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Coding and Billing Compliantly for APPs

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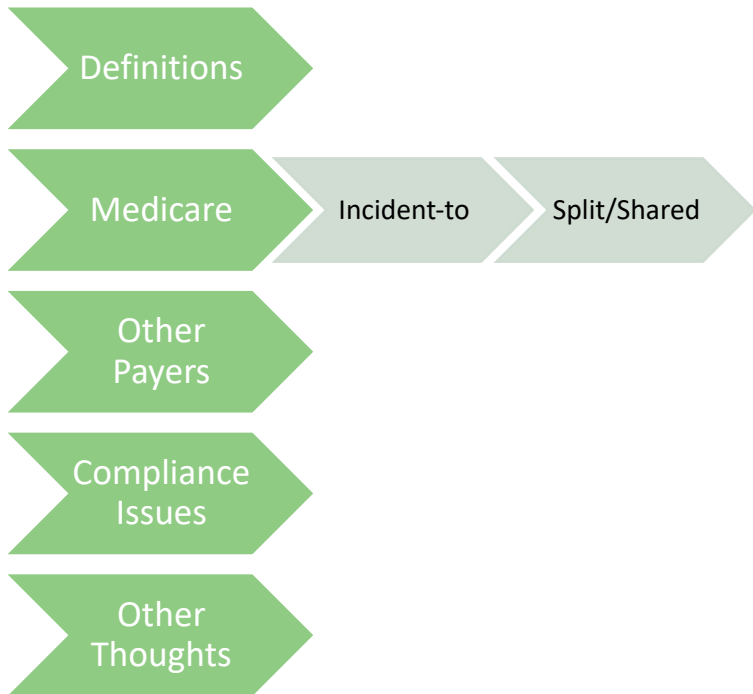


Presenter reports no conflicts of interest as of time of presentation.

Learning Objectives

- Produce necessary requirements in coding and billing for APP services
- Demonstrate when incident-to billing can be used appropriately
- Discover documentation coding opportunities and necessary employment considerations for APPs

Non-Physician Practitioners Coding and Billing



Non-Physician Practitioners

- Nurse Practitioner (APN, APRN, CRNP, etc.)
- Clinical Nurse Specialist
- Certified Nurse Midwife
- Physician Assistant

Different rules for different insurers – must pay attention to the patient's insurance when deciding how to utilize these providers in your practice.

Billing options

- NPPs own provider number
- Incident-to physician's service
- Shared visit

Nurse Practitioners must have Master's or Doctorate in Nursing (or credentialed prior to 1/1/2003)

Nurse Practitioners can be paid directly, but PA payment must go to the employer.

NPP's Provider Number

- Any services allowed by the NPP's state scope of practice
- Reimbursed at 85% of the physician fee schedule

- “Incident-to” a Medicare term
 - NPP must be eligible
- Billed under the physician’s number
- Paid at 100% of the physician’s fee schedule

Incident-To Rules

- Incident to a physician's professional service
- In the physician's office
- Under the physician's direct supervision
- Furnished by an individual who qualifies as an employee – either W-2 employee or contracted employee

Incident-To Rules

Incident-to a physician's professional service

An integral, though incidental part of the physician's professional service

Following a plan of care established by the physician

Physician must perform initial service and be involved in subsequent services of a "frequency which reflect active participation and management"

Some MACs give more specific requirements – Cahaba, for example, requires co-signature

Furnished in the physician's office or clinic

Direct Supervision

Under the physician's direct supervision

In the office suite and immediately available

What constitutes an office suite?

How do you prove immediately available?

Supervision can be provided by another physician in the group practice

Service billed under supervising physician

Ordering physician's name and NPI entered in box 17

Direct Supervision in Public Health Emergency

“In general, we are revising the definition of direct supervision to include, during the PHE, a virtual presence through the use of interactive telecommunications technology, for services paid under the Physician Fee Schedule.”

<https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>

Updated 11/12/2020

Employee of the Physician

W-2 employee of the physician, group practice or legal entity that employs the physician

1099 contracted/leased employee

Under the control of the physician

Must represent an expense to the physician, group practice, or legal entity

Services Incident-To an NPP

Services performed by auxiliary personnel supervised by NPP and following plan of care established by NPP.

Billed under the provider who ordered the service and who is supervising – the NPP, not the collaborating physician

Internet Only Manual section 30.6.1.B

“When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician’s or the NPP’s UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient’s medical record) then the service may only be billed under the NPP’s UPIN/PIN. Payment will be made at the appropriate physician fee schedule rate based on the UPIN/PIN entered on the claim.”

Per Terrence Kay, Director of the Division of Practitioner and Ambulatory Care in the Center for Medicare Management, CMS –

“...any face-to-face portion of an E/M encounter (i.e., history, physical exam, or medical decision-making in whole or in part). A social salutation alone does not constitute a face-to-face portion or “physician work” of an E/M service.”

From Palmetto GBA -

“...the medical record should contain enough detail to allow a reviewer to:

- Identify both providers

- Link the physician notes to those of the NPP

- Include legible signatures from both providers

- Confirm that the physician and the NPP both saw the patient face-to-face

- Include legible/electronic signature”

- <https://palmettogba.com/palmetto/providers.nsf/DocsR/JJ-Part-B~AXGPUY8807>

Documentation Examples

- “I have personally performed a face to face diagnostic evaluation on this patient. My findings are as follows: ...Patient presents with abscess, onset 3 days ago. Has tried a warm compress; hot shower for relief. Exam shows right gluteal abscess 3cm warm tender and fluctuant. Incision and drainage not indicated, started on MRSA antibiotic coverage" Signed by treating physician
- “I have personally performed a face to face diagnostic evaluation on this patient. I have reviewed and agree with the care plan. History and Exam by me shows: abdomen was tender to touch, no rebound. Labs /CT scan negative. IM Toradol given for pain. Pt discharged home.” Signed by treating physician

Not Acceptable Documentation

- "I have personally seen and examined the patient independently, reviewed the PA's History, exam and MDM and agree with the assessment and plan as written" signed by the physician
- "Patient seen" signed by the physician
- "Seen and examined" signed by the physician
- "Seen and examined and agree with above (or agree with plan)" signed by the physician
- "As above" signed by the physician
- Documentation by the NPP stating "The patient was seen and examined by myself and Dr. X., who agrees with the plan" with a co-sign of the note by Dr. X
- No comment at all by the physician, or only a physician signature at the end of the note

Not Shared Visits

- Procedures
- Welcome to Medicare
- Critical Care

Shared Visits in the Office

Must still meet incident-to guidelines

If visit dominated by and coded based on counseling and coordination of care, can combine NPP and physician time

CMS Program Integrity Manual update June 2017 on scribes – no documentation required

MACs may have more restrictive policies on scribes

“Human dictaphone” – cannot add any observations of their own (other than ROS and PFSH as allowed by Documentation Guidelines)

Best Practice: Sign as “Scribed by --- for Dr. ---”

Sandy and Kim’s opinion: Suspicion of use of employee at the level of NPP as clerical staff

CIGNA on Scribes

- If a nurse or mid-level provider (PA, NP, CNS) 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. yyy." Then, Dr. yyyy should co-sign, indicating that the note accurately reflects work and decisions made by him/her.
Note: The scribe is functioning as a "living recorder," recording in real time the actions and words of the physician as they are done. If this is done in any other way, it is inappropriate. This should be clearly documented as noted, by both the scribe and the physician. Failure to comply with these instructions may result in denial of claims.

Scenarios for Medicare Patients

Always bill under NPP's number

Always bill under MD's number

Documentation for visit determines how to bill -
may vary from patient-to-patient, visit-to-visit

Limitation on Level of Service?

Officially no limitation on level of service billed, some consultants consider higher levels of medical decision-making “what it means to be a physician”

Some payers limit the levels of service payable to NPPs

Other Payers

Some allow billing under the MD regardless of incident-to guidelines or physician presence

Some credential providers separately and allow independent billing

Other Payers - Example

Definition of “incident-to” is not the same as Medicare

- Physician must also see the patient on the date of service
- Not specified which portions of the service each can perform
- Billed under the physician and paid at the physician fee schedule

Other Payers - Examples

For some payers, NPPs can be credentialed and billed under their own NPI

- Payment may be based on patient's contract benefits
- Only certain CPT codes (E&M codes and some minor surgery – some exclude hospital visits)
- Payment usually at 70-80% of physician fee schedule and may vary by CPT code)
- Must be billed this way when the MD does not see the patient on the same date of service

Other Payers – United Healthcare

Starting 9/1/2017 – when patient is seen by NPP and claim billed under physician

Modifier SA

Rendering provider NPI in field 24J

Other Payers – Examples

BCBS of Alabama –

- Visit must be billed under the provider who documents the History of Present Illness

BCBS of Arkansas –

- Nurse practitioners limited to moderate complexity medical decision-making: 99201, 99202, 99203 – 99211, 99212, 99213, 99214 and minor procedures
- PAs limited to assistant at surgery, lower level ED services – no inpatient

Compliance Issues – Red Flags

- High number of visits billed under physician's provider number
- Physician did not know he/she was “supervising physician”
- Patient dissatisfaction

Auditing Considerations - Medicare

Office Service – Need entire medical record - not just one date of service

- Are incident-to requirements met?
 - Established patient – established problem
 - Previous visit to establish plan to treat this problem
 - Visits by physician addressing this problem – does your MAC/payer establish frequency requirements?
 - Established patient – “minor” problem
 - If requirements met, and more than 50% of the visit is counseling, can combine MD and NPP time
- If requirements not met, must bill under NPP’s own provider number

Hospital Service

- Admission, Subsequent Visit or Discharge
 - Is there a face-to-face visit by the MD?
 - Combine documentation from both MD and NPP to determine level of service
- Consultation
 - Cannot combine documentation – must bill under either the MD or the NPP based on each individual's documentation

Nursing Facility Service

- Must bill under NPP's own number

Other Issues/Thoughts

- Income distribution - for NPP and supervising
- Not just what income the NPP brings in, but what this provider frees the physician to do

Medicare Requirements for PA Billing

These requirements must be met for services to be billed under the supervising physician

Shared

- Only in the hospital – inpatient, outpatient, Emergency Department
- Physician must see patient face-to-face on same day & document some portion of the visit
- “Seen and agree” not sufficient

Incident-To

- Only in the office
- MD must perform entire first visit or visit for new problem
- PA must be following a plan of care established at previous visit
- MD must be in the office suite and immediately available

If these requirements are not met, the service should be billed under the PA.
Other payer requirements may vary.

- Nurse Practitioner Scope of Practice

<https://www.aanp.org/advocacy/state/state-practice-environment>

- American Academy of Physician Assistants

<https://www.aapa.org/advocacy-central/state-advocacy/state-laws-and-regulations/>

- Medicare Benefit Policy Manual, chapter 15, section 60 –

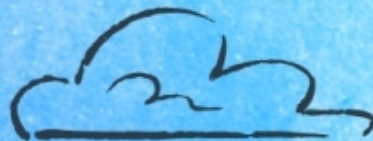
<http://www.cms.gov/manuals/Downloads/bp102c15.pdf>

- Medicare Claims Processing Manual, chapter 12, section 30.6.1-

<http://www.cms.gov/manuals/downloads/clm104c12.pdf>



QUESTIONS





THANK YOU

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