Nonphysician Practitioner Reference Guide

A comprehensive resource for maximizing your NPP revenue with expert coding, billing, documentation, and compliance essentials

THIRD EDITION
Disclaimer
Decisions should not be made solely upon information within this reference guide. All judgments impacting career and/or an employer must be based upon individual circumstances including legal and ethical considerations, local conditions, payer policies within the geographic area, and new or pending government regulations, etc.

AAPC does not accept responsibility or liability for any adverse outcome from using this reference guide for any reason including undetected inaccuracy, opinion, and analysis that might prove erroneous or amended, or the individual’s misunderstanding or misapplication of topics.

Application of the information in this text does not imply or guarantee claims payment. Inquiries of your local carrier(s)’ bulletins, policy announcements, etc., should be made to resolve local billing requirements. Payers’ interpretations may vary from those in this program. Finally, the law, applicable regulations, payers’ instructions, interpretations, enforcement, etc., may change at any time in any particular area.

AAPC has obtained permission from various individuals and companies to include their material in this reference guide. These agreements do not extend beyond this program. It may not be copied, reproduced, dismantled, quoted, or presented without the expressed written approval of AAPC and the sources contained within.

No part of this publication covered by the copyright herein may be reproduced, stored in a retrieval system or transmitted in any form or by any means (graphically, electronically, or mechanically, including photocopying, recording or taping) without the expressed written permission from AAPC and the sources contained within.

Medicare Disclaimer
This publication provides situational examples and explanations, of which many are taken from the Medicare perspective. The individual, however, should understand that while private payers typically take their lead regarding reimbursement rates from Medicare, it is not the only set of rules to follow.

While federal and private payers have different objectives (such as the age of the population covered) and use different contracting practices (such as fee schedules and coverage policies), the plans and providers set similar elements of the quality in common for all patients. Nevertheless, it is important to consult with individual private payers if you have questions regarding coverage.

AMA Disclaimer
CPT\textsuperscript{®} copyright 2022 American Medical Association. All rights reserved.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT\textsuperscript{®}, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

CPT\textsuperscript{®} is a registered trademark of the American Medical Association.

The responsibility for the content of any “National Correct Coding Policy” included in this product is with the Centers for Medicare & Medicaid Services and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable to or related to any use, nonuse or interpretation of information contained in this product.

© 2023 AAPC
2233 South Presidential Drive, Suite F, Salt Lake City, Utah 84120
800-626-2633, Fax 801-236-2258, www.aapc.com
Published: 04142023. All rights reserved.
Print ISBN: 978-1-635278-439
e-Book ISBN: 978-1-635278-446
Contents

Introduction ............................................................................................................................................... 1

CHAPTER 1
Types of Healthcare Providers ............................................................................................................. 3
  Employing and Credentialing Mid-Level Providers .......................................................................... 4
  Mid-Level Providers ........................................................................................................................... 4
  Start With the Positives ..................................................................................................................... 5
  Don’t Forget the Negatives .................................................................................................................. 5
  Check Scope of Practice Limitations .................................................................................................. 6
  Review Other Important Details .......................................................................................................... 6
  Credentialing a Provider ...................................................................................................................... 6
  Payment Under Fee-For-Time Compensation (formerly referred to as Locum Tenens Arrangements) .... 7
  Reciprocal Billing .................................................................................................................................. 8
  Questions and Answers ...................................................................................................................... 9

CHAPTER 2
Incident To, Split/Shared, and Concurrent Care ................................................................................. 11
  Incident-to Guidelines ......................................................................................................................... 11
  Shared/Split Services ............................................................................................................................ 12
  Concurrent Care .................................................................................................................................... 12
    Ensure the Care Is ‘Concurrent,’ Not ‘Duplicative’ ............................................................................ 12
    When a Patient Has Multiple Issues, Focus on Diagnosis Codes ...................................................... 13
  Questions and Answers ...................................................................................................................... 13

CHAPTER 3
Evaluation and Management Services .................................................................................................. 17
  Medical Necessity ................................................................................................................................. 17
  An Overview of E/M Documentation Guidelines .............................................................................. 17
    Levels of E/M Service ......................................................................................................................... 18
    Determining Code Level Based on MDM ......................................................................................... 18
    Determining Code Level Based on Time ......................................................................................... 20
    Hotspots for E/M Claims Denials ...................................................................................................... 21
  New vs. Established .............................................................................................................................. 23
  There’s More to the 3-Year Rule Than Meets the Eye ....................................................................... 23
  Can We Use 99211 for a New Patient? ............................................................................................... 23
  Reporting 99211 .................................................................................................................................. 24
CHAPTER 4
Compliance and Regulations ............................................................... 39

Compliance and Regulatory Guidelines ........................................... 39
Compliance History ........................................................................... 39
Operation Restore Trust (ORT) ......................................................... 39

Federal Regulations ........................................................................ 39
Federal False Claims Act (FCA) ........................................................ 40
Physician Self-Referral Law and Anti-Kickback Law ......................... 43
Exclusion Statute ............................................................................. 44
Civil Monetary Penalties Law (CMP) ............................................... 46
Compliance Plans ............................................................................ 47

Overpayments .................................................................................. 50
CMS Provides Clarifications on Texting Physician Orders .................. 51
Cybersecurity Failures Are Overwhelming Practices .......................... 52

Physician Assistant Change Should Ease Hospice Access ................. 54
Services Furnished in Home ‘Susceptible To Fraud,’ the Budget Proposal Says ......................................................... 55
PA Provision Should Improve Hospice Access ................................. 55

Signature Requirements .................................................................. 57
Step 1: Know When the Signature Itself Needs Support .................... 57
Step 2: Determine Who Must Sign .................................................... 58
Step 3: Consider the Exceptions ....................................................... 58
Step 4: Find out Which E-Signatures Work ........................................ 58
Step 5: Get the Rules on Amendments .............................................. 59
Know the Records That Require Signatures ..................................... 59
Amendments, Corrections, and Addenda .......................................... 59
Contents

Physician Order Signatures ...................................................... 60
5 Rules You Can Follow to Improve Provider Documentation .......... 60
  Rule 1: Start With Authentication Requirements .......................... 60
  Rule 2: Check Timing Requirements .......................................... 61
  Rule 3: Be Careful Making Alterations ...................................... 61
  Rule 4: Know the Rules for Using Scribes ................................. 62
  Rule 5: Watch Out for EMR Pitfalls .......................................... 62
Questions and Answers ............................................................. 63

CHAPTER 5
Resources ............................................................................... 65

APPENDIX
Clip-and-Save Tools ............................................................... 73
  Avoid Substitute Physician Billing Challenges With These 12 Tips ........ 73
  Be Sure You Know the Difference Between Modifiers Q5 and Q6 .......... 73
  Incident-to Audit Checklist ...................................................... 75
one or two days each week. In such cases, the PA confers with the supervising physician and other medical professionals as needed, and as required by state and federal law. PAs also may make house calls or go to hospitals and nursing care facilities to check on patients, after which they report back to the physician. The duties of PAs are determined by the supervising physician and by state law.

Certified registered nurse anesthetists (CRNAs) provide anesthesia and related care before, during, and after surgical, therapeutic, diagnostic, and obstetrical procedures. They also provide pain management and emergency services, such as airway management.

CNMs provide primary care to women, including gynecological exams, family planning advice, prenatal care, assistance in labor and delivery, and neonatal care.

NPs serve as primary and specialty care providers, providing a blend of nursing and healthcare services to patients. They may also prescribe certain medications. The most common specialty areas for NPs include family practice, adult practice, women’s health, pediatrics, acute care, and geriatrics. However, NPs are found practicing in many different specialties. Some states allow NPs to function independently so you will want to check with your state.

**Employing and Credentialing Mid-Level Providers**

Physicians and mid-level providers are considered healthcare providers in medical clinics. There are, however, significant differences between the two in scope of clinical practice, business ownership, and their relationships with payers and hospital systems. Physicians can be employed or be an owning partner in a practice. Although, in some states, a mid-level provider can practice independently, in most cases, mid-level providers are found practicing in clinics alongside physicians in employed relationships. In this section, we will look at the employment of both physicians and mid-level providers.

**Mid-Level Providers**

- Many clinics will hire mid-level providers to work alongside their physicians. Mid-level healthcare providers are typically defined as PAs or NPs. Both are healthcare providers credentialed to provide medical services with physician supervision. In many states, an NP can operate their own clinic without direct supervision. There are a few reasons why hiring mid-level providers is appealing to medical practices, including enhanced patient satisfaction, improved physician work/life balance, improved revenues, and greater access to care for patients. Additionally, patient satisfaction can be increased by providing additional access to care so that patients are able to see a provider sooner or spend more time with a provider than may otherwise be possible.

- Physician work life balance can improve as more patients are able to be seen without physician involvement. The economic impact also helps a physician maintain an income level without working extensive hours.

- Because mid-level salaries are lower than physician salaries, if a mid-level is productive, they can positively affect the bottom line of a practice. Some surveys estimate an average annual benefit of $30,000 per mid-level provider to the profit of a clinic.

- With the impending shortage of physicians, mid-level providers can provide an option for needed primary care services.
Incident-to Guidelines

Incident-to services supervised by NPPs are typically reimbursed at 85 percent of the Medicare physician fee schedule. The incident-to billing rules provide an exception, allowing 100 percent reimbursement for non-physician services that meet the requirements detailed in the Medicare Benefit Policy Manual, Chapter 15, Section 60 (Services and Supplies Furnished Incident to a Physician’s/NPP’s Professional Service). Six basic requirements are needed to qualify as incident-to services:

1. The service must take place in a noninstitutional setting, which the Centers for Medicare & Medicaid Services (CMS) defines as “all settings other than a hospital or skilled nursing facility.”

2. A Medicare-credentialed physician must initiate the patient’s care.

3. Subsequent to the initial encounter (during which the physician arrives at a diagnosis and establishes a plan of care), an NPP may provide follow-up care. This care must occur under the direct supervision of a qualified provider. The definition of direct supervision is that the supervising physician must be present in the clinic and immediately available. The provider cannot be in another state, another country, or performing surgery at the hospital. They must be considered immediately available. The supervising provider does not have to be physically present in the patient’s treatment room while these services are provided but must provide direct supervision and be physically present in the office suite to render assistance if necessary. In addition, the patient should not be seen by the NPP for new conditions such as a follow-up from a recent hospitalization which does not have an established plan of care. This scenario could not be billed as an incident-to service.

4. A physician must actively participate in and manage the patient’s course of treatment. When services are reported as incident to, significant new diagnoses should be evaluated by the supervising provider and should be documented in the patient’s medical record on the date of service.

5. Both the credentialed physician and the qualified NPP providing the incident-to service must be employed by the group entity billing for the service (if the physician is a sole practitioner, the physician must employ the NPP). Providers cannot be employed by different practices and see patients in a hospital clinic, and then bill this as incident-to.

6. The incident-to service must be the type of service usually performed in the office setting and must be part of the normal course of treatment for a diagnosis or illness.

part of the physician’s services to diagnose or treat the injury or illness and be
provided under a physician’s direct supervision. If the patient has not previously
been seen by the physician for a particular condition, the physician must also
have a face-to-face encounter on the same day, with the patient, in order to bill the
service as incident-to.

Question: Incident-to billing is only possible when an NPP is working under
direct supervision of a physician. What is direct supervision?

Answer: This is an area that often causes confusion. If you want to bill under the
supervising physician and be paid at 100 percent (100%) of the allowable amount, a
physician with the practice must be in the office suite.

For example, the physician cannot be across the street, three blocks away, or
available via cell phone in Aruba, but not in person.

The physician supervision rule is in place for patient safety. For example, if the
patient has an adverse reaction to an injection, or passes out during a routine
venipuncture, the physician must be immediately available to provide care to the
patient.

Question: For incident-to billing purposes, who qualifies as an NPP?

Answer: Medicare has a list of NPPs that it allows to bill incident to the physician.
For a full list of qualifying providers, refer to the Medicare 855i application at
CMS019477.

For private payers that have incident-to style billing rules in place, check your
contract for a list of eligible NPPs.

Question: Are incident-to services for E/M services only?

Answer: Yes, incident-to rules only cover E/M services directly related to the
problem in the established plan of care; if the NPP performs any procedures — or
addresses a new problem during an E/M — incident-to billing is no longer possible.

Not only are procedures banned from incident to, but incident to is also not
applicable to:

- New patient office visits
- Established patients being seen for new problem/condition (physician has not
  seen patient and established care for this new problem/condition)
- Consultation services
- Services performed in an institutional setting (i.e., hospital inpatient/
  outpatient, emergency department, skilled nursing facility)

Best bet: If you have any doubt as to whether a service is billable incident to, check
with your Medicare payer to be sure.
The most common service performed by physicians are office visits, which are reported with E/M codes. E/M codes are under close review by federally funded and other payers. Proper documentation training is essential to reduce your risk of an audit. The information provided in this reference guide for E/M services is a high-level overview. The practice manager needs to understand documentation requirements to provide physicians with the tools and training required to document their services properly.


E/M services are reported for visits made by physicians or other qualified healthcare providers in the office, urgent care centers, hospitals, and nursing homes. All services must be documented appropriately and must be medically necessary. CMS requires the following documentation for each encounter:

- Reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results (if available);
- Assessment, clinical impression, or diagnosis;
- Medical plan of care; and
- Date and legible provider signature.

Medical Necessity

Services provided must be medically necessary. For example, repeating a comprehensive history and physical may not be necessary on a two-week follow-up visit to recheck and verify the patient’s blood pressure is normal. Physicians and coders need to be trained to understand the various E/M levels and the requirements necessary to meet each level.

An electronic medical record (EMR) may guide a physician to select a comprehensive review without consideration of medical necessity. The number of elements selected by the physician may result in a comprehensive, high level 5 service. However, remember that medical review by the payer may find the same documentation does not meet medical necessity for the nature of the visit. For example, a young, healthy patient who comes in with a stubbed toe may not require the same amount of time and effort as a sick, elderly patient with symptoms of a stroke.

An Overview of E/M Documentation Guidelines

There are three general principles regarding documentation and to ensure credit can be thoroughly verified. It is important to follow these rules of thumb:

1. Documentation should be legible to someone other than the documenting physician or provider and their staff.
surgeon would report the initial E/M service using an appropriate new patient code (for instance, 99204).

Watch Your Language

One way to combat transfer of care versus consultation confusion is to cut out ambiguous terminology. Although the terms “referral” or “consult and treat” do not specifically denote a transfer of care, physicians should avoid these terms when requesting or describing a consultation. Auditors and payers may automatically consider “referral” or “consult and treat” to mean that the physician to whom the patient is presenting for an opinion or advice is assuming complete patient care, and therefore may not reimburse for a legitimate consultation. Consequently, the requesting physician should use language such as “requesting your opinion on” and the consultant should indicate in their notes that their “opinion was requested for.” Also note that although Medicare requires that a referring physician’s NPI be indicated on the claim, refer to the physician asking for the opinion as the “requesting physician,” not “referring physician,” because the word “referring” conjures up the concept of transfer of care.

Beware of Multiple E/Ms on the Same Day

Although 99202-99205, 99211, and 99212-99215 are per episode rather than per day codes, you generally will not report more than one outpatient visit code per patient, per day.

**Here is why:** Medicare payers will consistently combine or deny multiple same-day outpatient visits, unless you can show that the visits were for totally unrelated problems.

**Here is what you should do:** If your physician sees the patient twice on the same day, combine the MDM or time for the two visits, and select a single E/M service code that best describes the combined service.

**Example:** If a patient comes in with elevated blood pressure due to hypertension and diabetes, the physician may give them medication and encourage them to come back later that day. In this case, because the visits are for the same complaint, you would combine the two visits into a single E/M service.

A different problem on the same day could call for a separate service code. Your documentation should clearly show, however, that a different complaint/diagnosis prompted each service.

**Example:** A patient comes in with diabetes and hypertension for a monthly follow-up visit, but then returns later that day reporting that they’ve been vomiting for the past two hours.

In this case, because the complaints are unrelated, you may report the E/M services separately and maintain separate documentation showing the MDM and diagnosis are different for each visit.

**Same-day Service or Procedure Calls for a Modifier**

If you report a separate and significant E/M service, including outpatient visits 99202-99215, on the same day as another service or procedure, you will — in most cases — have to append a modifier to the E/M service code. This is because minor procedures (those with 0- or 10-day global periods and per National Correct
The study will evaluate “whether the timely access to hospice care by patients admitted to a hospital has been affected” by the payment change, the legislation added. MedPAC would have to report its preliminary results to Congress in March 2020, and its final report in March 2021, according to the law.

NHPCO is “discouraged” by this new policy, one industry insider said.

More bad news: NHPCO also is disappointed that the budget deal lacked “a provision that would allow Rural Health Clinics and Federally Qualified Health Centers to receive payment for serving as the hospice attending physician - which would be a significant benefit to Medicare beneficiaries in rural and underserved communities who face barriers in accessing hospice,” the expert added.

Services Furnished in Home ‘Susceptible To Fraud,’
the Budget Proposal Says

Meanwhile, the administration’s budget proposal for 2019 called for increased enforcement for “additional funding to address fraud, waste, and abuse in home health and other noninstitutional-based services.”

Specifically: “Services provided in a beneficiary’s home or other noninstitutional settings, including home health, hospice, and other home- and community-based services, are susceptible to fraud,” the budget said. The OIG “will develop new recommendations for targeted program safeguards for beneficiaries in homes- or community-based settings and prevent fraud by bad actors while limiting the burden on legitimate providers,” the proposal went on to say. “Through data analytics, OIG can also detect new and emerging fraud schemes, enabling us to monitor trends and evolution of known fraud schemes.”

ROI: CMS “actuaries conservatively project that, for every new dollar spent by HHS to combat healthcare fraud, about $2 is saved or avoided,” the budget said.

The budget also included charging surveyed providers a user fee for survey revisits.

While the president’s budget is widely considered DOA as an entire document, don’t be surprised to see policy- and lawmakers cherry pick cost-cutting ideas from the proposal.

PA Provision Should Improve Hospice Access

It may not go as far as some hospices want, but the welcome PA change in the 2019 hospice payment final rule provided some relief for hospice providers and their patients.

Old way: “The attending physician is defined as a Doctor of Medicine or osteopathy ... or a nurse practitioner and is identified by the individual as having the most significant role in the determination and delivery of the individual’s medical care,” the rule notes.

New way: “Medicare will pay for medically reasonable and necessary services provided by PAs to Medicare beneficiaries who have elected the hospice benefit and who have selected a PA as their attending physician,” the rule said. “PAs are paid 85 percent of the fee schedule amount for their services as attending physicians.”

What PAs can’t do: “Since PAs are not physicians ... they may not act as medical directors or physicians of the hospice or certify the beneficiary’s terminal illness,”
Physician Order Signatures

The Medicare Manual rule requiring physicians who order therapy or other patient services to personally sign those orders is not new, but facilities continually see denials citing such technicalities. Medicare Administrative Contractors are enforcing the rule when denying Medicare payment for orders in instances where the authoring physician did not sign the order.

Such a situation can arise pretty easily, especially if physicians and colleagues are verbally discussing therapy or other care options with a patient and forget to cross the t’s and dot the i’s.

If, for example, an NP signs a therapy order that a physician gave verbally, the MAC may deny Medicare payment for that therapy because the authoring physician did not sign the order.

The good news: You can prevent future denials of the same vein by adjusting your order processing and documentation across the board.

The bad news: Attestations are not allowed for physician’s orders, making this particular denial very difficult to appeal.

Take note of the specific information the Medicare Program integrity Manual tells MACs in 3.3.2.4 - Signature Requirements: “Reviewers shall NOT consider attestation statements from someone other than the author of the medical record entry in question (even in cases where two individuals are in the same group, one should not sign for the other in medical record entries or attestation statements).”

Note: “For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author,” the Medicare Program Integrity Manual says. “The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.”

Take a look at all of your systems for procuring orders, and make sure they are conducive to accurate, legible, and timely documentation — including the necessary signatures.

Your first (and most important) step should be educating physicians and NPPs about this rule and how its enforcement produces Medicare denials.

The bottom line: Whoever authors an order should sign the order.

5 Rules You Can Follow to Improve Provider Documentation

Documentation compliance is as important as coding accuracy when it comes to facing an audit by the payer. Complete and clear documentation can go a long way to save you from potential denials or fines. You can adopt some simple rules to ensure your provider documentation can face payer or government scrutiny at any time.

Rule 1: Start With Authentication Requirements

Every medical record must have authentication. Every service your medical staff administers, or orders, MUST be authenticated by the author. All notes should be dated, preferably timed, and signed by the author.
Medicare Carriers Manual

60 - Services and Supplies Furnished Incident To a Physician’s/NPP’s Professional Service

(Rev. 1, 10-01-03)

B3-2050

A - Noninstitutional Setting

For purposes of this section a noninstitutional setting means all settings other than a hospital or skilled nursing facility Medicare pays for services and supplies (including drug and biologicals which are not usually self-administered) that are furnished incident to a physician’s or other practitioner’s services, are commonly included in the physician’s or practitioner’s bills, and for which payment is not made under a separate benefit category listed in §1861(s) of the Act. A/B MACs (A) and (B) must not apply incident to requirements to services having their own benefit category. Rather, these services should meet the requirements of their own benefit category. For example, diagnostic tests are covered under §1861(s)(3) of the Act and are subject to their own coverage requirements. Depending on the particular tests, the supervision requirement for diagnostic tests or other services may be more or less stringent than supervision requirements for services and supplies furnished incident to physician’s or other practitioner’s services. Diagnostic tests need not also meet the incident to requirement in this section. Likewise, pneumococcal, influenza, and hepatitis B vaccines are covered under §1861(s)(10) of the Act and need not also meet incident to requirements. (Physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, clinical psychologists, clinical social workers, physical therapists and occupational therapists all have their own benefit categories and may provide services without direct physician supervision and bill directly for these services. When their services are provided as auxiliary personnel (see under direct physician supervision, they may be covered as incident to services, in which case the incident to requirements would apply.

For purposes of this section, physician means physician or other practitioner (physician, physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, and clinical psychologist) authorized by the Act to receive payment for services incident to his or her own services.

To be covered incident to the services of a physician or other practitioner, services and supplies must be:

- An integral, although incidental, part of the physician’s professional service (see §60.1);
- Commonly rendered without charge or included in the physician’s bill (see §60.1A);
- Of a type that are commonly furnished in physician’s offices or clinics (see §60.1A);
- Furnished by the physician or by auxiliary personnel under the physician’s direct supervision (see §60.1B).

B - Institutional Setting

Hospital services incident to physician’s or other practitioner’s services rendered to outpatients (including drugs and biologicals which are not usually self-administered by the patient), and partial hospitalization services incident to such services may also be covered.

The hospital’s A/B MAC (A) makes payment for these services under Part B to a hospital.
Refer to the Medicare Claims Processing Manual, Chapter 10, “Home Health Agency Billing,” for a more in depth discussion of home health services.

60.4.1 - Definition of Homebound Patient Under the Medicare Home Health (HH) Benefit

(Rev. 192, Issued: 08-01-14, Effective: 09-02-14, Implementation: 09-02-14)

This definition applies to homebound for purposes of the Medicare home health benefit.

For a patient to be eligible to receive covered home health services, the law requires that a physician certify in all cases that the patient is confined to his/her home. For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

1. Criteria-One:

   The patient must either:
   
   - Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence

   OR

   - Have a condition such that leaving his or her home is medically contraindicated. If the patient meets one of the Criteria-One conditions, then the patient must ALSO meet two additional requirements defined in Criteria-Two below.

2. Criteria-Two:

   - There must exist a normal inability to leave home;

   AND

   - Leaving home must require a considerable and taxing effort.

If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive healthcare treatment. Absences attributable to the need to receive healthcare treatment include, but are not limited to:

- Attendance at adult day centers to receive medical care;
- Ongoing receipt of outpatient kidney dialysis; or
- The receipt of outpatient chemotherapy or radiation therapy.

Any absence of an individual from the home attributable to the need to receive healthcare treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited to furnish adult day-care services in a state, shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of an infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. It is expected that in most instances, absences from the home that occur will be for the purpose of receiving healthcare treatment. However, occasional absences from the home for nonmedical purposes, eg, an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the healthcare provided outside rather than in the home. Some examples of homebound patients that illustrate the factors used to determine whether a homebound condition exists would be:

- A patient paralyzed from a stroke who is confined to a wheelchair or requires the aid of crutches in order to walk;
- A patient who is blind or senile and requires the assistance of another person in leaving his or her place of residence;
- A patient who has lost the use of the upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., requires the assistance of another individual to leave his or her place of residence;
Avoid Substitute Physician Billing Challenges With These 12 Tips

Be Sure You Know the Difference Between Modifiers Q5 and Q6

At some point your physician will need time off, whether for vacation, maternity leave, or illness. Avoid unnecessary complications and delayed payments by knowing the details of locum tenens billing before you hire a substitute physician for your office. Keep this clip-and-save checklist handy for quick how-to advice on billing during your provider’s absence.

1. **Know What Reciprocal Billing Means.** Remember that reciprocal billing allows an absent physician to submit claims and receive Medicare payments for services that have been arranged for a substitute physician to provide on an occasional, reciprocal basis.

2. **Get to Know Modifier Q5.** To appropriately report services a physician performs under a reciprocal billing agreement, use modifier Q5 *Service furnished by a substitute physician under a reciprocal billing arrangement.* The physician providing reciprocal services does not receive any payment from the absent physician or his office.

3. **Nail Down Locum Tenens Specifics.** Locum tenens allows your doctor to receive payment for services another physician performs. But a locum tenens physician cannot work for another practice, and your physician cannot restrict the locum’s services to your office.

4. **Consider Per-Diem Pay Requirements.** The absent physician pays a locum tenens physician on a per-diem or fee-for-time basis.

5. **Make Q6 Your Locum Tenens Go-to Modifier.** When reporting locum tenens physician services, always use modifier Q6 *Service furnished by a locum tenens physician.*

6. **Keep Track of Days on Your Calendar.** Medicare will not pay for reciprocal billing or locum tenens services for more than 60 continuous days, although reciprocal care is often for much shorter periods of time.

7. **Make Sure Doc Isn’t On-Site.** To use modifiers Q5 and Q6, your doctor must be unavailable to provide services. This means that your physician should be out of the office while the substitute physician provides services.

8. **Keep Intent in Mind.** The Medicare patient must have arranged or sought to receive your vacationing physician’s services.

9. **Make Recordkeeping a Priority.** The patient’s regular physician must maintain all of the substitute physician’s service on record, along with the substitute physician’s NPI number.

   You can make an extra copy of each of the locum’s claims and keep the copies in a separate paper file for the locum tenens, or you can use your computer system to track the locum tenens services.
Make your days a little easier in one, simple move.

Create an AAPC account and stay up to date through the year

- Learn from industry pros in our virtual webinars and workshops
- Order tools and resources to help you navigate through your career
- Get the latest healthcare news in our Knowledge Center
- Discover new products and the latest deals on existing products
- Find free tools, including the E/M Analyzer, CPT® RVU Calculator, and more

CPT® is a registered trademark of the American Medical Association.

Create an account to stay up to speed on timely changes, available resources, and special promotions like #FREEAAPC and training scholarships.

Set up your account today at aapc.com