Agenda

CMS Guidelines on:

• Incident-to
  • Nurse Visits

• Split-Shared

• Teaching Physicians
  • Medical Students
  • Primary Care Exception
  • Modifiers GC & GE

• Scribes
**Incident-To**

"services or supplies [which] 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."
Physician Definition

**Physician:** Any *provider* who is authorized to receive payment incident-to *his* or *her* own services:

- MD/DO
- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Nurse Midwife
- Clinical Psychologist

Supervision Requirement

**Direct Supervision:**

The physician must be present in the office suite and immediately available to provide assistance throughout the time the NPP or auxiliary personnel is providing a service.

- *In a group practice – any physician member of the group may be present in the office to supervise*
  - The incident-to service is *billed* under the physician who is *supervising*
Role of NPPs

A nonphysician practitioner such as a physician assistant or a nurse practitioner may be licensed under State law to perform a specific medical procedure and may be able (see §§190 or 200, respectively) to perform the procedure without physician supervision and have the service separately covered and paid for by Medicare as a physician assistant’s or nurse practitioner’s service. However, in order to have that same service covered as incident to the services of a physician, it must be performed under the direct supervision of the physician as an integral part of the physician’s personal in-office service. As explained in §60.1, this does not mean that each occasion of an incidental service performed by a nonphysician practitioner must always be the occasion of a service actually rendered by the physician. It does mean that 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 nonphysician practitioner is an incidental part, and there must be subsequent services by the physician of a frequency that reflects the physician’s continuing active participation in and management of the course of treatment.

What About Other Locations?

Hospitals and outpatient hospital departments do not follow Incident-To. If NPP and physician work together, this falls under split-shared criteria.

Within the confines of an “office” area of a SNF, Incident-To is allowable.

There is no Incident-To billing in patient homes. The billing provider must be present.
Documenting Incident-To

Physician
Sees new patients,
Sees established patients with new problems,
Present in office suite for NPP visits,
Remains actively involved in patient’s care over time.

NPP
Sees established patients and follows physician’s treatment plan for established problems,
Reimbursed at physician rate.

Incident-To Timeline
Steps for Accurate Documentation

1. Physician must first see the patient and initiate a treatment plan
2. Non-physician practitioner or auxiliary personnel follows the physician’s original treatment plan on follow-up visits with the patient
   a) **Physician is present in office suite for assistance**
3. Physician remains actively involved in the course of treatment over time
4. Signature of provider **performing** service **must** be present
   a) Payers vary on requirement of supervising physician signature
      - Cahaba states that this verifies active involvement
      - Palmetto requires it for 99211, not for any other incident-to services

What About 99211?

- There must be a **medically necessary, face-to-face, exchange of information** between auxiliary (nursing) staff and the patient
- Follows same Incident-To criteria
  - Physician-established treatment plan
  - Periodic supervising physician visits
  - Supervising physician must be in office suite
  - Signature of performing staff must be present
- Do not bill 99211 when another more appropriate CPT code describes the service (blood draw only, injection/immunization only, etc)
The following situations would be considered to represent a change or modification in treatment plan and would therefore **not** meet the incident to requirements.

- Change in treatment plan regardless of protocol or lab tests results including changes from the original plan/order related to:
  - The frequency of services
  - Duration
  - Dosage
  - Drugs or biological administered
  - Administration method
  - Orders for diagnostic tests
  - Treatment of new problems

**Anticoagulation Documentation Best Practices - CGS**

**(History)**
- Document indication, current dose, PT/INR results

**(Physical Exam)**
- Assess the patient in-person for signs and symptoms of bleeding/adverse effects/changes in health status that could impact lab results (new meds that may interact)

**(Plan/Medical Decision Making)**
- Provide medically necessary education
  - Document the identity of the ancillary staff performing this service "incident to" the supervising physician
  - Document the name of the physician who was notified of results, gave orders, and provided direct supervision
Split-Shared:

When a hospital inpatient/hospital outpatient (on campus-outpatient hospital or off campus outpatient hospital) 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.
Billing Criteria

**Face to Face Requirement:**

- **Both** providers must see the patient face-to-face and document their individual portions of the visit

- The physician cannot simply review the medical record and “agree” with the NPP – physician **must** see patient in order to bill under physician’s name

What Do Payers Say?

**Palmetto GBA:**

**Question:** Can a split/shared service occur in POS 19 or 22 (outpatient hospital)?

**Answer:** When a hospital inpatient/hospital outpatient or emergency department Evaluation and Management (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 National Provider Identifier (NPI).

*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 NPI.*

**Note:** The physician must document a substantive portion of the E/M service. A substantive portion of an E/M visit involves at least one of the three key components (History, Examination, or Medical Decision Making).
What Do Payers Say?

**WPS:**

Q5. Is it necessary to have the physician sign the medical record when the NPP and the physician provide a shared/split visit? Can the NPP document that the physician agrees?

A5. Under a shared/split visit situation, both parties must document and sign the work they perform. A notation of "seen and agreed" or "agree with above" would not qualify the situation as a shared/split visit because these statements do not support a face-to-face contact with the physician. Only the NPP could bill for the services.

What Do Payers Say?

**CGS:**

The physician MUST have a medically necessary encounter where the physician and the NPP each personally perform a **substantive** portion of an E/M visit (face to face encounter) with the patient on the same day

- "**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."
- This encounter must consist of more than a review of the medical record by the physician."
Split-Shared Documentation Example

• NP: The patient complains of increasing abdominal pain – no nausea or vomiting today, but has been nauseous over the last few days.

• NP: Physical exam shows an elevated temperature, TTP and abdominal guarding in the right lower quadrant. No MRG, normal respirations, and trace edema in the lower extremities

• NP: Discussed case with physician to determine next steps

• Physician: I have seen the patient and concur with the NP’s history and physical exam findings. Abdomen is tender and the patient seems to be in distress. We will order an abdominal x-ray and start the patient on fluids. At this point, there are multiple conditions to consider.

Split-Shared Exclusion

• Critical care may never be shared – this is the work of a single provider at a time
  − May be a qualified APC or physician

• First “hour” is 30-74 minutes (99291) – reported once per calendar day

• Add-on “hours” (99292) may be reported by same specialty providers in group

<table>
<thead>
<tr>
<th>99291 (30-74 min)</th>
<th>+99292 (≤ 30 min)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. A sees patient for 80 minutes at 8am</td>
<td>Dr. B sees same patient for 20 minutes at 4pm</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>99291 (30-74 min)</th>
<th>+99292 (≤ 30 min)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. A sees patient for 80 minutes at 8am</td>
<td>APC sees same patient for 30 minutes at 8:50am</td>
</tr>
</tbody>
</table>
Teaching Physician Presence

• CMS will pay for services provided by a teaching physician in the following scenarios:

1. The teaching physician personally performs the entire patient visit;
2. The resident furnishes the care to the patient under the direct supervision of the physician;
   • The teaching physician must be present for the critical or key portion(s) of the service
   OR
3. The resident furnishes low levels of care to the patient without direct supervision when in a primary care setting (aka Primary Care Exception)
Documentation Requirements

- Resident and teaching physician documentation is *combined* to support medical necessity and billed service
  - Teaching physician must *attest* to presence and participation, at a minimum.
    - "*Macros*" are acceptable, but documentation unique to each encounter must also be included to support medical necessity:

  "I have seen the patient with the resident and agree with findings as noted above. The patient's wheezing and physical exam findings lead me to believe that there may be some underlying etiology requiring additional workup."

  It is unacceptable for the resident to document the teaching physician's presence and participation – this attestation MUST come from the teaching physician him/herself.

Primary Care Exception
Primary Care Exception – Resident Requirements

- The resident must have at least 6 months in an approved residency program
- Residents can see low complexity patients without teaching physician presence in Primary Care Centers (outpatient, ambulatory):
  - Family Practice
  - Internal Medicine
  - Geriatrics
  - Pediatrics
  - Ob/Gyn

  ➢ These primary care centers MUST be considered the patient’s primary service center

- Low complexity = No higher than level 3 E/M (99201-99203, 99211-99213)
  - CMS recently added IPPE/AWVs to the list of approved services in PCE clinic

Typical Low Complexity Services

<table>
<thead>
<tr>
<th>LEVEL OF RISK</th>
<th>PRESENTING PROBLEM(S)</th>
<th>DIAGNOSTIC PROCEDURE(S) ORDERED</th>
<th>MANAGEMENT OPTIONS SELECTED</th>
</tr>
</thead>
</table>
| MINIMAL       | One self-limited or minor problem (for example, cold, insect bite, tinea corporis) | • Laboratory tests requiring venipuncture  
• Chest x-rays  
• EKG/EEG  
• Urinalysis  
• Ultrasound (for example, echocardiography)  
• KOH prep | • Rest  
• Gargles  
• Elastic bandages  
• Superficial dressing |
| LOW           | Two or more self-limited or minor problems  
• One stable chronic illness (for example, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH)  
• Acute uncomplicated illness or injury (for example, cystitis, allergic rhinitis, simple sprain) | • Physiologic tests not under stress (for example, pulmonary function tests)  
• Non-cardiovascular imaging studies with contrast (for example, barium enema)  
• Superficial needle biopsies  
• Clinical laboratory 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 |
Primary Care Exception – Teaching Physician Requirements

• During the visit:
  • No presence required for critical/key portion(s)
    • **Must** not have any other obligations during the visit
    • **Must** be within close proximity for immediate availability to resident, if needed

• After the visit:
  • **Review** the care the resident provided to ensure it is reasonable & necessary
  • **Attest** to the extent of participation and the review of the resident’s documentation

• Resident with < 6 months of training:
  • Teaching physician must be physically present for key/critical portion(s) as in a regular teaching scenario (i.e., a non-primary care excepted clinic)

CMS Modifiers for Teaching Scenarios

<table>
<thead>
<tr>
<th>GC</th>
<th>GE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Teaching Physician</strong></td>
<td><strong>Primary Care Exception (PCE)</strong></td>
</tr>
<tr>
<td>Signifies that the service was provided in part by a resident under the direction of a teaching physician</td>
<td>Signifies that the service was performed by a resident without the presence of a teaching physician under the primary care exception</td>
</tr>
</tbody>
</table>

*Keep supporting documentation on file that conditions have been met to allow Primary Care Exception billing*
Medical Students – 2018 Guidance

Medical Students need practice too!

• Previously:
  • Only ROS and PFSH could be used for coding/billing
  • All other documentation (HPI, exam, MDM) performed by medical student had to be RE-documented by another provider (NPP, resident, physician)

• Now:
  • Encounter can be fully performed & documented by a medical student
  • Teaching physician MUST be physically present for the entire visit
  • Teaching physician must PERFORM or RE-PERFORM physical exam & MDM
  • Teaching physician must verify all documentation – history, exam, MDM

Moonlighting – NOT a Collaborative/Teaching Scenario

• Qualified* residents can see patients independently outside of the GME program:
  ✓ Different facility
  ✓ Different department of GME facility
    • ED
    • Outpatient department of facility

* ONLY IF resident is fully licensed in the state where services are provided
Is Scribing Collaborative?

*Think of scribing as very advanced recording*

- No physical/cognitive involvement in patient care
- No independent actions
- Simply documents what the PROVIDER PERFORMS

- **Scribe attestation:**
  “I, Lara, acting in the role of a scribe for Dr. A, documented the patient visit in the presence of Dr. A.”

- **Provider attestation:**
  “I, Dr. A, have personally performed this service and attest to the accuracy of the documentation performed by Lara, acting in the role of scribe.”

Thank You!

Laraheishman@yahoo.com