Non-Physician Practitioners Coding, Billing and Documentation Guidelines

Medical Compliance Services
Non-Physician Practitioners (NPPs) Billing and Documentation Guidelines

Agenda

Billing for “incident to” Evaluation & Management (E/M) Services in the Hospital Inpatient/Outpatient/Emergency Department Setting

Billing “Incident to” in the Hospital Setting

Billing Split/Shared E/M Services in the Office Setting

Billing Split/Shared E/M visits in the Hospital Setting

NPPs Direct Payment by Other Third Party Payors

Use of Scribe(s)
“Incident to” Billing Requirements in the Hospital Setting

No “incident to” Billing is Permitted for:

- Inpatients (POS 21)
- Outpatients (POS 19, 22)
- Observation (POS 22)
- Discharge Day Management (POS 21)
- Emergency Department (POS 23)

“Incident to” provision is not applicable in the hospital setting
Billing Split/Shared E/M Visits in the Office Setting

Encounter between a physician and an NPP (ARNP, PA, CNS, CNM)

NPP is employed by the physician or physician group

Not applicable to a NPP who is salaried by a facility that is reimbursed on a cost-related basis. If the cost for the NPP’s salary is included in the facility’s cost report, the services of the NPP may not be billed.

Not applicable to medical students, nurses, residents, and fellows

Not applicable to Consultations, Procedures or Critical Care Services
Billing Split/Shared E/M Visits in the Office Setting

Encounter between a physician and an NPP (ARNP, PA, CNS, CNM)

Service must be medically necessary.

Service must be within the scope of practice and licensure of the NPP.

The NPP and the physician services may occur jointly or at independent times on the same calendar day.

Both the NPP and physician should each document what each portion of the E/M service that he/she personally performed.

The combined documentation by both the NPP and the physician should support the level of care billed.

Services can be billed under the physician’s provider number and reimbursed at 100% of the physician fee schedule; or

Services can be billed under the NPP’s provider number and reimbursed at 85% of the physician’s fee schedule.
Billing Split/Shared E/M Visits in the Hospital Setting

Hospital Inpatient/Outpatient/Hospital Observation/Hospital Discharge/Emergency Department Setting

When an E/M encounter is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face substantive portion of the E/M, it can be billed under:

- Either the physician’s NPI # at 100% of the PPS; or
- the NPP can bill under his/her NPI # if the collaboration/general supervision rules are met and the services are within the scope of practice of the NPP.

The ROS and/or PFSH may be documented by ancillary staff or on a form completed by the patient. There must be a notation supplementing or confirming the information recorded by others by the NPP or Physician billing for the service.

If there is no face-to-face encounter by the physician, even if the physician participated in the service, (e.g., only by reviewing the medical record) then the service may only be billed by the NPP.
Billing Split/Shared E/M Visits in the Hospital Setting

Attending Physician sees patient (face-to-face) with NPP from the same group practice employed by the clinical department.

E/M Service must be documented by both & may be billed by either the Physician or NPP.
Billing Split/Shared E/M Visits in the Hospital Setting

Attending Physician (face-to-face) visits the patient in the morning and

NPP from the same group practice (face-to-face) visits the patient in the afternoon

E/M Service must be documented by both & may be billed by either the Physician or NPP
Billing Split/Shared E/M Visits in the Hospital Setting

Attending Physician reviews the Medical Record but has no face-to-face visit with the patient.

NPP from the same group practice (face-to-face) visits with the patient.

E/M Service must be documented & billed by the NPP.
Billing Split/Shared E/M Visits in the Hospital Setting

Attending Physician (face-to-face) visits the patient

NPP (employed by the hospital & salary reported on cost report) face-to-face visit with the patient can document ROS and PFS Hx

E/M Service must be documented entirely by the Physician, except ROS and PFS Hx, in order for the Physician to bill the service
Billing Split/Shared E/M Visits in the Hospital Setting

Billing for Split/Shared Visits is **NOT** Permitted for:

- **Consults**
- **Critical Care Visits**
- **Procedures**

These services must be provided, documented and billed entirely by either the Physician or the NPP.
In addition, they cannot be billed if provided in an SNF/NF setting.
Overview of Medicare Billing Rules
“Incident to” and Split/Shared E/M Visits

<table>
<thead>
<tr>
<th>Evaluation and Management (E/M) Scenarios</th>
<th>Billing/Reporting</th>
<th>Medicare Reimbursement</th>
<th>Evaluation and Management (E/M) Documentation Guidelines (1995 or 1997 version) and Other Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician performs the E/M service (regardless of place of service)</td>
<td>Must be billed using the physician’s UPIN/PIN (NPI, when effective)</td>
<td>100% of physician fee schedule</td>
<td>The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.</td>
</tr>
<tr>
<td>NPP performs the E/M service (regardless of place of service)</td>
<td>Must be billed using the NPP’s UPIN/PIN (NPI, when effective)</td>
<td>85% of the physician fee schedule</td>
<td>The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.</td>
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**Split/Shared E/M Encounter — APPLIES ONLY TO SELECTED E/M VISITS AND SETTINGS**

Encounter between a physician and a non-physician practitioner (NP, PA, CNS or CNM)

- NPP is employed by the physician or they share the same employer
- Not applicable to medical students, nurses, residents
- Not applicable to consultations, procedures and critical care services
- A split/shared E/M visit cannot be reported in the SNF/NF setting

**Office/Clinic Setting — “incident to” is met and patient is an “established patient”**

- Can be billed using the physician’s or NPP’s UPIN/PIN (NPI, when effective)
- 100% of physician fee schedule if billed using physician’s UPIN/PIN or NPP’s UPIN/PIN/PNI

**Office/Clinic Setting — When “incident to” is not met**

NPPs should bill under their own name/number when:
- Seeing new patients
- Seeing established patients with new problems
- Physician not physically present in office suite

**Hospital Inpatient/Outpatient/Hospital Observation/Hospital Discharge/Emergency Department Setting**

E/M encounter is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face substantive portion of the E/M encounter with the patient.

**Consultations**

Effective 01/01/06, a consultation cannot be billed as a split/shared visit (regardless of the place of service i.e., office, hospital inpatient, hospital outpatient).
- Intent of consultation service is that a physician or qualified NPP or other appropriate source is asking another physician or qualified NPP for advice and opinion in evaluating a patient.
- Consult must be performed either by physician or by NPP.
Billing Guidelines

“Incident to”

• Physician must personally provide the first visit and remain actively involved in the course of treatment.

• Services provided under the physician’s direct personal supervision (Physician must be present in the office suite and be immediately available to provide assistance and direction throughout the time the services are being performed)

• Commonly rendered without charge (included in physician’s professional services)

• Commonly furnished in a physician’s office Place of Service 11 Doctor’s office (not in a hospital setting)

• NPP must be directly employed by the physician, physician group or entity that employs the physician or may be a leased employee or independent contractor.

Split/Shared Visit

• Service must be medically necessary and must be within the scope of practice and licensure of NPP

• The NPP must be employed by the physician or physician group practice

• Both the Physician and NPP see the patient face-to-face and document what each personally performed

• The services may occur jointly or independently on the same calendar day

• The total documentation by both the Physician and NPP must support the level of service billed

• Split/Shared visits is not applicable to Consultations, Procedures and Critical Care services, or billed in the SNF/NF setting
Use of Scribes

A scribe is a person who just writes or dictates what a physician performs. The use of Scribes is strongly discouraged by Medicare.

• This individual must not see the patient in a clinical capacity independently (must not render any services to patients).

• If a nurse, NP, PA, CNS acts as a scribe for the physician, the individual writing or dictating the note (progress note, discharge summary, or any entry in the medical record), should note “written by or dictated by XXX, acting as a scribe for Dr. YYY.”

• Dr. YYY should then co-sign, and document that the note accurately reflects the work and decisions made by him/her. “I was present with [patient name] during the time the encounter was recorded. I have reviewed and verified the accuracy of the information which was performed by me.” [Name of provider][Date and time of entry].
It is inappropriate for a NPP or other employee of the clinical department/physician group practice to make rounds at one time or see the patient in their clinical capacity and document in the medical record and then for the physician to make rounds or see the patient in the clinic later in the day and note, “agree with above” and bill the service under the physician’s name and NPI number.
Counseling/Coordination of Care CCC

- Time shall be considered for coding an E/M in lieu of H-E-MDM when > 50% of the total billable practitioner visit time is counseling/coordination of care (CCC).
  - Time is only Face-to-face for OP setting
- Coding based on time is generally the exception for coding.
- It is typically used:
  - Significant exacerbation or change in the patient’s condition,
  - Non-compliance with the treatment/plan,
  - Counseling regarding previously performed procedures or tests to determine future treatment options, or
  - Behavior/school issues.

Required Documentation For Billing:
1. Total time of the encounter excluding separate procedure if billed
   - The entire time to prep, perform and communicate results of a billable procedure to a patient must be carved out of the E/M encounter time!
2. The amount of time dedicated CCC for that patient on that date of service. A template statement would not meet this requirement.
Counseling/Coordination of Care CCC

Proper Language used in documentation of time:

• “I spent ____ minutes with the patient and family and over 50% was in counseling about her diagnosis, treatment options including _______ and ______.”

• “I spent ____ minutes with the patient and family more than half of the time was spent discussing the risks and benefits of treatment with……(list risks and benefits and specific treatment)”

• “This entire _____ minute visit was spent counseling the patient regarding ________ and addressing their multiple questions. Total time spent and the time spent on counseling and/or coordination of care must be documented in the medical record.

Documentation must reflect the specific issues discussed with patient present.
## Time-Based coding and Billing for CCC

<table>
<thead>
<tr>
<th>Outpatient Counseling Time:</th>
<th>Inpatient Counseling Time:</th>
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<tbody>
<tr>
<td>99201 10 min</td>
<td>99221 30 min</td>
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<tr>
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<td>99222 50 min</td>
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<td>99223 70 min</td>
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<td>99214 25 min</td>
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<tr>
<td>99215 40 min</td>
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</table>
Incident-to services are those services commonly furnished in a physician’s office that are “incident to” the professional services of a physician.

Physician must personally perform an initial service and for each new condition, make an initial diagnosis, and establish a treatment plan.

Physician must personally perform subsequent services at a frequency that reflects his/her active participation in and management of the course of the treatment for each medical condition.

Services must be performed under a physician’s direct personal supervision: (Present in the office suite and immediately available to provide assistance and direction throughout the time ancillary staff or NPP is performing the “incident to” services).
“Incident to” Billing Requirements in the Office Setting

Services can be billed using the physician’s provider number and reimbursed at 100% of the physician fee schedule or,

Services can be billed using the NPP’s provider number and reimbursed at 85% of the physician fee schedule (PPS)

The Review of Systems (ROS) and Past Medical, Family and Social History (PFSH) may be documented by ancillary staff or on a form completed by the patient.

The physician or the NPP must documented that he/she reviewed the information recorded by others, may also add supplemental information, and date and sign.
“Incident to” Billing Requirements in the Office Setting

Examples of “Incident to” Provision:

• A patient comes to the physician’s office. The nurse (RN employed by the Clinical Department) takes the vital signs. The physician performs the history, examines the patient and orders a chest X-ray, urine test and an EKG.

How should this visit be billed:

• The physician performed the history, examination and plan of care; therefore an E/M service may be billed by the physician.

• The vital signs were taken by the nurse **should not** be billed separately because they are included as part of the E/M service.
“Incident to” Billing Requirements in the Office Setting

Initial Visit: The physician sees Ms. Jones for high blood pressure. He/she prescribes medication and diet; and as a part of the treatment plan, he/she requests that her blood pressure be checked every week for two weeks.

Second Visit: The physician is on vacation and the ARNP in the office checks her blood pressure.

Third Visit: Ms. Jones returns to the office the following week, but the physician is seeing another patient; the ARNP checks her blood pressure.

How should these visits be billed?

• The initial visit is billed as an Evaluation & Management (E/M) visit under the group provider number, physician’s provider name and provider number as the rendering provider.
• The second visit cannot be billed “incident to” under the physician’s provider number because the criterion of the physician being on the premises, in the office suite, has not been met. Therefore, the second visit must be billed under the ARNP’s provider number.
• The third visit can be billed “incident to” (under the physician’s provider number) because the “incident to” criteria was met:
  – The service was provided in the physician’s office
  – The physician was on premises (direct supervision)
  – An employee of the physician provided the service
  – The service was part of the treatment plan initiated by the physician
Office Setting –

When the “incident to” provision is not met

- **NPPs** should bill under their own name and provider number as the rendering provider when:
  
  - Seeing New Patients
  - Seeing Established Patients with new problems
  - Physician is not physically present in the office suite