BILLING AND CODING ISSUES FOR PHYSICIAN, NP, PA, CNS

Alva S. Baker, MD, CMD

Objectives:

- Describe basic billing and coding practices applicable to long term care
- Delineate task performance in nursing homes by physicians and NPPs as proscribed and permitted in the Federal regulations

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BILLING AND CODING ISSUES FOR PHYSICIAN, NP, PA, CNS
23RD ANNUAL FALL SYMPOSIUM – THE CHANGING FACE OF GERIATRICS

PRESENTED BY
ALVA S. BAKER, MD, CMD
NOVEMBER 5, 2011

Faculty Disclosures:

Dr. Baker has disclosed that he has no relevant financial relationship(s).

This presentation is based, in part, on educational sessions created collaboratively by
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Learning Objectives

- Describe basic billing and coding practices applicable to long term care
- Delineate task performance in nursing homes by physicians and NPPs as proscribed and permitted in the Federal regulations

Pre-Course Assessment

Session Outline

1. Billing Codes in Long Term Care: Routine Care
   1. Codes
2. Special Requirements and Important Concepts: Nursing Homes
   1. POS, SNF vs. NF, AI modifier,
   2. Medical Necessity
      1. regulatory visits vs E/M visits
   3. Face to face
   4. Initial vs. subsequent
3. Physician Task Delegation to NPPs
Billing Codes in Long Term Care: Routine Care

### Nursing Homes

<table>
<thead>
<tr>
<th>Code</th>
<th>Patient</th>
<th>Visit Type</th>
<th>Time</th>
<th>E/M Components</th>
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<td>New or Established</td>
<td>Initial *</td>
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<td>3</td>
</tr>
<tr>
<td>99306</td>
<td>New or Established</td>
<td>Initial</td>
<td>45</td>
<td>3</td>
</tr>
<tr>
<td>99307</td>
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<td>10</td>
<td>2</td>
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<tr>
<td>99318</td>
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<td>Annual</td>
<td>30</td>
<td>2</td>
</tr>
</tbody>
</table>

* Initial: *Initial Nursing Facility Care, per day*
** Subsequent: *Subsequent Nursing Facility Care, per day*

### Special Requirements and Important Concepts: Nursing Homes
Session Outline

3. Special Requirements and Important Concepts:
   Nursing Homes
   1. POS, SNF vs. NF, AI modifier,
   2. Medical Necessity
      1. regulatory visits
      2. E/M visits
   3. Initial vs. subsequent

POS, SNF vs. NF

- Place of Service Code
  - 31 = SNF, 32 = NF
- SNF vs. NF: in a nursing facility, the resident is in a
  - SNF bed: when the resident is receiving Medicare Part A benefits ("skilled care")
  - NF bed: when the resident is not receiving Medicare Part A benefits

AI Modifier

- Starting in 2010, the AI modifier (A-eye, not A-one) is to be added by the attending physician when billing for the initial comprehensive visit (99304, 99305, 99306)
- Procedure for when the initial comprehensive visit is performed by a covering practitioner is not clear and is being clarified with CMS by AMDA
Medical Necessity

- Medical Necessity is the overarching criterion required to bill for services provided.

Medicare Claims Processing Manual, Pub.100-04

SEC. 30.6.1 - Selection of Level of Evaluation and Management Service

- A. Use of CPT Codes
  - “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.”
  - “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 reported.”
  - AMDA White Paper


Medicare Claims Processing Manual, Pub.100-04,

30.6.13 - Nursing Facility Services

**Medically Necessary Visits**

“Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B”
Federally Mandated Visits

- Patient must be seen initially (within 30 days) and then at least every 30 days for the first 90 days, then at least once every 60 days thereafter.

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Medicare Claims Processing Manual,
Pub.100-04,

30.6.13 - Nursing Facility Services

B. Visits to Comply With Federal Regulations (42 CFR 483.40)

“Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits. Following the initial visit by the physician, payment shall be made for federally mandated visits that monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.”

“Beginning January 1, 2006, the new CPT codes, Subsequent Nursing Facility Care, per day, (99307 – 99310) shall be used to report federally mandated physician E/M visits and medically necessary E/M visits.”

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Medicare Claims Processing Manual,
Pub.100-04,

30.6.13 - Nursing Facility Services

B. Visits to Comply With Federal Regulations (42 CFR 483.40)

“Carriers shall not pay for more than one E/M visit performed by the physician or qualified NPP for the same patient on the same date of service.”

i.e., one payment for mandatory visit combined w/ medically necessary visit

“Medicare Part B payment policy does not pay for additional E/M visits that may be required by State law for a facility admission or for other additional visits to satisfy facility or other administrative purposes.”
Medicare Claims Processing Manual, Pub.100-04,

30.6.13 - Nursing Facility Services

B. Visits to Comply With Federal Regulations (42 CFR 483.40)

“E/M visits, prior to and after the initial physician visit, that are reasonable and medically necessary to meet the medical needs of the individual patient (unrelated to any State requirement or administrative purpose) are payable under Medicare Part B.”

Initial vs. Subsequent Care

- Every time a patient is admitted to a nursing facility, an Initial Visit must be done
- Initial visit codes are used even if the patient is an established patient of the provider performing the visit

Initial vs. Subsequent Care

- Initial Visit: the comprehensive history and examination, writing of orders and development of the care plan
  - performed upon admission to the nursing facility
  - 99304, 99305, 99306
  - attending physician appends “AI” modifier
  - must be done by physician in SNF
  - must be performed within 30 days of admission
**Initial vs. Subsequent Care**

- **Subsequent Visit:**
  - all other E/M visits (even if performed prior to the Initial Visit being done)
  - includes federally mandated visits
  - 99307, 99308, 99309, 99310
  - may be shared with Non-Physician Providers (NPPs) as allowed by Federal and State regulations and scope of practice
  - includes 99315, 99316, 99318

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**Initial-subsequent vs. New-established**

- **SNF and NF**
  - Initial Visit (IV)
  - subsequent visit (sv)
  - VOID – patient goes to hospital
  - NH Discharge
  - Bed Hold
  - IV
  - sv

- **Office, etc.**
  - New Patient
  - established
  - established
  - VOID – patient not seen for 3 yrs

**Physician Task Delegation to NPPs**
Non-Physician Practitioners (NPPs)

- Nurse Practitioners
- Physician Assistants
- Nurse Clinical Specialists

30.6.13 C Visits by Qualified Nonphysician Practitioners

- State Regulations, State Scope of Practice
  - “All E/M visits shall be within the State scope of practice and licensure requirements where the visit is performed and all the requirements for physician collaboration and physician supervision shall be met when performed and reported by qualified NPPs.”
  - “General physician supervision and employer billing requirements shall be met for PA services in addition to the PA meeting the State scope of practice and licensure requirements where the E/M visit is performed.”

- Federally Mandated Visits
  - SNF (31)
    - “Following the initial visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.”
30.6.13 C Visits by Qualified Nonphysician Practitioners

- Federally Mandated Visits
  - NF (32)
    - Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.

30.6.13 C Visits by Qualified Nonphysician Practitioners

- “Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.”

<table>
<thead>
<tr>
<th></th>
<th>Order to Admit</th>
<th>Admission Treatment Orders</th>
<th>Initial Comprehensive Visit</th>
<th>Other Required Visits</th>
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<tr>
<td>SNF</td>
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</tr>
<tr>
<td>NP &amp; CNS employed by facility</td>
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<td>NP &amp; CNS not a facility employee</td>
<td>N</td>
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<td>N</td>
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<td>PA regardless of employer</td>
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<tr>
<td>NF</td>
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<td>NP, CNS &amp; PA employed by facility</td>
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**Other Medically Necessary Visits**

<table>
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<tr>
<th></th>
<th>Other Medically Necessary Visits</th>
<th>Other Medically Necessary Orders</th>
<th>Certification/Recertification</th>
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<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

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**The Ubiquitous Area of Confusion**

- Hospice

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**Medicare Claims Processing Manual**

**Pub.100-04**

**Chapter 11 – HOSPICE**

- **40 - Billing and Payment for Hospice Services Provided by a Physician**
  - **40.1 - Types of Physician Services**
    - **40.1.1 - Administrative Activities**
    - **40.1.2 - Patient Care Services**
    - **40.1.3 - Attending Physician Services**

- **50 - Billing and Payment for Services Unrelated to Terminal Illness**
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- 50 - Billing and Payment for Services Unrelated to Terminal Illness

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**Chapter 11 – HOSPICE**

- 40.1 - Types of Physician Services
  - 40.1.1 - Administrative Activities

  Payment for physicians’ administrative and general supervisory activities is included in the hospice payment rates. These activities include participating in the establishment, review and updating of plans of care, supervising care and services and establishing governing policies. Nurse practitioners may not serve as or replace the medical director or physician member of the IDG.

- 40.1.2 - Patient Care Services

  Payment (to Hospices) for physicians or nurse practitioner serving as the attending physician, who provide direct patient care services and who are hospice employees or under arrangement with the hospice, is made in the following manner:

  - Hospices establish a charge and bills the FI (MAC) for these services.
Medicare Claims Processing Manual
Pub.100-04

Chapter 11 – HOSPICE

40.1 - Types of Physician Services

40.1.3 - Attending Physician Services

An “attending physician” means an individual who:

- Is a doctor of medicine or osteopathy or
- A nurse practitioner; and
- Is identified by the individual, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of their medical care.

In order to bill Medicare as an “attending physician”:

1. Not employed nor receives compensation by Hospice
2. Professional services only (not technical)
3. Can be in addition to the services of hospice-employed physicians
4. The professional services of a non-hospice affiliated attending physician for the treatment and management of a hospice patient’s terminal illness are not considered “hospice services.”

5. Services are reasonable and necessary for the treatment and management of a hospice patient’s terminal illness
6. Services not furnished under a payment arrangement with the hospice
7. Must be coordinated with any direct care services provided by hospice physicians.
8. These services are coded with the GV modifier: “Attending physician not employed or paid under agreement by the patient’s hospice provider”
Medicare Claims Processing Manual
Pub.100-04

Chapter 11 – HOSPICE

- 40.1 - Types of Physician Services
  - 40.1.3 - Attending Physician Services

- Can NOT bill Medicare as an “attending physician:”
  - When services related to a hospice patient’s terminal condition are furnished under a payment arrangement with the hospice by the designated attending physician, the physician must look to the hospice for payment.
  - In this situation the physicians’ services are hospice services and are billed by the hospice to its FI (MAC).

Medicare Claims Processing Manual
Pub.100-04

Chapter 11 – HOSPICE

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    - 40.1.1 - Administrative Activities
    - 40.1.2 - Patient Care Services
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- 50 - Billing and Payment for Services Unrelated to Terminal Illness

Medicare Claims Processing Manual
Pub.100-04

Chapter 11 – HOSPICE

- 50 - Billing and Payment for Services Unrelated to Terminal Illness
  - Any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and which are furnished during a hospice election period, may be billed by the rendering provider to the carrier for non-hospice Medicare payment.
  - These services are coded with the GW modifier: “service not related to the hospice patient’s terminal condition”
Hospice -Summary

<table>
<thead>
<tr>
<th>1. Care not related to terminal illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bill Medicare – modifier GW</td>
</tr>
<tr>
<td>2. Care related to terminal illness</td>
</tr>
<tr>
<td>• MD not associated with hospice</td>
</tr>
<tr>
<td>• Bill Medicare – modifier GV</td>
</tr>
<tr>
<td>• MD associated/employed with hospice</td>
</tr>
<tr>
<td>• Bill Hospice / Contract</td>
</tr>
<tr>
<td>• POS: site-specific, per visit code</td>
</tr>
</tbody>
</table>

Consultations

99241-99255

| 1. 30.6.10 - Consultation Services |

Consultations – Gone With the Wind

- Consultation codes no longer recognized by CMS effective 1/1/10 (except telehealth codes)
- Fiscal Effect
  - Increase the work relative value units (RVUs) for new and established office visits
  - Increase the work RVUs for initial hospital and initial nursing facility visits
  - Incorporate the increased use of these visits into the practice expense (PE) and malpractice calculations
  - Increase the incremental work RVUs for the codes that are built into the 10-day and 90-day global surgical codes

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Revised Consultation Policy

- Inpatient hospital setting and nursing facility setting
- "All physicians (and qualified non-physician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221 – 99223) or nursing facility care codes (99304 – 99306)."
- AMDA clarified language re: initial evaluation in SNF and NPP: MLN MATTERS SE 1010
- 30.6.10 - Consultation Services

Use of initial nursing facility (NF) care codes for E/M services that could be described by CPT consultation codes

- Physicians may bill an initial NF care CPT code for their first visit during a patient’s admission to a NF in lieu of the CPT consultation codes these physicians may have previously reported, when the conditions for billing the initial NF care CPT code are satisfied.
- The initial visit in a skilled nursing facility (SNF) and nursing facility must be furnished by a physician except as otherwise permitted as specified in CFR Section 483.40(c)(4).
- The initial NF care CPT codes 99304 through 99306 are used to report the initial E/M visit in a SNF or NF that fulfills federally-mandated requirements under Section 483.40(c)"

Initial E/M service that could be described by a CPT consultation code not meeting the requirements for reporting an initial NF care CPT code

- May bill a subsequent NF care CPT code in lieu of the CPT consultation codes they may have previously reported.
- Otherwise, the subsequent NF care CPT codes 99307 through 99310 are used to report either a federally-mandated periodic visit under Section 483.40(c), or any E/M service prior to and after the initial physician visit that is reasonable and medically necessary to meet the medical needs of the individual resident.
Revised Consultation Policy

- Principal physician of record is identified in Medicare as the physician who oversees the patient’s care from other physicians who may be furnishing specialty care.
- Only the principal physician of record shall append modifier “-AI”, Principal Physician of Record, in addition to the E/M code.
- Follow-up visits in the facility setting shall be billed as subsequent hospital care visits and subsequent nursing facility care visits.

DOCUMENTATION

- “Conventional medical practice is that physicians making a referral and physicians accepting a referral would document the request to provide an evaluation for the patient.
- In order to promote proper coordination of care, these physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician.
- This is not to be confused with the specific documentation requirements that previously applied to the use of the consultation codes.”
WHEW!!

Thanks!