Medical Compliance Services Office of Billing Compliance Non-Physician Practitioner Services & Documentation Based on Time

Department of Interventional Radiology

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UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM

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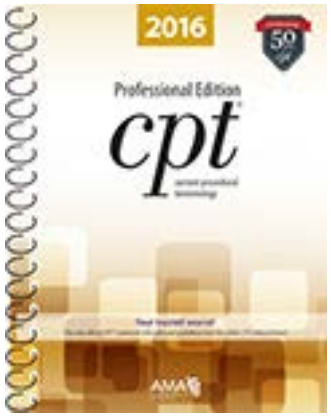
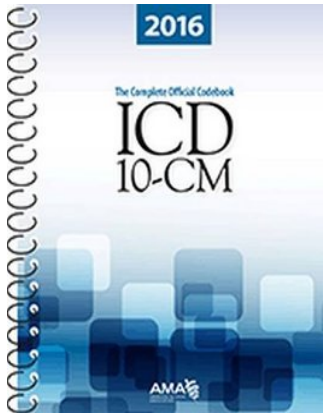
of MEDICINE

Inpatient and Outpatient

Evaluation and Management E/M Documentation and Coding





Medical Necessity

- *Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.*

- *The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service billed. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.*

Using Time to Code

- **In the case where counseling and/or coordination of care dominates (more than 50%) of the physician or non-physician practitioner/patient and/or family encounter (face-to-face in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.** This includes time spent with parties who have assumed responsibility for the care or decision making of the patient, whether or not they are family members (e.g., foster parents, legal guardians, person acting in locum parentis).

- **If the physician/non-physician practitioner elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor/unit time, as appropriate) should be documented and the record should describe the counseling and/or activities performed to coordinate care.**

- **The physician/non-physician practitioner need not complete a history and physical examination in order to select the level of service.**

Using Time to Code

- **Counseling is defined as one or more of the following areas:**
- Diagnostic results, impressions, and/or recommended diagnostic studies;
- Prognosis;
- Risks and benefits of management (treatment) options;
- Instructions for management (treatment) and/or follow-up;
- Importance of compliance with chosen management (treatment) options;
- Risk factor reduction; and
- Patient and family education.

NOTE: Only time spent counseling or coordinating care face-to-face with the patient and/or family that has assumed responsibility for the care or decision of the patient is counted toward the established office visit.

In the office or outpatient setting:

- Face-to-face time refers to the time with the physician or the non-physician practitioner only.
- In addition, the patient has to be in the office.

The following cannot be counted toward the time used to select the level of care:

- Review of test results away from the patient
- Counseling performed by other staff
- Time spent on the phone with the drugstore or the home health company once the patient has left the office.

Using Time to Code

- **In an inpatient setting**, the counseling and/or coordination of care must be provided at the bedside or on the patient's hospital floor or unit that is associated with an individual patient. Time spent counseling the patient or coordinating the patient's care after the patient has left the room or the physician has left the patient's floor or begun to care for another patient on the floor is not considered when selecting the level of service to be reported.
- Time shall be considered for coding an E/M in lieu of H-E-MDM when > 50% of the total billable physician or practitioner visit time is counseling/coordination of care (CCC.)
- Coding based on time is generally the exception for coding.
- It is typically used:
  - Significant exacerbation or change in the patient's condition,
  - Non-compliance with the treatment/plan,
  - Counseling regarding previously performed procedures or tests to determine future treatment options, or
  - Behavior/school issues.

Required Documentation For Billing:

1. Total time of the encounter excluding separate procedure, if performed and billed
   - The entire time to prep, perform and communicate results of a billable procedure to a patient must be carved out of the E/M encounter time!
2. The amount of time dedicated CCC for that patient on that date of service.

Time-Based Billing for CCC

Outpatient Counseling Time:

99201	*10 min*
99202	*20 min*
99203	*30 min*
99204	*45 min*
99205	*60 min*
99241	*15 min*
99242	*30 min*
99243	*40 min*
99244	*60 min*
99245	*80 min*
99211	*5 min*
99212	*10 min*
99213	*15 min*
99214	*25 min*
99215	*40 min*

Inpatient Counseling Time:

99221	*30 min*
99222	*50 min*
99223	*70 min*
99231	*15 min*
99232	*25 min*
99233	*35 min*
99251	*20 min*
99252	*40 min*
99253	*55 min*
99254	*80 min*
99255	*110 min*

Counseling/Coordination of Care CCC

Proper Language used in documentation of time:

- "I spent ____ minutes with the patient and family and over 50% was in counseling about her diagnosis, treatment options including _____ and _____."
- "I spent ____ minutes with the patient and family more than half of the time was spent discussing the risks and benefits of treatment with……(list risks and benefits and specific treatment)"
- "This entire _____ minute visit was spent counseling the patient regarding _____ and addressing their multiple questions.

Total time spent and the time spent on counseling and/or coordination of care must be documented in the medical record.

Documentation must reflect the specific issues discussed with patient present.

New Patients

Patient not seen by you **or your billing group** in the past **three years** (as outpatient or inpatient)

Non-Physician Practitioners (NPP's) or Physician Extenders

Who is a NPP?

- Physician Assistant (PA)
- Nurse Practitioner (NP)

NPP Agreements & Billing Options

- Collaborative agreement between the NPP and the group they are working with is required.
  - The agreement extends to all physicians in the group.
    - If the NPP is performing procedures it is recommended a physician confirm their competency with performance of the procedure.
- NPPs can bill independent under their own NPI # in all places-of-service and any service included in their State Scope of Practice.
- Shared visit can take place in the hospital or hospital based clinic (POS 19,21, 22, 23) Off-campus Outpatient Hospital, Inpatient Hospital, Outpatient/Observation Hospital and Emergency Room.
  - Supervision is general (available by phone) when billing under their own NPI number.
  - Medicare and many private insurers credential NPPs to bill under their NPI.
  - Some insurers pay 85% of the fee schedule when billing under the NPP and others pay 100% of the fee schedule.
- Incident-to in the office (POS 11) ONLY

Shared Visits Between NPP and Physician

Shared visits may be billed under the physician's name if and only if:

1. The physician provides a medically necessary face-to-face portion of the E/M encounter (even if it is later in the same day as the PA/ARNP's portion); and
2. The physician personally documents, in the patient's record the details of their face-to-face portion of the E/M encounter with the patient.
3. An Attestation alone, by the Attending Physician, is not acceptable as Physician Documentation. The Teaching Physician Rule does not apply to NPPs (Nurse Practitioners or PAs).

- If the physician does not personally perform and personally and contemporaneously document their face-to-face portion of the E/M encounter with the patient, then the E/M encounter cannot be billed under the physician's name and must be billed under the NPP.
- The NPP MUST be an employee (or leased) to bill a shared visit. Documentation from a hospital employed NPP may not be utilized to bill a service under the physician unless it's only the ROS and PMFS Hx.

Shared Visits Between NPP and Physician

In order to bill under the physician name and NPI#,

- Sufficient medical record documentation is the key to proper reimbursement. In all cases, documentation must substantiate the medical necessity of the shared/split visit; support the level of E/M code submitted, and the medical record should contain enough detail to allow a reviewer to:
- identify both providers
- link the physician notes to those of the NPP
- include legible signatures from both providers
- confirm that the physician and the NPP both saw the patient face-to-face
- include legible/electronic signature

Following examples that would adequately meet physician documentation requirements for a split/shared visit:

- "I have personally performed a face to face diagnostic evaluation on this patient. My findings are as follows: …Patient presents with abscess, onset 3 days ago. Has tried a warm compress; hot shower for relief. Exam shows right gluteal abscess 3cm warm tender and fluctuant. Incision and drainage not indicated, started on MRSA antibiotic coverage**" Signed by treating physician**
- "I have personally performed a face to face evaluation on this patient. I have reviewed and agree with the care plan. History and Exam by me shows: abdomen was tender to touch, no rebound. Labs /CT scan negative. IM Toradol given for pain. Pt discharged home."
  Signed by treating physician
- "I have personally seen and evaluated Ms. X with (ARNP name). "My examination shows XYZ". "Based on the findings, my plan is to schedule the patient for tumor ablation."
  Signed by treating physician

Shared Visits Between NPP and Physician

Examples of physician documentation that would *not* adequately meet the shared/split visit requirements:

- "I have personally seen and examined the patient independently, reviewed the ARNPs/PAs history, exam and medical decision making and agree with the assessment and plan as written" signed by the physician.
- "Patient seen" signed by the physician
- "Seen and examined" signed by the physician
- "Seen and examined and agree with above (or agree with plan)" signed by the physician
- "As above" signed by the physician
- 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.

In the last three examples, the physician is only documenting that he/she agrees with the findings that the NPP has already documented. The documentation does not show that the physician had face-to-face contact with the patient or that he/she performed any of the history, exam or medical decision making elements. The guidelines require that there must be documentation of the face-to-face portion of the E/M encounter between the patient and the physician. The medical record should clearly identify the part(s) of the E/M service that were personally provided by the physician and those that were provided by the NPP.

Note: The physician must personally document his/her involvement in the patient's care and cannot leave his/her documentation of the visit to the NPP.

Bill Independently and Not Shared

Billing Under The NPP NPI

- Does not require physician presence.
- Can evaluate and treat new conditions and new patients.
- Can perform all services under the state scope-of-practice.
- Can perform services within the approved collaborative agreement.
  - Recommend physician establish competency criteria and demonstration of performance of procedures within the collaborative agreement between the NPP and physician.

"INCIDENT TO"

- "Incident to" services must be an integral part of the patient's treatment course
- Physician must personally perform an initial service and for any new condition, make an initial diagnosis, and establish a treatment plan.
- Physician must personally perform subsequent services at a frequency that reflects his/her active participation in and management of the course of the treatment for each medical condition.
- Provided under the physician's direct personal supervision (Physician must be present in the office suite and be immediately available to provide assistance and direction throughout the time the services are being performed by the practitioner)
- Commonly rendered without charge (included in physician's professional services)
- Commonly furnished in a physician's office POS 11 (not in a hospital setting)
- Auxiliary Personnel must be directly employed by the physician, physician group or clinical department that employs the physician or may be a leased employee.

Scribed Notes

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- Record entries made by a "scribe" should be made upon the direction of the physician. A scribe should be merely that, a person who writes what the physician dictates and does. This individual should not act independently or obtain any information independently except to ROS and PFSH. They cannot obtain the HPI, any portion of the PE or MDM.
- The scribe must note "written by xxxx, acting as scribe for Dr. yyyy." Then, Dr. yyyy indicating that the note accurately reflects work and decisions made by him/her and then authenticate with signature.
- It is inappropriate for an employee of the physician to round at one time and make entries in the record, and then for the physician to see the patient at a later time and note "agree with above…".
- AAMC does not support someone “dictating” as a scribe by an NPP, as scribing is over the shoulder immediate documenter with no services personally performed by the scriber. In this case, the physician should be dictating their own visit. Scribes can do EMRs under their own password.

Scribed Notes

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- Individuals can only create a scribe note in an EHR if they have their own password/access to the EHR for the scribe role. Documents scribed in the EHR must clearly identify the scribe's identity and authorship of the document in both the document and the audit trail.
- Scribes are required to notify the provider of any alerts in the EPIC System. Alerts must be addressed by the provider.
- Providers and scribes are required to document in compliance with all federal, state, and local laws, as well as with internal policy.
- Failure to comply with this policy may result in corrective and/or disciplinary action by the hospital and/or department under the University of Miami Medical Group disciplinary policies applicable.
- Verbal orders may neither be given to nor by scribes. Scribes may pend orders for providers based upon provider instructions.

The following attestation must be entered by the scribe:

- **"Scribed for [Name of provider] for a visit with [patient name] by [Name of scribe] [date and time of entry].**

The following attestation should be entered by provider when closing the encounter:

- **"I was present during the time of the encounter was recorded with [patient name]. I have reviewed and verified the accuracy of the information which was performed by me." [Name of provider][Date and time of entry].**

Available Resources at University of Miami, UHealth and the Miller School of Medicine

- If you have any questions or concern regarding coding, billing, documentation, and regulatory requirements issues, please contact:
  - ***Medical Compliance Services/Office of Billing Compliance***
    - ***Phone: (305) 243-5842***
    - ***Fax: (305) 243-6487***
    - **Officeofbillingcompliance@med.miami.edu**
    - **Office of billing Compliance website**: **www.obc.med.miami.edu**

- If you have any billing compliance concerns, also available is The University's fraud and compliance hotline, via the web, at www.canewatch.ethicspoint.com or toll-free at 877-415-4357 (24hours a day, seven days a week). Calls and reporting via the web may remain anonymous.