Navigating the Maze of Provider Billing, Documentation and Coding in a Palliative Care Setting

Session 1: E/M Services Based on Complexity

Incident To

FQHC Billing

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Presented by:
Acevedo Consulting Incorporated

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While most hospice and palliative care organizations have fairly robust compliance programs, a focus on physician billing is often missing. ACI can help to ensure that an organization can incorporate compliance functions for the physician billing while optimizing the revenue stream. Let ACI assist you in safeguarding your organization against retrospective recoupment of payment by insurers while also optimizing the revenue potential of its physician services.

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Denise Caposella is a Certified Professional Coder with the American Academy of Professional Coders with more than 30 years of healthcare experience. Throughout her career, Denise's focus has been physician practice and operations management. Her past experience spans the gamut between managing a medium-sized physician practice to being responsible for all South Florida specialty practices managed by a publicly traded physician practice management firm. Before re-joining ACI in 2011, she was the Executive Director of a freestanding Ambulatory Surgery Center responsible for overall operational & financial control.

Denise was the first Associate Consultant at ACI, and has a particular expertise in coding, chart audits and documentation, and compliance for physicians, Hospices and Ambulatory Surgery Centers. She also has a wealth of experience in traversing the Medicare registration process, including CMS 855 completion and submission. Denise is a Past President Elect for the Palm Beach County Chapter of the AAPC and formerly taught an "Introduction to Coding and Billing" course for the Palm Beach County Medical Society. She is a member of the American Academy of Professional Coders, and the Health Care Compliance Association.

Today's Speaker:

Denise Caposella, CPC
Senior Consultant

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AGENDA

- Medical Necessity
- General E&M Documentation Guidelines
  - The 3 Key Components
- Incident To
- FQHC Billing

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OIG RISK AREA: Medical Record Documentation*

- Validates
  - The site of service
  - The appropriateness of the services provided
  - The accuracy of the billing
  - Identity of the care giver (provider)

*OIG's Physician Compliance Guidance

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Risk Area: Medical Record Documentation

- Each encounter should
  - Be complete and legible
  - Every page in the chart should have the patient's name and date of service.
  - Document the reason for the encounter
  - Have a documented impression
  - Have a documented plan of care/f-up
  - Be dated and have the identity of the provider
    - Sign, initial, typed name on dictation
    - All providers and staff

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Medical Necessity

- Medicare law requires that in order for expenses incurred for items or services to be covered, they must be "*reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member*."
- "*Medical necessity 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 service than is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service billed.*"

(Pub 100-4, Medicare Claims Processing Manual, Ch. 12, §30.6)

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In Plain English

- Think of Medicare as any other health insurance
- Certain items/services are covered
  - And others are not
- And those that are, must meet the coverage criteria
  - That the service is "reasonable and necessary" or be one of the preventive benefits

Briefly: Medical Necessity & E/M

- Documentation software may facilitate carry-overs and repetitive fill-ins of stored information.
- Even when a "complete" note is generated, only medically necessary services for condition of patient at time of encounter as documented can be considered when selecting appropriate level of E/M service.
- Information not pertinent to patient's condition at time of encounter cannot be counted.
  - Patient seen in 'routine' follow-up of stable pain
  - History is "comprehensive" including past, family & social history. Was it "medically necessary" to repeat these history elements?

Noridian's Perspective on Medical Necessity

A vast majority of the documentation submitted to support claims billed with CPT® 99334–99337 fails to establish the medical necessity of the service. The documentation does not support any active issues or new injuries, and does not support any changes to the plan of care and/or medications. The documentation essentially supports a routine visit by the physician. The burden of proof for medical necessity of the service is that of the provider. Claims will be denied as not medically reasonable and necessary when the person who renders the service fails to document the medical necessity of the service.

**Based on Medical Review Level of Service findings performed by Noridian's Medical Review department.*

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Noridian's Perspective on Medical Necessity - cont.

- Another trend noted by Part B MR is the MDM does not correlate to the chief complaint. One such example would be the HPI supports a follow-up visit for renal functions tests, hypertension, and reflux. The medical management of that patient is then a Physical Therapy referral for low back pain, with no mention of medical management of the issues that brought the patient to the clinic. The documentation did not support complaints of low back pain. Part B MR has also noted that the plan of care simply lists the medical diagnoses of the patient, with no mention of changes to the plan of care if any, or continuation of current treatment regimens. It is difficult to determine the medical necessity of a visit when the documentation lacks important information, or when the documentation does not support medical management of the patient's chief complaint.

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HPI & Impression/Plan: The Most Important?

- HPI
  - Description of the illness/problem from its onset or since the last time patient seen…
- Impression/Plan
  - Not only indicates what today's findings and thought processes, but substantiates future intervention!

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Duplicative vs. Concurrent Care (Particularly for Palliative Care)

Concurrent Care

- ❖*"reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient's treatment, for example, because of the existence of more than one medical condition requiring diverse specialized medical services,"*
- ❖1) Does the patient's condition" *warrant the services of more than one physician on an attending (rather than consultative) basis?*", and
- ❖2) are the services provided by each physician/NPP "*reasonable and necessary?"*

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Duplicative vs. Concurrent Care

Duplicative Care

- ❖Medicare Benefit Policy Manual: Chapter 15, Section 30 E.
  - clearly warns Medicare contractors to "*assure that the services of one physician do not duplicate those provided by another*."

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Patients in SNF, ALF or Home

Particularly for palliative care

- Cannot be seen just because you are at the SNF, ALF or passing by the home
- Must be sure to paint a clear picture of the services you are providing
- Patients likely still receiving care from their PCP

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E&M DOCUMENTATION

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Multiple E/M Guidelines

- E/M guidelines were significantly changed in 2021 for the OFFICE setting
- The following slides pertain to Home, ALF, Inpatient, Nursing Facility services ONLY.

Whichever is more favorable for the physician

- 1995 E&M Documentation Guidelines
- 1997 E&M Documentation Guidelines

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7 Components Define E&M Services:

- Key elements in selection of level
  - History
  - Examination
  - Medical decision making
- Ancillary elements in selection of level
  - Counseling
  - Coordination of care
  - Nature of presenting problem (medical necessity)
  - Time

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Using time to assign the level of E&M service.

- If a visit consists **predominantly** of counseling or coordination of care, time is the key element to assign the appropriate level of E&M service.
- The total length of time of the encounter should be documented and the record should describe the counseling and/or activities to coordinate care.

**Time based services will be discussed in another session*

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Let's look at the 3 Key Components

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Required Components

- "Key Components"
  1. History
  2. Physical Exam
  3. Medical Decision Making
- Documentation of all three key components must meet the code's definition for
  - "New patient" visits
  - "Initial" patient visits
- Documentation of two of the three key components must meet the code's definition for
  - "Established patient" visits
  - "Subsequent" visits

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#1: Documentation of History

- Based on 4 types
  - Problem Focused
  - Expanded Problem Focused
  - Detailed
  - Comprehensive
- History elements
  - Chief Complaint (CC)
  - History of present illness (HPI)
  - Review of systems (ROS)
  - Past, family and/or social history (PFSH)

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Chief Complaint

- Concise statement describing symptoms, problems, condition, physician recommended return, or other factor that is the reason for the encounter.
- Chief complaint must be explicitly stated or easily inferred from documentation:
  - "Severe abdominal pain for past 8 hours" (explicit)
  - "Less agitation since adding Ativan" (inference is that visit is to f/up on medication change)

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History of Present Illness

- History of Present Illness elements:
  - Location – body area (abdomen)
  - Quality – sharp, burning, deep
  - Context – how? what happened?
  - Severity – intensity of illness (9 on a scale of 1-10)
  - Duration – how long symptoms last (past 8 hours)
  - Timing – relation to events (constant)
  - Modifying factors – precipitating or alleviating factors (relieved by pain med)
  - Associated signs (objective evidence) or symptoms (subjective evidence) (e.g., nausea)

  Or
  - ***The status of at least three chronic or inactive conditions***

  Or
  - ***Documentation of 4 or more comorbidities***

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Review of Systems

- Constitutional symptoms; e.g. fever
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/ Lymphatic
- Allergic/Immunologic

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Review of Systems (ROS), cont.

- A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.
- Complete ROS addresses system related to problem plus all additional body systems.
  - At least 10 organ systems, must be reviewed
  - For remaining systems, notation indicating "all other systems negative" may be permissible
- In the absence of such a notation, at least ten systems must be individually documented. Avoid using the following statements, '10 systems negative, 12 systems negative, etc.'
- Do not count physical observations as ROS (count them as Physical Examination)
- Do not record unnecessary information solely to meet requirements of a high-level service when the nature of the visit dictates a lower-level service to have been medically appropriate

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Past, Family and/or Social History consists of:

- Past history (the patient's past experiences with illnesses, operations, injuries and treatments);
- Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk); and
- Social history (an age appropriate review of past and current activities).

Do not use "noncontributory"!

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When History is Unobtainable

- Times when you cannot obtain a history from patient, due to patient's condition, and there may be no one else present with knowledge of patient's history.
- This situation does *not* automatically qualify as a comprehensive history.
- Must document your attempts to obtain the missing history element(s) from other sources (eg., chart, nurses, family).
- Be specific about what portion of history is obtained from other sources

"Family History: Unobtainable."
(yet family is at the bedside)

"No further ROS or family history obtainable; chart reviewed, no family present."
What history elements could the doctor get "credit" for?

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History Documentation Guidelines

- History documentation is dependent upon the physician:
  - Clinical judgment
  - Nature of presenting problem(s)
- CC, ROS, and PFSH - list separate or w/the HPI
- ROS and/or PFSH obtained prev. does NOT have to be re-recorded. Documentation should reflect that the physician reviewed the previous entry noting the date and location.
- ROS and/or PFSH can be recorded by the patient or ancillary staff.
- If you are unable to obtain a patient history, document why and your attempt to obtain from another source.

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Selecting *Level of History

HPI	ROS	PFSH	Level
Brief (1-3 elements)	n/a	n/a	**Problem Focused**
Brief (1-3 elements)	Problem Pertinent (system directly related to problem identified in HPI)	N/A	**Expanded Problem Focused**
Extended (4 or more elements)	Extended (system directly related to problem identified in HPI & a limited # of add'l systems - 2-9 total	Pertinent (at least 1 specific item from any of the 3 areas)	**Detailed**
Extended (4 or more elements)	Complete (system directly related to problem identified in HPI + all add'l systems or a minimum of 10 systems)	Complete (2 or all 3 of the PFSH depending on E/M category)	**Comprehensive**

*To qualify for a given level of history, **all 3 elements** in the history table must be met.

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#2: Documentation of Exam (1995 DG)

Comprehensive: General multi-system **(8+ OS)** or complete single system organ system exam.

Body Areas:

- Head, including face
- Neck
- Chest, incl. breasts & axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, incl. spine
- Each extremity

Organ Systems:

- Constitutional
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

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Documentation of Exam

Problem Focused	A limited exam of the affected body area or organ system **(1+ BA/OS)**
Expanded problem focused	A limited exam of the affected body area or organ system and any other symptomatic/related area(s)/system(s) **(2-7 BA/OS)**
Detailed	An extended exam of the affected body area(s) or organ system(s) and any other symptomatic or related area(s)/system(s) **(2-7 BA/OS)**
Comprehensive	Gen'l multi-system **(8+ OS)** or complete single organ system exam.

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EPF v. Detailed Exam - Example

- ***Expanded Problem Focused exam*** **"**a limited examination of the affected body area or organ system and other symptomatic or related organ system(s)." 2-7 BA/OS

Constitutional: VSS

Heart: RRR

Lungs: Clear

- ***Detailed exam*** "an extended examination of the affected body area(s) and other symptomatic or related organ system(s)" 2-7 BA/OS

Constitutional: VSS. Well developed, well nourished white female in no acute distress.

Heart: RRR, S1 S2. No murmurs, rubs or gallops.

Lungs: Clear to P&A. Normal expiratory effort w/decreased breath sounds noted. No rales or rhonchi.

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Noridian's Perspective

Noridian nurse reviewers and physicians have a clinically derived method called 4 x 4, to assist in implementing the E/M guidelines and decreasing the area of ambiguity.

- The 4 x 4 method applies to the exam only and is a way to ensure you have 4 exam items in 4 body areas or 4 exam items in 4 organ systems; thus, reducing reviewer variability..
- When reviewing a medical record, Noridian medical staff will automatically score a detailed exam if 4 or more exam items are noted in the medical record for 4 or more body areas or organ systems. **However, less than such can still be a detailed exam based on the reviewer's clinical judgment, which is considered clinical inference**.
- Our nurse reviewers also use their clinical knowledge while reviewing medical record documentation to determine the correct and appropriate level of care. It provides for an individual consideration, and makes the review of all services (including E/M examinations) fairer to the physician.
- **Note:** Clinical inference overrides the 4 x 4 method; and is in keeping with CMS instructions for reviewing all medical records.

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Exam guidelines

- Specific abnormal and relevant negative findings should be documented. A notation of "abnormal" w/o elaboration is insufficient.
- Abnormal or unexpected findings of any asymptomatic area(s)/system(s) should be described.
- A brief statement indicating "negative" or "normal" is sufficient to document normal findings related to unaffected area(s) or asymptomatic system(s).

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#3: Medical Decision Making
(2:3 variables required)

1. The number of possible diagnoses/number of management options that must be considered
2. Amount/complexity of medical records, diagnostic tests, &/or other information obtained, reviewed and analyzed
3. Risk of significant complications, morbidity &/or mortality, as well as comorbidities associated w/the patient's presenting problem(s), the diagnostic procedure(s), &/or possible management options

Each variable can be one of four levels: from minimal/none to extensive/high.

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DX/Mgmt Options

Number of Diagnosis/Management Options	# Problems	X Points	= total
Self-limited or minor (stable, improved, or worsening).	Max = 2	1	
Established problem (to examining MD); stable or improved.		1	
Established problem (to examining MD); worsening.		2	
New problem (to examining MD); no additional work up planned.	Max = 1	3	
New problem (to examining MD); additional work up planned (e.g., admit/transfer).		4	
Total			

Legend for #Dx and Amt of Data:
Straightforward = 1 pt
Low = 2 pts
Moderate = 3 pts
High = 4 pts

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Amount/Complexity of Data

Amount and/or Complexity of Data Reviewed	Points
Review and/or order clinical lab tests(regardless of # ordered).	1
Review and/or order tests in the radiology section of CPT (nuclear medicine and all imaging except echocardiography and cardiac cath).	1
Review and/or order of tests in the medicine section of CPT, (EEG, EKG, echocardiography, cardiac cath, non-invasive studies, pulmonary function studies).	1
Discussion of tests results with performing physician.	1
Decision to obtain old records and/or obtain history from someone other than the patient.	1
Independent review of image, tracing, or specimen (not simply review of report).	2
Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion with other health provider.	2
Total	

Legend for #Dx and Amt of Data:
Straightforward = 1 pt
Low = 2 pts
Moderate = 3 pts
High = 4 pts

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Table of Risk

TABLE OF THE RISK OF COMPLICATIONS, MORBIDITY AND MORTALITY

Level of Risk	Presenting Problems	Diagnostic Procedures Ordered	Management Options Selected
Minimal **Level I - II**	• One self-limited problem, e.g., cold, insect bite, tinea corporis	• Lab tests requiring venipuncture • Chest X-rays • Urinalysis • Ultrasound [e.g., echocardiography] • KOH prep	• Rest • Gargles • Elastic Bandages • Superficial Dressings
Low **Level III**	• Two or more self-limited or minor problems • One stable chronic illness [e.g., well-controlled hypertension or non-insulin-dependent diabetes, cataract, BPH] • Acute uncomplicated illness or injury [e.g., cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress [e.g., pulmonary function tests] • Non-cardiovascular imaging studies with contrast [e.g., barium enema] • Superficial needle biopsies • Clinical lab tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate **Level IV**	• One or more chronic illnesses with mild exacerbation, progression or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis [e.g., lump in breast] • Acute illness with systemic symptoms [e.g., pyelonephritis, pneumonitis, colitis] • Acute uncomplicated injury [e.g., head injury with brief loss of consciousness]	• Physiologic tests under stress [e.g., cardiac stress test, fetal contraction stress test] • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors [e.g., arteriogram, cardiac catheterization] • Obtain fluid from body cavity [e.g., lumbar puncture, thoracentesis, culdocentesis]	• Minor surgery with identified risk factors • Elective major surgery [open, percutaneous or endoscopic] with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High **Level V**	• One or more chronic illnesses with severe exacerbation, progression or side effects of treatment • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function [e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status [e.g., seizure, TIA, weakness or sensory loss]	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiologic tests • Diagnostic electrophysiologic tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery [open, percutaneous or endoscopic] with identified risk factors • Emergency major surgery [open, percutaneous or endoscopic] • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

One criteria must be met or exceeded.

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Determining MDM

Putting these elements together…

Medical Decision Making	Straight-forward	Low	Moderate	High
Number of Diagnoses or Management Options	< 1	2	3	4 or more
Amount and Complexity of Data	< 1	2	3	4 or more
Overall Risk	Minimal	Low	Moderate	High

Which equates to…

Straight-forward	99341
Low	99221, 99231
Moderate	99222, 99232, 99344
High	99223, 99233, 99345

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Sample Patient – Visit 1

- A new patient is seen in the home for a palliative consult requested for neoplasm related pain. A CXR and lab results from a previous hospital admission are reviewed. History is obtained from the husband and the decision is made to start the patient on PO Morphine.
  - # of diagnoses and management options = 3 or moderate
    (new problem to examining MD; no additional work up planned)
  - Amount and complexity of data = 4 or high
    (review lab and CXR; obtain history from someone other than the patient)
  - Level of risk = 3 or moderate
    (prescription medication management)

Level of MDM = Moderate

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Sample Patient – Visit 2

- A follow up visit is made and the patient's pain is now controlled but she has new onset of nausea and vomiting. There is no data reviewed during this visit. The decision is made to continue the PO Morphine and start the patient on Zofran.
  - # of diagnoses and management options = 4 or high
    (1 stable problem; new problem to examining MD; no additional work up planned)
  - Amount and complexity of data = 0
  - Level of risk = 3 or moderate
    (prescription drug management)

Level of MDM = Moderate

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Sample Patient – Visit 3

- A follow up visit is made and the patient's pain continues to be controlled; nausea and vomiting is now resolved. The husband reports that the patient's appetite has improved. The decision is made to change the PO Morphine and Zofran to PRN.
  - # of diagnoses and management options = 2 or low
    (2 stable or controlled problems)
  - Amount and complexity of data = 2 or low
    (history obtained from someone other than the patient)
  - Level of risk = 3 or moderate
    (prescription drug management)

Level of MDM = Low

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99344/99326/99222/99305
Documentation Required (all of the below)

1. Comprehensive History
   - Chief complaint
   - HPI (4 or more elements; e.g. location, severity, quality, timing, context, modifying factors, etc.)
   - ROS – 10 or more systems
   - Past/Family/Social History
2. Comprehensive Exam (8 or more organ systems)
3. Medical Decision Making of Moderate Complexity (at least 2 of the following)
   - Moderate # of diagnoses or management options
   - Moderate amount or complexity of data (to be) reviewed
   - Moderate degree of risk

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99345/99327/99223/99306
Documentation Required (all of the below)

1. Comprehensive History
   - Chief complaint
   - HPI (4 or more elements; e.g. location, severity, quality, timing, context, modifying factors, etc.)
   - ROS – 10 or more systems
   - Past/Family/Social History
2. Comprehensive Exam (8 or more organ systems)
3. Medical Decision Making of High Complexity (at least 2 of the following)
   - Extensive # of diagnoses or management options
   - Extensive amount or complexity of data (to be) reviewed
   - High degree of risk

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Incident To, Briefly

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Medicare Benefit Categories

- Immunizations
- Diagnostic tests
- Therapy and Rehabilitation
- Incident to
- Preventive & screening services
- Others…

"Incident to" Benefit

- Its own benefit category
- Under §1861(s) of the Social Security Act:
  - Medicare pays for certain services and supplies furnished incident to a physician's/NPP's services and for which payment is not made under a separate benefit category.

Keep in mind that non-Medicare payers may have their own rules, guidelines, and documentation requirements for services billed by a physician but performed by someone other than the physician.

Incident to

- Applies to the following settings:
  - Physician's Office/Clinic
  - Patient's Home
    - **If** it's in a rural area and there is no home health agency that could have seen the patient- must still follow incident to requirements of direct physician supervision
  - NOT inpatient hospital or SNF/NF services

The Rule of 5 "E's"

- Employed NPP
- Enrolled NPP
- Established patient to physician
- Established problem to physician
- Established plan of care by physician

+Physician's direct supervision

The burning question….

- What are the circumstances that must be met for the patient's doctor to be able to bill using his/her NPI for services provided by a member of the practice's staff (whether MA, RN or Nonphysician Practitioner/NPP)?

'Incident to' Requirements, cont'd

- The services/supplies are furnished under the physician's direct personal supervision.
  - A member of the group who is physically in the office suite
- When performing incident to a physician, the ARNP/PA is a Medicare Provider
- The services/supplies are furnished by an individual who qualifies as an employee of the physician.
  - W2, 1099 or leased employee
  - Cannot bill for the hospital's PA/ARNP

Documentation must:

- Identify who rendered the service
- Indicate supervision requirement is met
- Show physician's initiation and continued involvement in treatment
- Reasonable and necessary
- If service is provided by an NPP it must be within scope of practice for the NPP

Personnel Who Can Perform Services Incident-to a Physician

- Auxiliary Personnel
  - RNs
  - LPNs
  - MAs
  - Technicians
- These can always be direct billed!
  - PAs
  - NPs
  - PTs
  - OTs
  - CPs
  - CSWs

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How Does This Impact The Role of The RN?

In order for the billing provider to bill for services performed in part or entirely by an RN:

- Services must be ordered by the physician or NPP
- Ordering provider must have seen the patient and developed a treatment plan
- Ordering provider must be in the office suite or patient home during the RN/Patient encounter

Non-Physician Practitioners

- Can supervise auxiliary personnel for incident-to purposes
  - Under Medicare
- Must meet all other requirements for billing
- Billed as if NPP performed the service
  - If payer allows!

FQHC Services, Briefly

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FQHCs provide:

- Physician services
- Services and supplies "incident to" physician services
- Nurse practitioner (NP), physician assistant (PA), certified nurse-midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW) services
- Services and supplies provided "incident to" NP, PA, CNM, CP, or CSW services
- Medicare Part B-covered drugs supplied "incident to" FQHC practitioner services
- Patient homebound visiting nurse services in an area where CMS certified a shortage of home health agencies
- Outpatient diabetes self-management training (DSMT) and medical nutrition therapy (MNT) for patients with diabetes or renal disease from qualified DSMT and MNT practitioners when provided in a 1-on-1, face-to-face visit
- Certain care management services, such as transitional care management (TCM), chronic care management (CCM), general behavioral health integration (BHI), principal care management (PCM), and psychiatric collaborative care model (CoCM) services
- Certain virtual communication services such as communications-based technology and remote evaluation services

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FQHC visits must:

- Be medically necessary
- Be face-to-face medical or mental health visits or qualified preventive health visits between the patient and an FQHC practitioner (physician, NP, PA, CNM, CP, or CSW), and the practitioner provides one or more qualified FQHC services
- In certain limited situations, include a registered nurse (RN) or a licensed practical nurse (LPN) homebound patient visit
- Under certain conditions, a qualified practitioner offers outpatient DSMT or MNT services when the FQHC meets the relevant program requirements to provide these services

FQHC visits may take place:

- In the FQHC
- At the patient's home, including an assisted living facility
- In a Medicare-covered Part A skilled nursing facility (SNF)
- At the scene of an accident

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FQHC visits can't take place at:

- An inpatient or outpatient hospital department, including a critical access hospital (CAH)
- A facility with specific requirements excluding FQHC visits

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Incident To & FQHC RN Home Visits

- Services furnished incident to a physician's visit by RHC or FQHC auxiliary personnel in the patient's home or location other than the RHC or FQHC **must have direct supervision by the physician**.
- For example, if an RHC or FQHC nurse accompanies the physician to a patient's home and administers an injection, the nurse's services would be considered incident to the physician's visit.
- If the same nurse makes the call alone and administers an injection, the services are not incident to services since the physician is not providing direct supervision.
- The availability of the physician by telephone and the presence of the physician somewhere in the building does not constitute direct supervision.

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FQHC & Incident To

- "Incident to" refers to services and supplies that are an integral, though incidental, part of the service and are:
- Commonly rendered without charge or included in the FQHC bill
- Commonly furnished in an outpatient clinic setting
- Furnished under the physician's direct supervision
- Furnished by a member of the FQHC

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FQHC & Incident To

"Incident to" services and supplies include:

- Drugs and biologicals that are not usually self-administered, and Medicare-covered preventive injectable drugs (e.g., influenza, pneumococcal)
- Venipuncture
- Bandages, gauze, oxygen, and other supplies
- Physical Therapy, Occupational Therapy and Speech Language Pathology
- Assistance by auxiliary personnel such as a nurse, medical assistant, or anyone acting under the supervision of the physician

Submit separate service lines with revenue codes and HCPCS codes to reflect any cost associated with incident to services for data reporting purposes only.

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FQHC Payment Codes

- G0466 - FQHC visit, new patient (reported with revenue codes 052X or 0519)(Federally Qualified Health Centers)
- G0467 - FQHC visit, established patient (reported with revenue codes 052X or 0519)(Federally Qualified Health Centers)
- G0468 - FQHC visit, Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) (reported with revenue codes 052X or 0519)(Federally Qualified Health Centers)
- G0469 - FQHC visit, mental health, new patient (reported with revenue codes 0900 or 0519)(Federally Qualified Health Centers)
- G0470 - FQHC visit, mental health, established patient (reported with revenue codes 0900 or 0519)(Federally Qualified Health Centers)

Each specific payment code listed above **must be submitted with a qualifying visit code on a separate line (ie. E/M visits, ACP services, preventive medicine services, etc.). A complete list of qualifying visit code can be found here:*

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-PPS-Specific-Payment-Codes.pdf

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Multiple FQHC Visits on Same DOS

Per encounter date of service.

- When multiple encounters occur on same date of service, only one claim is submitted including coding for both encounters.
- Second encounter rendered must include modifier 59 signifying separate time of day, treatment and illness occurred subsequent to another medical or mental health visit.

Modifier 59 - Distinct procedural service. Modifier 59 is the FQHC's attestation that the patient, subsequent to the first visit, suffers an illness or injury that requires additional diagnosis or treatment on the same day.

- Append to services when reporting unrelated services that occurred at separate times during the day (e.g., the patient left the FQHC and returned later in the day for an unscheduled visit for a condition that was not present during the first visit).
- Append on FQHC Payment Code G0467 (established patient visit).
- Do not append to services when a patient sees more than one practitioner on the same day, or has multiple encounters with the same practitioner on the same day, unless the patient, subsequent to the first visit, leaves the FQHC and then suffers an illness or injury that requires additional diagnosis or treatment on the same day.

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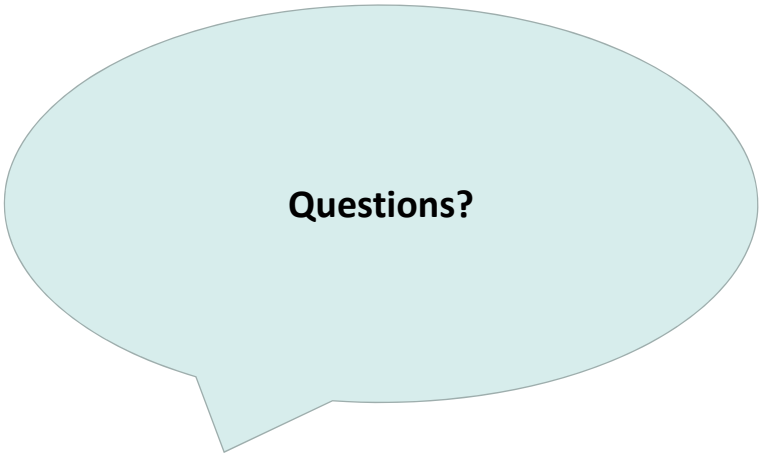

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Acevedo Consulting Incorporated
2605 West Atlantic Avenue, Suite D-102
Delray Beach, FL 33445
561.278.9328
www.AcevedoConsultingInc.com

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