Care Management
Non Physician Practitioner Billing
• I HAVE NO FINANCIAL RELATIONSHIPS TO DISCLOSE.

AND

• I WILL NOT DISCUSS OFF LABEL USE OR INVESTIGATIONAL USE IN MY PRESENTATION.
Agenda – Alphabet Soup

• Advance Care Planning (ACP)
• Transitional Care Management (TCM)
• Chronic Care Management (CCM)
• Chronic Disease Management
• Non Physician Practitioners (NPP)
  • Nurse Practitioners (NP)
  • Physician Assistants (PA)
Clinical Staff – CMS’s Definition

• Clinical staff can be any individual who is acting under the supervision of a provider, regardless of whether the individual is an employee, leased employee, or independent contractor of the provider and meets any applicable requirements to provide the services, including licensure, imposed by the State in which the services are being furnished (42 CFR §410.26)
Clinical Staff - CPT’s Description

• CMS references CPT’s definition of clinical staff. A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service, but does not individually report that professional service.
Advance Care Planning (ACP)
Advance Care Planning (ACP)

- Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional:
  - 99497 – First 30 minutes, face to face with the patient, family member(s) and/or surrogate
  - 99498 – Each additional 30 minutes (list separately in addition to code for primary procedure)

Effective: January 1, 2016
Advance Care Planning (ACP)
- What is it?

• Voluntary ACP means **discussion** about the **care** you would like to receive if you become unable to speak for yourself including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional face to face with the patient, family member(s) and/or surrogate.
Advance Care Planning (ACP) - Frequency

• Per CPT
  • No limits on number of times ACP can be reported for a given beneficiary in a given time period

• Per CMS
  • No established frequency limits
  • If billed multiple times
    • Expectation of a documented change in beneficiary's health status and/or wishes regarding his/her end of life care
Advance Care Planning (ACP) - Limitations, Location, Diagnosis

• May be billed by physicians and non-physician practitioners
  • Based on state scope
• Not limited to particular physician specialties
• No place of service restrictions
  • May be billed at Facility and Non-facility settings
• No specific diagnosis required
  • Report condition you are counseling the beneficiary on
  • Report well exam diagnosis is part of an AWV
Advance Care Planning (ACP) - Patient Liability

Performed/billed on same day as covered Annual Wellness Visit (AWV)

- Deductible and co-insurance waived
- Only payable once per calendar year
  - Like AWV
- Billed with modifier -33 (Preventive Service)

Performed in conjunction with E&M or As stand alone service

- Patient responsible for deductible and co-insurance
Advance Care Planning (ACP)
- Incident to

• Possible if
  • Physician must
    • Manage
    • Participate
    • Meaningfully contribute to provision of services
  • State law and scope of practice requirements are met
  • Incident to rules are met
    • Minimum of direct supervision
Advance Care Planning (ACP) - Documentation

• Check with Medicare Administrative Contractors

• Account of discussion
  • Voluntary nature of encounter
  • Explanation of advance directives
  • Who was present
  • Time spent face to face
Advance Care Planning (ACP) - Documentation

- A 68-year-old male with heart failure and diabetes is on multiple medications. He is seen by his physician for the Evaluation and Management (E/M) of these two diseases, including adjusting medications as appropriate.

- In addition to discussing the patient’s short-term treatment options, the patient expresses his interest in discussing long-term treatment options. The doctor and patient talk over the possibility of a heart transplant if his congestive heart failure worsens, and ACP. That includes discussing the patient’s desire for care and treatment if he suffers a health event that adversely affects his decision-making abilities.

- In this case, the physician would report a standard E/M code for the E/M service and one or both of the ACP codes, depending on the duration of the ACP service. The ACP service described in this example does not necessarily have to occur on the same day as the E/M service.
Transitional Care Management (TCM)
Transitional Care Management - What is it?

• Providing or overseeing the management and coordination of services, as needed
  • All medical conditions
  • Psychosocial needs
  • Activity of daily living supports
Transitional Care Management - Code Description

99495 - Transitional Care Management Services with the following required elements:

• Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
• Medical decision making of at least moderate complexity during the service period
• Face-to-face visit within calendar days of discharge

99496 - Transitional Care Management Services with the following required elements:

• Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
• Medical decision making of high complexity during the service period
• Face-to-face visit within 7 calendar days of discharge
Transitional Care Management
- CMS Comments

• Physicians should not undertake TCM services unless they are capable and willing to assume comprehensive responsibility for a patient's care during the period of the service

• We believe the lengthy list of services is quite appropriate to the nature of the service.
Transitional Care Management
- Frequency

• Only one health care professional may report services
• Only report services once per period
• Report/bill other E&M services when reasonable and necessary
• Watch 30 day of care requirement
  • Patient’s readmission
  • Patient’s death
• Watch Overlap with CCM
  • TCM – 30 days
  • CCM - Monthly
Transition From Where to Where?

**Patient Discharged From:**
- Inpatient hospital setting
  - Including acute hospital, rehabilitation hospital, long-term acute care hospital
- Partial hospitalization
- Observation status in a hospital
- Skilled nursing facility/nursing facility,

**Patient Discharged To:**
- The patient’s community setting
  - Home
  - Domiciliary
  - Rest home
  - Assisted living
Transitional Care Management - Limitations, Diagnosis

- May be billed by physicians, Physician Assistant, Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwife
  - Based on state scope
- Not limited to particular physician specialties
- No specific diagnosis required
  - Diagnosis for the visit
Transitional Care Management  
- Non Face-To-Face Service

• Clinical Staff must make contact within 2 business days
  • Via email, telephone or face-to-face
  • This call determines anticipated severity of MDM and when patient should be seen
• Medication reconciliation no later than first appointment
• Obtain discharge
• Review need for further testing
• Establish or re-establish referrals
• Assist in scheduling follow up with community providers and services
Transitional Care Management - Face-To-Face Service

• Communicate with agencies and community services that beneficiary uses

• Provide education to beneficiary, family/guardian and/or caretaker to support self management, independent living and activities of daily living

• Assess and support treatment regime adherence and medication management

• Identify available community and health resources
Transitional Care Management - Medical Decision Making

• Medical Decision Making
  • Number of possible diagnoses and/or number of management options
  • Amount and complexity of medical records, diagnostic tests and/or other information that must be obtained, reviewed and analyzed
  • The risk of significant complications, morbidity and/or mortality as well as comorbidities associated with patient’s problem
Transitional Care Management
- Incident To

• Face to Face visit must be furnished at a minimum of Direct supervision
• Non face to face visit may be furnished under General supervision
Transitional Care Management
- Documentation

• At a minimum you must document the following information
  • Date of discharge
  • Date of interactive contact and with whom
  • Date of face to face visit
  • Complexity of Medical Decision Making
Chronic Care Management (CCM)
CMS STUDY ON CHRONIC CONDITIONS

- Patients with identified multiple chronic conditions are at increased risk for:
  - Hospitalizations
  - Use of post-acute services
  - Emergency department visits
Conditions in Report

- Alzheimer’s/dementia
- Arthritis (including rheumatoid and osteoarthritis)
- Asthma
- Atrial fibrillation
- Cancer (breast, colorectal, lung, and prostate)
- Chronic kidney disease
- COPD
- Depression
- Diabetes (excluding diabetic conditions related to pregnancy)
- Heart failure
- Hyperlipidemia (High cholesterol)
- Hypertension (High blood pressure)
- Ischemic heart disease
- Osteoporosis
- Stroke/Transient ischemic attack
Chronic Care Management (CCM) - What is it?

• 99490 - Chronic Care Management Services, at least 20 minutes of clinical staff time, directed by a physician or other qualified healthcare professional, per calendar month with the following requirements:
  • Multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
  • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation or functional decline
  • Comprehensive care plan established, implemented, revised or monitored
Chronic Care Management
- Frequency

• Not a per beneficiary/per month code
• Something must be done and documented for this 20minute code
Chronic Care Management
- Initiation

- CMS REQUIRES the billing practitioner to furnish a comprehensive evaluation and management (E&M) visit, Annual Wellness Visit (AWV) or Initial Preventive Physical Examination (IPPE) prior to the CCM service.

- CCM will be initiated as part of this visit.
Chronic Care Management
- Comprehensive Care Plan

• A comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:
  • Problem list
  • Expected outcome and prognosis
  • Measurable treatment goals
  • Symptom management
  • Planned interventions and identification of the individuals responsible for each intervention
  • Medication management
  • Community/social services ordered
  • A description of how services of agencies and specialists outside the practice will be directed/coordinated
  • Schedule for periodic review and, when applicable, revision of the care plan.
Chronic Care Management
- Limitations, Location, Diagnosis

• Only one practitioner will be paid for CCM services for a given month
• May be billed by physicians, Physician Assistant, Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwife
  • Based on state scope
Chronic Care Management (CCM) - Patient Agreement Requirements

- The patient must be informed of the availability of CCM and obtain consent BEFORE furnishing or billing services including:
  - Inform patient of service and obtain written agreement to have services provided including authorization for the electronic communication of medical information with other treating providers
  - Explain and offer the CCM service to the patient. In their medical record document this discussion and note patient’s decision to accept or decline the service
  - Explain how to revoke service
  - Inform patient only one practitioner can furnish and be paid for CCM services in a month
Chronic Care Management (CCM) - Patient Agreement Process

• The agreement process should include a discussion with the patient and caregiver, when applicable, about
  • What CCM service is
  • How to access elements of service
  • How the patient’s information will be shared among providers
  • How cost sharing (co-insurance and deductible) applies to these services
  • How to revoke the service
Chronic Care Management
- Incident to

• Services provided directly by an appropriate physician or non-physician practitioner or clinical staff incident to the billing physician or non-physician practitioner count toward the minimum amount of service time to bill CCM

• CMS provided an exception under Medicare's I “incident to” rules that permits clinical staff to provide the CCM services incident to the services of the billing physician under the general supervision
Chronic Care Management - Documentation

• Document
  • Informed consent
  • Initiation of Management
    • Comprehensive Care Plan
  • Care Management
  • EHR technology requirements
Chronic Care Management
- Summary of 2015 Final Rule

1. Structured recording of demographics, problems, medications, medication allergies, and the creation of a structured clinical summary record, using a certified EHR
2. 24/7 access to care management services
3. Continuity of care with a designated member of the care team
4. Systematic assessment of health needs and receipt of preventive services
5. Electronic care plan
6. Management of transitions
7. Coordination with home and community-based clinical service providers as appropriate
8. Enhanced communication opportunities for patient and caregiver
9. Informed consent
Chronic Disease Management
ICD-10-CM Coding Guidelines
- Documentation of conditions

• **J. Code all documented conditions that coexist**

• Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
1995 & 1997 E&M Guidelines
- Document status of diagnosis

• The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.

• For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

• For a presenting problem with an established diagnosis the record should reflect whether the problem is
  • a) improved, well controlled, resolving or resolved
  • b) inadequately controlled, worsening, or failing to change as expected.
1995 & 1997 E&M Guidelines  
- Documentation of Co-morbidities  

• Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.
Comorbidities
– Document when appropriate

• Document all conditions that increase the complexity of medical decision making
  • 1995 & 1997 E&M Guidelines

• Code all documented conditions that co-exist
  • ICD-10-CM Guidelines

• If a condition is diagnosed, treated, addressed or affects MDM, it should be documented and coded.
Services of Non-Physician Practitioners
Nurse Practitioners
Physician Assistants
# Billing Methodology

## Direct Billing
- NPP is a provider billing insurance company directly
- Billed under their own NPI number

## Incident To
- NPP is following a plan of care set by attending physician
- Billing is done under physician’s NPI
- Only for stable patients where plan of care is easily followed and no changes in therapy needed

## Split Shared
- NPP sees the patient and documents a substantive portion of the history, exam and/or medical decision maker
- Physician sees the patient and documents a substantive portion of the history, exam and/or medical decision making
- Billing is done under physician’s NPI
Incident To Billing
Medicare Benefit Policy Manual
Chapter 15 – 60.1

• **Incident To Services**

  Incident to a physician’s professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness.
Medicare Benefit Policy Manual
Chapter 15

• Direct Personal Supervision

• Direct supervision in the office setting means the physician must be present in the office suite and immediately available and able to provide assistance and direction throughout the time the service is performed. Direct supervision does not mean that the physician must be present in the same room with his or her aide.
Medicare Benefit Policy Manual
Chapter 15

• **Services of Non-physician Personnel**

• A. 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 by the non-physician is an incidental part; and

• B. There must be subsequent services by the physician of a frequency that reflects his or her continuing active participation in and management of the course of treatment; and

• C. The physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary.
Incident To Care – Link Service to Plan of Care

• Reference in NPP care’s documentation
  • a ‘link’ between today’s visit/service and the plan of care and service to which their service in incidental.
  • The date and location of the plan of care and any other documentation that supports the active involvement of the physician.
• Write legibly
• 1. The progress note must substantiate the service performed and be signed by the person performing it.

• 2. When the physician is involved with a particular service, his or her contribution to the care must be documented. This will assist in substantiating his or her continued involvement in the patient's care.

• 3. The extent of physician involvement should reflect the patient's condition, increasing with instability and uncertainly of the situation.

• 4. All documentation should support the level of care provided.
Differences NP vs PA

Nurse Practitioner
• State Scope
• Collaboration - CMS
• Payment made to NP
  • Must accept assignment

Physician Assistant
• State Scope
• Supervision - CMS
• Payment made only to the actual qualified employer of the PA
  • Must accept assignment
Physician’s Assistant - State Scope - Michigan

• (1) Except in an emergency situation, a physician's assistant shall provide medical care services only under the supervision of a physician or properly designated alternative physician, and only if those medical care services are within the scope of practice of the supervising physician and are delegated by the supervising physician.

• (2) Subject to section 17048, a physician who supervises a physician's assistant may delegate to the physician's assistant the performance of medical care services for a patient who is under the case management responsibility of the physician, if the delegation is consistent with the physician's assistant's training.
Physician’s Assistant -
State Scope - Michigan

• 333.17049 Responsibilities of physician supervising physician's assistant. (cont’d)

• (6) Notwithstanding any law or rule to the contrary, a physician is not required to countersign orders written in a patient's clinical record by a physician's assistant to whom the physician has delegated the performance of medical care services for a patient.
Michigan Supervision Rules

• “Supervision” means the overseeing of or participation in the work of another individual by a health professional licensed where at least all of the following conditions exist
  - The continuous availability of direct communication in person or by radio, telephone, or telecommunication between the supervised individual and a licensed health professional.
  - The availability of a licensed health professional on a regularly scheduled basis to review the practice of the supervised individual, to provide consultation to the supervised individual, to review records, and to further educate the supervised individual in the performance of the individual's functions.

  • Excerpted from Public Act #368 section 333.16109
• (b) If the services were performed by a physician's assistant working for a physician or facility engaging in general family practice, a physician need not have been physically present on the premises when the physician's assistant performed the services so long as a consulting physician is within 150 miles or 3 hours' commute to where the services are performed.
Incident To at a Glance

**Incident To**
- Does not apply in hospital setting
- Must be expense to physician or group
- Requires physician supervision (Dr In Suite)
  - Reflected on claim form
- Cannot See New Patients
- Cannot diagnose/treat new problem
- Physician initiates treatment plan
  - Has a documented plan of care
  - PA references physician and date of plan of care at beginning of note

**Physician actively participating in patient’s ongoing care**
- No signature required by physician *
- Bill any level of E&M service
- Bill under physician’s name and PIN
  - Big “S’ and Little “s” supervision considerations
- No reduction in payment

* Unless state law dictates
Split

The Controversy
Split Shared Visit - Medicare

“Hospital Inpatient/Outpatient/Emergency Department Setting

• 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.

MCM – Chapter 12 – 30.6.1b
H. Split/Shared E/M Visit (Skilled Nursing/Nursing Facility)

• A split/shared E/M visit cannot be reported in the SNF/NF setting. A split/shared 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 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.

• 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. The physician and the qualified NPP must be in the same group practice or be employed by the same employer.
H. Split/Shared E/M Visit (Skilled Nursing/Nursing Facility)  [cont’d]

• The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non facility clinic visits, and prolonged visits associated with these E/M visit codes).

• The split/shared E/M policy does not apply to consultation services, critical care services or procedures.
Split Shared Visit - Medicare

Office/Clinic Setting

• In the office/clinic setting when the physician performs the E/M service the service must be reported using the physician’s UPIN/PIN. When an E/M service is a shared/split encounter between a physician and a non-physician practitioner (NP, PA, CNS or CNM), the service is considered to have been performed “incident to” if the requirements for “incident to” are met and the patient is an established patient.

• If “incident to” requirements are not met for the shared/split E/M service, the service must be billed under the NPP’s UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment.”
Split Shared at a Glance

- Service must be provided in
  - Hospital (Inpatient, Outpatient, Emergency Department)
- Physician and NPP must EACH perform AND document a part* of the E&M service and document as such
- New or established patients
- New or established problems
- Bill any level of E&M service
- CANNOT do procedures/surgery split shared
- Billed under physician number
- No reduction in payment
Inpatient Split/Shared Evaluation And Management (E/M) Services

Current review of medical records indicates an increasing number of Initial and Subsequent Hospital, as well as Emergency Department services, being billed as split/shared visits between the billing physician and a Non-Physician Practitioner (NPP) from the same group practice. The purpose of this article is to provide guidance on the appropriate documentation of split/shared services.

For a split/shared service to be reimbursed by Medicare Part B, the supporting medical records must satisfy the documentation requirements found in the Internet-Only Manual (IOM) references. An inpatient Split/Shared Evaluation and Management (E/M) service is defined by the Centers for Medicare & Medicaid Services (CMS IOM Publication 100-04, Chapter 12, Section 30.6.1(B), as an E/M service, "...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." Additionally, IOM Publication 100-04, Chapter 12, Section 30.6.13 (H) states that, "A split/shared 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 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. 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."
Inappropriate Documentation – Split Shared

All were signed by the attending physician

• I have personally seen and examined the patient independently, reviewed the PA's Hx, exam and MDM and agree with the assessment and plan as written

• Patient seen

• Seen and examined

• 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.
Q. When billing Medicare for services that are provided 'incident to' by a physician assistant (PA), does the supervising physician have to sign the PA's progress notes?

A. It is recommended that the physician co-sign the PA's progress notes as the physician's signature lends credence to the 'incident to' requirements having been met, as well as the fact that the physician supervised the PA's work.
Hospital Employed NPP’s

• After it self-disclosed conduct to the OIG, Inova Health Care Services d/b/a Inova Fairfax Hospital (Inova), Virginia, agreed to pay $528,158 for allegedly violating the Civil Monetary Penalties Law provisions applicable to kickbacks and physician self-referrals.
CAUTION – Hospital Employed NPP’s

• The OIG alleged that Inova paid remuneration to Arrhythmia Associates (AA) in the form of services provided by certain physician assistants (PA) within the office of AA. Specifically, Inova provided PA services to AA without written contracts in place and failed to bill and collect for those PA services.
Provider Based Billing

Place of Service 22 – Outpatient Hospital
NPP, Incident To Guidelines and POS 22

- Incident to service guidelines do not apply to those items billed in POS 22. Therefore, a mid-level provider seeing a patient must bill under his/her own NPI.
- In POS 22, in order to bill under the physician's provider number either the physician has performed the service or the situation meets the shared/split guidelines.
- The shared/split guidelines indicate both the MD/DO and the mid-level provider are in the same group (meaning under the same tax id) and both are providing a portion of the service to the patient.

* Publication 100-04, Chapter 12 Section 30.6.1.B.
NPP, Incident To Guidelines and POS 22

- Physicians who have billed for services provided by the mid level provider in POS 22 when the shared/split guidelines did not apply should refund Medicare the difference in payment. Physicians are allowed at 100% of the Medicare Fee Schedule and mid level providers are allowed at 85%. We have instructions on our Payment Recovery web page concerning refunding Medicare.

- If you have large numbers of payments to return, you can contact our Payment Recovery telephone analysts at 1-866-345-0275 for more information.
Palmetto Provider Based Billing

• **1. What provider types are impacted by the provider-based regulations?**
  Provider types impacted are those for which provider-based status affects the Medicare payment. The common situation is outpatient clinics of hospitals. If considered provider-based, the clinic would bill a facility charge under the hospital number to the intermediary and the physician's professional services to the carrier. If not considered provider-based, the clinic services would only be billed to the carrier.

• **3. Campus Criteria**
  For purposes of these regulations, the definition of 'campus' affects the criteria that applies. Campus means the physical area immediately adjacent to the provider's main buildings. A facility within 250 yards of the main buildings is generally considered to be on-campus. A facility outside of the 250 yard criteria but within 35 miles of the campus is generally considered to be off-campus.
Jurisdiction 11 Part BE/M WEEKLY TIP: 'INCIDENT TO' PLACE OF SERVICE (POS) 22

• Incident to services are limited to the office setting (POS 11). However, if a provider establishes an office in a larger outpatient setting, the 'incident to' services and requirements are confined to this discrete part of the facility designated as his/her office.

Reminder:
• Hospital Based Physician (employees of the hospital)
  • The hospital is billing and 'incident to' does not apply
  • Bill POS 22
• Group of physicians (not employees of the hospital) and the office is confined to the discrete part of the facility
  • The physicians are incurring the expense and 'incident to' would apply
  • Bill POS 11 (not POS 22)

Resource
• For more information, please visit the Medicare Claims Processing Manual, 100-02, chapter 15, Section 60.1 at CMS website (PDF, 1.22 MB).
FINAL QUESTIONS & COMMENTS

• Thank you!!

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