later and note “agree with above,” unless the employee is a licensed, certified provider (PA, NP) billing Medicare for services under his/her own name and number.

Record entries made by a “scribe” should be made upon dictation by the physician, and should document clearly the level of service provided at that encounter. This requirement is no different from any other encounter documentation requirement. Medicare pays for medically necessary and reasonable services, and expects the person receiving payment to be the one delivering the services and creating the record. There is no carrier Part B “incident to” billing in the hospital setting (inpatient or outpatient). Thus, the scribe should be merely that, a person who writes what the physician dictates and does. This individual should not act independently, and there is no payment for this activity.

It is acceptable for a physician to use a scribe, but current documentation guidelines must be followed. The physician is ultimately accountable for the documentation, and should sign and note after the scribe’s entry the affirmation above that the note accurately reflects work done by the physician.

Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria (continued)**Provider Qualification****Training and Expertise**

CMS Online Manual System, Pub. 100-8, Program Integrity Manual, Chapter 13, Section 5.1 (<http://www.cms.hhs.gov/manuals/downloads/pim83c13.pdf>) outlines that “reasonable and necessary” services are “ordered and/or furnished by qualified personnel.” Services will be considered medically reasonable and necessary only if performed by appropriately trained providers.

This training and expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty or must reflect extensive continued medical education activities. If these skills have been acquired by way of continued medical education, the courses must be comprehensive, offered or sponsored or endorsed by an academic institution in the United States and/or by the applicable specialty/subspecialty society in the United States, and designated by the American Medical Association (AMA) as category I credit.

Drugs and Biologicals**General**

In order to be covered under Medicare, use of a drug or biological must be safe and effective and otherwise reasonable and medically necessary. The medical reasonableness and necessity of drugs and biologicals are extensively discussed in the Medicare manuals.

First Coast Service Options, Inc. (FCSO) has published numerous local coverage determinations (LCDs) and educational articles about drugs and biologicals, specifically anti-cancer agents. Please refer to these publications for more detailed information. The training requirements listed under “Provider Qualification” apply.

Dosage and Frequency

Drugs or biologicals approved for marketing by the FDA are considered safe and effective when used for indications specified on the labeling. The labeling lists the safe and effective, i.e. medically reasonable and necessary dosage and frequency. Therefore, doses and frequencies that exceed the accepted standard of recommended dosage and/or frequency, as described in the package insert, are considered not medically reasonable and necessary and, therefore, not reimbursable.

Route of Administration

CMS Online Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.4.1 addresses medical reasonableness and necessity based on the FDA approval and labeling: “Drugs or biologicals approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for indications specified on the labeling.” This statement extends to the mode of administration that is considered safe and effective, i.e., medically reasonable and necessary by Medicare’s criteria. Furthermore, the CMS Online Manual System, Pub. 100-2, Medicare Benefit Policy Manual, Chapter 15, Section 50.2 K – Reasonable and Necessary, stipulates that “carriers and fiscal intermediaries will make the determination of reasonable and necessary with respect to the medical appropriateness of a drug to treat the patient’s condition. Contractors will continue to make the determination of whether the intravenous or injection form of a drug is appropriate as opposed to the oral form.”

Based on the above, for agents administered parenterally, the mode of administration (IV, IM, SQ) must be in keeping with the instructions in the package insert, as approved by the FDA. If a drug is available in both oral and injectable forms and both forms are equally effective, the oral preparation shall be used, unless there is a medical reason not to do so.

Wastage

CMS Online Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 17, Section 40, Discarded Drugs and Biologicals addresses wastage as: “CMS encourages physicians to schedule patients in such a way that they can use drugs most efficiently. However, if a physician must discard the remainder of a vial or other package after administering it to a Medicare patient, the program covers the amount of drug discarded along with the amount administered.

Note: The coverage of discarded drugs applies only to single use vials. Multi-use vials are not subject to payment for discarded amounts of drug.”

Payment for wastage will only be made when single-use vials have to be utilized. No reimbursement will be made for wastage in the case of multi-use vials.

Place of Service and Patient Safety

In situations when life threatening and other severe adverse reactions could be expected as a result of the administration of certain drugs or the performance of other services, the administration/performance of these services must take place in a facility equipped and staffed for cardiopulmonary resuscitation and where the patient can be closely monitored by qualified personnel for an appropriate period of time based on his or her health status. For specific services, FCSO may proscribe a place of service (POS) by way of an LCD or other publication.

Unit Dose and Decimal Point Errors

The number of billable units may not be equal to the dose administered. For example, if a HCPCS code descriptor calls for 100 mg of a given agent, the number of units for 1000 mg administered would be 10 and not 1000. Similarly, if the descriptor reads 50 mg and 100 mg are administered, the correct number of units to bill is 2.

Requirements for the Payment of Medicare Claims—A Selection of Some Important Criteria (continued)**Diagnostic Tests****Medical Necessity and Documentation**

Code of Federal Regulations (CFR), Title 42, part 410.32, specifies that all diagnostic tests must be ordered by a provider who is the treating provider for the patient and who will use the test results in the patient's care (in regards to the treating provider, there may be exceptions for the diagnostic radiologist in certain institutional inpatient or outpatient patient settings). For laboratory tests, additional documentation of medical necessity may be requested of the referring (treating) provider (CMS Online Manual System, Pub. 100-08, Chapter 3, Section 3.4.1.2).

Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary. Like with any service reimbursed by Medicare, to support medical necessity there must be documentation in the medical record as to why a certain modality was chosen/performed. This entire documentation - not just the test report or the finding/diagnosis on the order - must be available to Medicare upon request (please see also under "Responding to Additional Documentation Request (ADR) Letters and Requests from the Comprehensive Error Rate Testing (CERT) Contractor" in this article).

Portable Diagnostic Equipment

Medicare recognizes that the miniaturization of electronic devices is an on-going trend that may be associated with either improved or diminished test performance. Hand-carried diagnostic equipment ranges in complexity and capability from lightweight pocket-sized units completely contained within the examiner's hand, to complex equipment systems where only a part, such as the ultrasonic probe itself, is hand-held. The appropriate assignment of a specific ultrasound CPT code is not solely determined by the weight, size, or portability of the equipment, but rather by the extent, quality, and documentation of the procedure. To be reimbursable by Medicare, a diagnostic ultrasound test must meet at least these minimum criteria (this is not an all inclusive list):

- It must be medically reasonable and necessary for the diagnosis or treatment of illness or injury.
- It should be done for the same purpose as a reasonable physician would order a standard ultrasound examination.
- It must be billed using the CPT code that accurately describes the service performed.
- The technical quality of the exam must be in keeping with accepted national standards and not require a follow-up ultrasound examination to confirm the results.
- The study must be performed and interpreted by qualified individuals.
- The medical necessity, images, findings, interpretation and report must be documented in the medical record.

Purchased Interpretations

According to the CMS Online Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 1, Section 30.2.9.1 "A person or entity that provides diagnostic tests may submit the claim, and (if assignment is accepted) receive the Part B payment, for diagnostic test interpretations which that person or entity purchases from an independent physician or medical group if:

- The tests are initiated by a physician or medical group, which is independent of the person or entity providing the tests and of the physician or medical group providing the interpretations;
- The physician or medical group providing the interpretations does not see the patient; and
- The purchaser (or employee, partner, or owner of the purchaser) performs the technical component of the test. The interpreting physician must be enrolled in the Medicare program. No formal reassignment is necessary."

Furthermore, it is noted in the Final Rule of 2005 that "Arrangements involving reassignment must not violate any other applicable Medicare laws or regulations governing billing or claims submission, including, but not limited to, those regarding "incident to" services, payment for purchased diagnostic tests, and payment for purchased test interpretations."

Consequently, a provider who initiates (orders) a test cannot purchase the interpretation and bill it to Medicare as professional component. For example, if a physician or a group perform testing on their patients with their own ultrasound equipment, and a radiologist, who is not a member of the practice, reads the tests, the group can bill only for the technical component (modifier TC). The radiologist must bill Medicare separately for the interpretation (professional component, modifier 26).

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