

601: Key Strategies & Case Studies to Reduce Your Compliance Risk with Non Physician Practitioners (NPPs)



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Disclaimer

- This material is designed to offer basic information for coding and billing and is presented based on the experience, training and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the presenter does not accept any responsibility or liability with regards to errors, omissions, misuse, or misinterpretation. This presentation and handout is intended as an education guide only.

Presentation Outline

1. Why the Increased Focus on NPPs?
2. NPP Risk Areas & Audit Considerations
3. Incident-to Services
4. Split/Shared E/M Visits
5. Case Studies & Discussion
6. Education Tools & Resources

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1: Why the Increased Focus on NPPs?

2013 OIG Work Plan & NPPs
OIG 2009 Report
2014 Proposed Changes Incident-to
Recent Compliance News

2013 OIG: Error Rate for Incident-To Services Performed by Non Physicians:



Also:

- 2012
-
- 2009
- 2008
- 2007
-
- 2004
- 2003
-
- 2001

- “We will review physician billing for **“incident-to” services to determine whether payment for such services had a higher error rate than that for non-incident-to services.** We will also assess Medicare’s ability to monitor services billed as “incident-to.” Medicare Part B pays for certain services billed by physicians that are performed by nonphysicians incident to a physician office visit. A 2009 OIG review found that when Medicare allowed physicians’ billings for more than 24 hours of services in a day, half of the services were not performed by a physician. We also found that unqualified nonphysicians performed 21 percent of the services that physicians did not personally perform. Incident-to services are a program vulnerability in that they do not appear in claims data and can be identified only by reviewing the medical record. **They may also be vulnerable to overutilization and expose beneficiaries to care that does not meet professional standards of quality. ...”**

Note:

FY 2014 OIG Work Plan January 2014 release instead of October 2013 5

2009 OIG Report: Prevalence & Qualifications of NPPs



- Identified quality of care & medical necessity issues:
 - 21 % of services not personally performed by physicians done by unqualified non physicians
 - \$12.6M for approximately 210,000 services
- OIG Recommendations to CMS:
 - Require physicians who bill services to Medicare that they do not perform to identify the services on their Medicare claims using a service code modifier

Reviewed days of service when more than 24 hours billed by a single physician

Report: OEI-09-06-00430
<http://oig.hhs.gov/oei/reports/oei-09-06-00430.pdf>

CMS 2013: CERT Findings: Split/Shared E/M Services

- Medicare Quarterly Provider Compliance Newsletter-
Volume 3, Issue 3, April 2013 (ICN908625):
- "Insufficient documentation errors":
 - No documentation to support that the physician had face-to-face evaluation and involvement in the E/M service billed
 - Code 99211 was billed incident to....there was no office visit note present to support that this E/M service was performed.
 - Documentation submitted was laboratory results

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MPFS CY2014 Proposed Rule: Incident to Changes

- CMS proposes to amend the "incident to" regulations to directly require that personnel performing "incident to" services meet any applicable state law requirements to provide the services, including licensure.
 - To provide a clear basis to deny claims and help ensure it has recourse to recover Medicare dollars when services are not furnished in compliance with state laws.
 - MPFS Final Rule expected 11/1/13

<http://www.gpo.gov/fdsys/pkg/FR-2013-07-19/pdf/2013-16547.pdf>

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Physicians Duty to Know: Certification Claim Form & Enrollment

Physicians are required to comply with all the applicable statutes, regulations and guidelines in order to be reimbursed by Medicare Part B.

Navigating the Fraud and Abuse Laws



Picture from OIG HEAT Provider Compliance Training Material:
http://oig.hhs.gov/newsroom/video/2011/heat_modules.asp

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CMS-1500 Claim Form: Incident-to Certification

- *Services performed were medically indicated and necessary for the health of the patient;*
- *Were personally furnished or **incident to** the physician's professional service by an employee under immediate personal supervision, except as otherwise expressly permitted by the regulations.*
 - *For services to be considered as "incident" to a physician's professional service,*
 - *1) they must be rendered under the physician's immediate personal supervision by his/her employee,*
 - *2) they must be an integral, although incidental part of a covered physician's service,*
 - *3) they must be of kinds commonly furnished in physician's offices, and*
 - *4) the services of nonphysicians must be included on the physician's bills.*

Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

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Recent Significant DOJ Settlements

DOJ 2/11/13: Dr. Wasserman, Dermatologist, Venice, FL:

- agreed to pay **\$26.1M** to resolve allegations that he violated the False Claims Act (FCA) by:
 - Accepting kickbacks from a pathology laboratory &
 - Billing the Medicare program for medically unnecessary services

DOJ Nov 12: Dr. J.Natale, Vascular Surgeon, Arlington, IL:

- serving **10 month prison sentence** for using CPT codes that allegedly represented more complicated procedures than the surgeries he performed
 - Sentencing Judge: "accurate coding is of extraordinary importance".

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2: NPP Risk Areas & Audit Considerations

NPP vs Auxiliary Staff
Billing Options
Specific Risk Areas
Audit Considerations

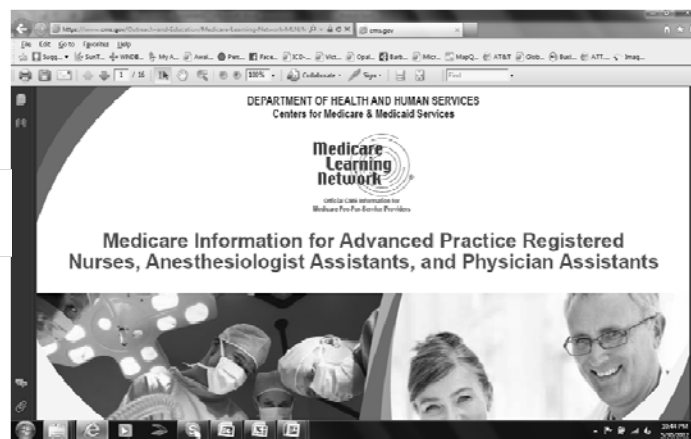
Non-Physician Practitioners (NPPs)

- Health care professionals permitted by law to provide care and services within the scope of the individual's licensure and consistent with individually granted privileges by a facility's governing body
- Examples of NPPs:
 - certified nurse-midwives, clinical psychologists, clinical nurse specialist, **physician assistants and nurse practitioners.**
 - American Academy of Nurse Practitioners (AANP.org)
 - American Academy of Physician Assistants (AAPA.org)

Key:
State
Licensure

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CMS Booklet for APRNs & PAs



Eligibility &
Coverage
Requirements

https://www.cms.gov/mlnproducts/70_apnpa.asp

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Auxiliary Staff

Examples of incident to services performed by auxiliary personnel such as nurses, technicians, and therapists:

- Anti-coagulation therapy
- Patient infusion therapy, and some types of cancer chemotherapy treatments
- Psychological services
- Some home care based medical services

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NPPs Services

- Unlike other auxiliary staff, NPPs may:
 - Render a much broader range of services under their scope of practice:
 - minor surgeries
 - Evaluation and Management (E/M) services
 - Bill independently for their services when the “incident to” requirements are not met.
 - Have auxiliary staff that provide services “incident to” their services

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Billing Options for NPPs

1. NPPs own provider number receiving 85% of the MPFS
2. Incident-to the MD receiving 100% of the MPFS
 - Supervising physician (box 24)
 - Ordering physician (box 17b)
3. Split/shared E/M visits allow NPPs and MDs who work for the same employer/entity to share patient visits on the same day by billing the combined work under the physician's provider number for 100% of the MPFS reimbursement although the NPP might have done the majority of the work.

(MPFS= Medicare Physician Fee Schedule)

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NPP Risk Areas

- Failing to understand regulations from different payors
 - general supervision rule requirements for NPPs under some state law will not satisfy the direct supervision requirements for Medicare "incident-to"
- Failing to ensure that NPPs practicing in a state are licensed and certified in the state they are practicing and not another state
- Employment requirements

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Incident-to Risk Areas

- Incorrect setting: institutional settings (**hospitals** or skilled nursing facilities)
(CMS Pub. 100-02: Medicare Benefit Policy Manual Chapter 15 §60.1B)
- New patients & established patients w/new problems
- Services provided by unqualified staff
- No documentation link between the NPP and MD
- Billing under wrong provider (MD not in office)
- Confusing incident-to with "supervision for diagnostic test" and "teaching physician guidelines"

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Specific Audit Considerations

- E/M level audits, include incident to & split/shared!
- Need entire medical record, not just date of service
- Notes dictated by NPP, billed using MD NPI
- EMR- authentication of incident-to & shared services
- "*Impossible Days*" – Minutes per Work RVUs
 - Billing for more than 16 hours per day
- If incident-to or split/shared E/M visit requirements not met, are NPPs credentialed?
 - Difference of returning 100% versus 15%!

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Review Sources for Audit Concepts

- **OIG 2013 Work Plan**
<http://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf>
- **CMS Medicare Quarterly Provider Compliance Newsletter**
http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf
- **CERT Reports**
https://www.cms.gov/CERT/10_CERT_Reports_and_Data.asp
- **CMS Publications & Manuals**
<https://www.cms.gov/manuals/downloads/clm104c12.pdf>
- **NCDs & LCDs**

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3: Incident-to Services

Basic Requirements
Physician Involvement
Documentation

Incident-to Basic Requirements

MBPM Ch.15§60-60.3: must be an integral, incidental part of the physician's personal professional services, and it must be performed under the physician's direct supervision.

1.
Physician
Office

2.
Employment
Status

3.
Direct
Supervision

4.
Prior MD
Service

5.
Active
Participation

NO:
HOSPITAL
NF*/SNF

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Physician Involvement

- MD physically present in the same office suite and immediately available to render assistance if necessary
- Direct personal service by MD to initiate the course of treatment of which the service being performed is an incidental part
- Subsequent services by the MD of a frequency that reflects the physician's continuing active participation in and management of the course of treatment

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Consider this Example: Incident-to Met?

- Physician office and hospital's surgery center are in the same building, but on different floors
- NPP in office seeing an established Medicare patient while MD is performing surgery downstairs
- Patient has a new problem and NPP goes downstairs to ask the MD to come up when finished to discuss treatment options with patient. NPP documents visit, MD co-signs
- Can this visit be billed using MD's NPI?
 - Incident-to met?
 - If provider based (POS 22) would answer change?

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Incident-to Documentation

- Link between the NPP and MD to support:
 - MD actively involved
 - MD delegated the service to the NPP referenced by date and location
- MD was available at the time the incident-to service took place:
 - "Dr. Smith was in the office suite while I saw this patient"
 - "The patient was also seen by Dr. Smith, who will write a separate note"
- Subsequent visits: MD reviews NPP documentation & denotes:
 - Input such as: "agree the current regimen is appropriate"
 - Notation and review of lab values
 - Review of any adverse reactions

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Billing Options: Established Patient & New Problem

- A Medicare patient seen in the office by NPP and complaining of a new problem. (MD in office suite)

- How should this be billed?
 1. The NPP may take care of the new problem and can bill incident-to the physician?
 2. The NPP may take care of the new problem and bill using his/her own name and NPI?
 3. The physician must see the patient and establish care?

(What option is not ok?)

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4: Split/Shared E/M Visits

Basic Requirements
Applicable Codes
Documentation
Medicaid & Private Payors

Medicare's Split/Shared E/M Visit Defined

- **Medically necessary** encounter with a patient where the physician and a qualified non-physician practitioner (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

- MD & NPP must be in the same group practice or employed by the same employer

(Medicare Claims Processing Manual, Pub.100-04, Ch.12,§30.6.13H)

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Split/Shared E/M Visit Basic Requirements



(Medicare Claims Processing Manual, Pub.100-04, Ch.12,§30.6.13H)

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Examples Split/Shared E/M Visit

- Hospital rounds at different times of the day
 - Must be same date of service
 - MD must provide face-to-face visit
 - MD must document substantial portion of E/M
 - Co-signatures not sufficient! (CERT Error)

- Office visits: incident-to applies
 - No new patients
 - No established patients with new problems

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Split/Shared E/M Visits Applicable E/M Codes:

- Hospital setting:
 - **Hospital admissions (99221-99223)**
 - Subsequent hospital visits (99231-99233)
 - Discharge management (99238-99239)
 - Observation care (99217-99220, 99234-99236)
 - Emergency department visits (99281-99285)
 - Prolonged care (99354-99357)
 - Hospital provider based office visits (99201-99215) (POS 22)

- Physician office setting (POS 11):
 - Established office visits (99211-99215) with an established plan of treatment.

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Split/Shared E/M Visits Do Not Apply To:

- Critical care services (CPT 99291-99292)
- Procedures
- NF/SNF
- Consultations (CPT 99241-99255) Prior to 1/1/2010
 - Physician ODF 4/14/10 : Providers can split/share a consultation-type service when using an applicable split/shared E/M code (such as hospital or office/outpatient E/M codes). <http://medicare.fcso.com/EM/168518.asp>
 - Check your MAC!

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Documentation Split/Shared E/M Visit

- E/M level based on combined work (using 95 or 97 CMS DG)
 - note should clearly identify providers (signatures)
- MD & NPP should **each personally document** in the medical record his/her portion of the visit & support
- MD face-to-face requirement:
 - *"I saw and evaluated the patient. Agree with NPP's note but lower extrmities are weaker, now 3/5; MRI of L/S Spine today."*
- Auxiliary staff & medical students may only document the review of systems and past family and social history.
 - The physician and NPP must personally review this documentation and confirm and/or supplement it in the medical record

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Examples of Unacceptable Documentation

- "Agree with above"
- "Rounded, Reviewed, Agree"
- "Discussed with NPP. Agree."
- "Seen and agree"
- "Patient seen and evaluated"
- "Patient seen and examined as above" (referring to NPP's exam)
- A legible countersignature or identity alone

- Even if all these examples were followed by "legible countersignature or identity" these examples do not make it possible to determine whether the physician was present, evaluated the patient, and/or had any involvement with the plan of care.

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Scribing

- If a nurse or NPP acts as a scribe for the physician, the individual writing the note (or history or discharge summary, or any entry in the record) should note
 - **"written by X, acting as scribe for Dr. Y."**
- Then, Dr. Y should co-sign, indicating that the note accurately reflects work and decisions made by him/her.

- Record entries made by a "scribe" should be made upon dictation by the physician, and should document clearly the level of service provided at that encounter. This requirement is no different from any other encounter documentation requirement.

*Source: First Coast Service Option, Part B Update Third Quarter 2006.
Check your MAC for specific instructions.*

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Consider This Example: Split/Shared E/M Visit?

- NPP sees hospital inpatient in the morning while the physician is in surgery.
 - Documents history, exam & medical decision making & signs the note.
- Physician provides a face-to-face visit with the patient later in the day & reviews the labs
 - Documents “labs reviewed, agree with treatment” and co signs the note

- Can this visit be billed under the MD’s NPI?

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Frequently Asked Questions

- Do shared visits apply to procedures?
- Can the shared visit occur at different times?
- Can private practice MD share a visit with a hospital employed NPP?
- Can the MD share a visit with a medical student?
- Can the MD’s nurse (RN) share the visit with the physician in the hospital setting post op?
- Can NPPs scribe for MDs?

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Private Payer Differences

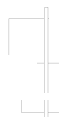
- Some private payers do not issue numbers to NPPs and request that billing occur under the supervising physician.
 - For example, some payers might only ask that state law is followed when NPPs deliver care.
- Query private payers to see what their rules are.
 - Credentialing of NPPs? Reimbursement rates?
 - Can NPPs services be billed using supervising MDs NPI?
 - Consider sending the private plans a certified letter advising the plan of the hospital's procedures for billing NPP service, unless the plan advises the hospital otherwise in writing.

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Medicaid (Florida) Know Your State

- Services provided by a NPP under the direct supervision of a physician may be billed using the physician's provider number instead of the NPPs provider number. Direct supervision means the physician:
 - Is on the premises when the services are rendered, and
 - Reviews, signs and dates the medical record.
- Exceptions are deliveries, psychiatric services and child health check-up screenings.
 - The NPP must directly render these services and bill using his or her Medicaid ID number. Medicaid will not reimburse the physician and the NPP for the same service to the same recipient on the same day.
- Florida Medicaid reimburses NPPs using a separate fee schedule (reimbursed at 80% of physician fee).

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5:

Case Studies & Discussion

11 Cases*
FAQs

**Additional cases (redacted medical records) will be provided during presentation if time allows*



Case Studies Billing Considerations

1. New or Established Problem- Biopsy?
2. New or Established Problem ?
3. Plan of Care-NPP Changing RX Ordered by MD
4. Split/Shared E/M Visit Office
5. Split/Shared E/M Visit ER
6. NPP Service: Hospital or Professional?
7. Professional NPP Service – Billable?
8. Injection Ordered by MD & Performed by NPP
9. Injection Ordered & Performed by NPP
10. Preventative Visit- Incident-to?
11. BP Check by auxiliary staff & supervised by NPP

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Case # 1

New or Established Problem- Biopsy?

- Established patient previously seen by MD for eczema
- Patient seen today by NPP while MD is in office suite
- Patient comes in for refills, and NPP finds a **lesion** requiring a **biopsy**

- Can this visit be billed using MD's NPI?
- Incident- to met?
 - Direct supervision
 - New or established problem?
 - Treatment plan initiated by MD?
 - Supervising MD (box 24) the same as ordering MD(box 17b)?

Assumptions: 1. Medicare patient & NPP is employed by MD

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Case # 2:

New or Established Problem?

- Established patient previously seen by MD with history of basal cell carcinoma
- Patient seen today by NPP while MD is in office suite
- Coming in for a **new spot suspected as a basal cell**
- Biller is suggesting since they have a history of basal cell to bill under the MD's NPI.

- Can this visit be billed under MD's NPI?
- Incident-to met?
 - New or established problem?
 - Treatment plan initiated by MD?

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Case # 3:

NPP Changing RX Ordered by MD

- Established patient previously seen by MD who had ordered x drug with x dosage
- Patient seen today by NPP while MD is in office
- NPP determines the current drug and dosage is not working and changes to y drug and y dosage
- Can this visit be billed using MD's NPI?
- Incident- to met?
 - Treatment plan initiated by MD?
 - New or established problem?

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Case # 4:

Split/Shared E/M Visit- Office?

- New patient seen by NPP, while MD is in the office
- NP takes history & performs the physical examination
- Physician and NPP discuss the diagnosis and treatment plan (MDM) and
- NPP documents MDM & implements the plan
- Physician cosign chart at a later time
- Can this visit be billed using MD's NPI?
- Split/shared visit met?
 - New patient?
 - Treatment plan initiated by MD?
 - Co-signature? Face-to-face?
 - Different answer if office was provider based (POS 22)?

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Case # 5

Split/Shared E/M Visit- ER?

- MD & NP both work for the hospital's ER
- NP performs all components of the visit
- NP dictates the note
- MD co-signs the note on the same day.
- Can this visit be billed using MD's NPI?
- Split/Shared E/M Visit apply?
 - Setting: Facility or office?
 - Face-to-Face?
 - Co-signature?

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Case # 6

NPP Service: Hospital or Professional

- Hospital employs NPPs who provide services to private practice surgeons' patients to improve the flow of admission or discharge during the surgical post op service
- Can the hospital bill for the NPPs professional services?
 - Employment MD vs NPP? Stark?
 - Hospital Cost report?
 - Services included in surgical global fees?

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Case # 7

Professional NPP Service- Billable?

- Hospital employs NPPs who provide physician services unrelated to surgery during the private surgeons post op period
 - For example, patient has heart surgery and on the third preop day develops otitis media, is treated by NPP
- Services are not billed by another MD or NPP
- Can the hospital bill for the NPPs professional services?
 - Employment MD vs NPP? Stark?
 - Hospital Cost report?

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Case # 8

Injection Ordered by MD?

- MD saw and evaluated an established patient and orders a joint injection (CPT 96372)
- NPP performs the joint injection while the physician is in the office suite
- Can the joint injection be billed using MDs NPI?
 - Incident-to? (MPFSDB Column PT/TC =5?)
 - What if location was Emergency room or provider based clinic?
 - Modifier -25 edits (E/M not separately billable)?

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Case# 9

Injection Ordered by NPP?

- NPP saw and evaluated an established patient and orders a joint injection (CPT 96372)
- The NPP performs the joint injection while the physician is in the office suite
- No prior visit with Physician were plan of care included providing future injections
- Can the joint injection be billed using MDs NPI?
 - Incident-to?
 - Established plan of care?

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Case # 10

Preventative Visits: Incident-to?

- Established patient seen by NPP, while MD is in the office
- NPP performs the initial preventative physical examination (IPPE) (Welcome to Medicare)
- NPP documents & MD co-signs same day
- Can this visit be billed using MD's NPI?
 - Incident-to?
 - Own benefit category?

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Case # 11

BP Check: Incident-to NPP?

- Established patient seen by auxiliary staff for blood pressure check, while NPP in the office
- No MD in office suite

- Can this visit be billed using NPP's NPI?
 - Incident-to NPP?
 - Plan of care?
 - Supervision?
 - E/M Level or only 99211?

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More Frequently Asked Questions:

- Can you bill physician services incident to another physician?
 - Locum tenens, residents?
- Can split/shared E/M services be used when time is the key component for selecting the E/M level?
- Does the EKG in the office setting fall under incident to or supervision for diagnostic test?
- Can NPPs provide fracture care?

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Summary

- **Audit, educate and then re-audit!**
- Enroll your NPPs in Medicare & Medicaid
- Know your state laws scope of practice
- Query Private Payers
 - Credential NPPs
 - Follow incident-to & split/shared visits
 - Reimbursement rates for NPPs
- CMS supervision requirements for diagnostic tests
 - Does documentation supports level of supervision?
 - Qualification of NPP if performing test?
 - Order for test?

Reduce risk by communicating with patients!

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6: Education Tools & Resources

"Incident-to" Checklist
Split/Shared Visits Checklist
Reference Tools
Resources

Audit Checklist: Incident-to

The screenshot shows a PDF document titled 'Audit Checklist Incident-to 2012.pdf'. At the top, there are fields for 'Month: Patient', 'Physician: Reviewer', and 'Met criteria: Payer'. Below this is a section titled 'If the answer is "no" to any of the questions, it is not appropriate to bill the service incident-to the physician.' This is followed by a 'DOCUMENTATION TASK' table with columns for 'YES' and 'NO'. The table includes questions about the location of service, physician supervision, and documentation.

DOCUMENTATION TASK	YES	NO
Location Does the place of service (POS) fall within the definition of an office or a physician directed clinic? The service is not performed in the institution of setting (i.e. hospital or skilled nursing facility)? Incident-to services cannot be performed in the emergency room, hospital outpatient department or provider based physician office (POS 22).		
Employment relationship Does the physician or group incur an expense and meet the employment requirements for the auxiliary staff? - OR Does the auxiliary staff include employees, leased employees, or independent contractors of the physician or the entity that employs or contracts with the physician?		
Supervision Did the physician perform direct supervision ? (Present in the office wait to assist, if necessary. The physician does not need to be physically present in the patient's treatment room for these services.) Is there a documentation link between auxiliary staff and the physician when the incident-to service was performed? (Archived records of when the supervising physician was in the office suite, i.e. physician schedule, etc. or documentation in the		

http://elinkunz.com/uploads/Kunz_AuditChecklist_Incident-to_2012.pdf

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Audit Checklist: Split/Shared Visit

http://elinkunz.com/uploads/Kunz_AuditChecklist_SharedVisit_2012.pdf

The screenshot shows a PDF document titled 'Audit Checklist Shared Visit 2012.pdf'. At the top, there are fields for 'Month: Patient', 'Physician: Reviewer', and 'Met criteria: Payer'. Below this is a section titled 'If the answer is "no" to any of the questions, it is not appropriate to bill the service as a shared/split visit under the physician's provider number.' This is followed by a 'DOCUMENTATION TASK' table with columns for 'YES' and 'NO'. The table includes questions about qualified staff, NTP licensure, and documentation.

DOCUMENTATION TASK	YES	NO
Qualified Staff Are auxiliary personnel performing physician services qualified non-physician practitioners (NPPs)? This includes Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists. Is the NPP licensed and certified to practice in the state in which they are practicing?		
Employment relationship Does the physician or group incur an expense and meet the employment requirements for the NTP? - OR Are the NTP's employees, leased employees, or independent contractors of the physician or the entity that employs or contracts with the physician?		
NTP's licensure Are collaboration agreements filed with the state and available?		

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Example Reference Tool: Statutory Authority

- Florida –Distinguishing between ARNP/PA:

STATUTORY AUTHORITY	
ARNP	PA
Nurse Practice Act Florida Statutes, Chapter 464	Medical Practice Act Florida Statutes, Chapter 458
Medical Practice Act Florida Statutes, Chapter 458	Osteopathic Medicine Act Florida Statutes, Chapter 459
Florida Administrative Code Board of Medicine §64B8 Board of Nursing §64B9	Florida Administrative Code Board of Medicine §64B8
Pharmacy Act Florida Statutes, Chapter 465	Pharmacy Act Florida Statutes, Chapter 465

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Example Reference Tool State Supervision

SUPERVISION	
ARNP	PA
<p>General supervision by a Florida-licensed medical doctor, osteopathic physician or dentist. Degree and method of supervision to be determined by the ARNP and Physician and identified in written protocols.</p> <p>General supervision: Supervising physician authorizes procedure being carried out but need not be present when such procedures are performed. Must be available for consultation and advice either in person or by communication device.</p> <p>Protocol may or may not require on-site supervision, but is not required by statute.</p> <p>Restrictions placed on the number of off-site locations a physician may supervise, but no restriction on the number of ARNPs which may be supervised (not applicable to licensed hospitals, ASCs and other entities exempted by statute).</p> <p>No requirement for physician responsibility other than protocol rules.</p>	<p>Responsible supervision by Florida-licensed medical doctor or osteopathic physician.</p> <p>Responsible Supervision: The ability of the supervising physician to responsibly exercise control and provide direction over the services of the PA. It requires the easy availability or physical presence of the supervising physician to the PA.</p> <p>Unless specifically prohibited by rule (see Attachment A) PA can be supervised indirectly without his/her supervising physician on-site as long as the supervising physician is easily available to communicate with the PA.</p> <p>MD or DO may oversee up to four PAs.</p> <p>Supervising physician assumes legal liability for the acts and omissions of the PA.</p>

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Sample E/M Training Checklist

Evaluation and Management Training Checklist for Physicians

#	Area:	Notes:	Complete:
1	Correct category - Admissions (99221AI- 99223AD) - Observation (99217-20, 99224-26 99234-36) - Initial Hospital (Admissions) (99221-99223) - Subsequent Hospital (99231-99233) - Discharges (99238-99239*) - Critical care (99291*-99292*) - Office visits (99201-99215) *Requires documentation of time		
2	2010 Medicare Consultation Coding: - Use 99221-99223 & 99231-99232		
3	Correct EM Level - Review AMA examples - Medicare National data percentages		
4	Presenting Problem - Medical necessity		
5	History - HPI		

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Resources: CMS Regulation

- Non institutional or office incident to services"
 - 42 Code of Federal Regulation (CFR) §410.26
 - "66 Federal Register
55246,55267(November1,2001)
 - 42 CFR §410.32

- Institutional or hospital Incident to services
 - 42 CFR §410.27
 - 66 FR 18434,18524 (April7,2000)

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Resources: CMS Policy

- Medicare Benefit Policy Manual, Chapter 15 §60
 - Incident-to Services
 - Homebound patients
- Medicare Claims Processing Manual, Chapter 12 §30
 - Evaluation & Management Services
 - Shared/Split visit
- Education Material
 - CMS: Medicare Information for Advanced Practice Nurses and Physician Assistants (September 2011)
 - Check your MAC FAQ & Manuals

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E/M Resources

- CMS 1995 & 1997 Documentation Guidelines for E/M Services:
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html>
- CMS Internet Only Manuals (IOM) Medicare Claims Processing Manual (MCPM) Publication 100-04, Ch.12:
<http://www.cms.gov/manuals/downloads/clm104c12.pdf>
(Guidelines for EM code categories etc.)
- CMS Internet Only Manuals (IOM) Medicare Benefit Policy Manual (MBPM) Publication 100-02, Ch.15:
<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>
- OIG's Compliance Program for Individual and Small Group Physician Practices Published in the Federal Register, Volume 65, No. 194, Thursday, Oct. 5, 2000 Pages 59434 – 59452:
<http://oig.hhs.gov/authorities/docs/physician.pdf>

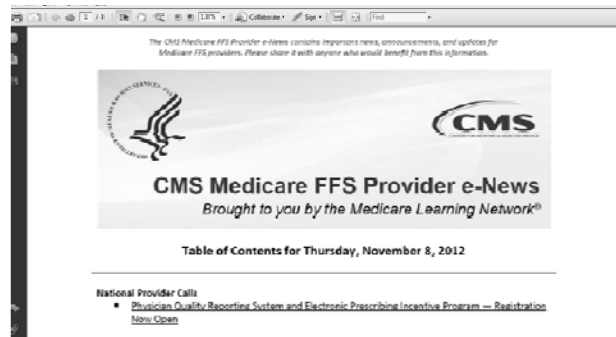
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2013 Update To CMS Pub.100-04, Ch.12, Non-Physician Practitioners (NPPs), CR 8010

- NPP assistant-at-surgery services should be billed with the "AS" modifier only
- Procedures billed with the assistant-at-surgery physician modifiers -80, -81, -82, or the AS modifier for physician assistants, nurse practitioners and clinical nurse specialists, are subject to the assistant-at-surgery policy.
- When a PA, NP, or CNS furnishes services to a patient during a global surgical period, Medicare contractors shall determine the level of PA, NP, or CNS involvement in furnishing part of the surgeon's global surgical package consistent with their current practice for processing such claims
- Specialty code 97 applies for PAs enrolled in Medicare.
- NPs use specialty code 50 & CNSs use specialty code 89

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CMS Medicare FFS Provider e-News



Use this Link To sign up for CMS e-News:

https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819

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CMS: Frequently Used Web Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network
National Health Care Education Center

HEALTH CARE PROFESSIONAL
Frequently Used
WEB PAGES

Table of Contents

General Medicare Information	2
Medicare Contracting	2
Provider Enrollment and Certification	3
Coverage	3
Billing and Payment - General Information	4
Billing and Payment - Provider Specific	5
Provider Centers	7
Quality	8
Outreach and Publications	8
Laws and Regulations	8

This educational tool is designed to provide education on the web pages used most frequently on the Centers for Medicare & Medicaid Services (CMS) website. It includes easily-accessible information on key topics such as enrollment, coverage, billing, and payment to assist health care professionals in navigating the CMS website. Select a link on the following pages to learn more!

CMS: Resources Billers & Coders

Download Quick References Now

Medicare Learning Network® (MLN)
Suite of Products & Resources for Billers and Coders

What's Inside the Suite?
Discover more than 90 products added from the comprehensive MLN Catalog of Products – geared to provide health care professionals with information about new and changing Medicare Program policies and procedures.

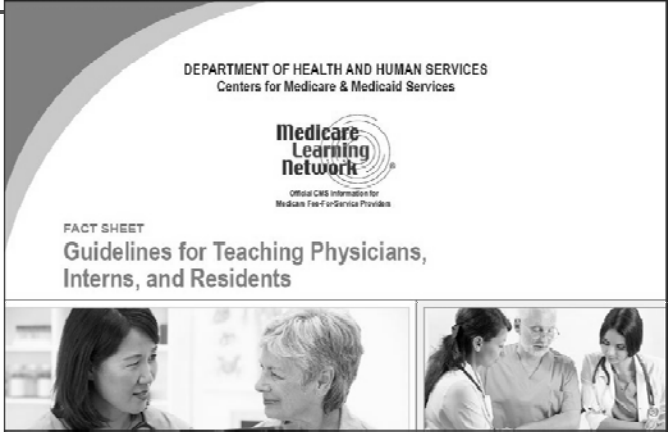
How Will the Suite Help Me?
MLN products can help you understand how to claim claims correctly the first time; in addition you'll strengthen your knowledge of Medicare Program basics, billing requirements, benefits, and coverage, and federal initiatives and incentives.

Start Learning Now
Just tell your cursor over one of the NCCI disk and you are linked to a product. You can download information, listen to a provider, search an article through MLN MedWatch, or even sign up for a web-based training course – many of which offer continuing education credits.

REIMBURSEMENT, CLAIMS REVIEW, AND COMPLIANCE

- 2012 Physician Quality Reporting System Claims Made Simple
- 2012 Physician Quality Reporting System Claims Based Coding and Reporting Principles
- Durability Medical Equipment and Supplies
 - Carrier Services: Complying with Documentation and Coverage Requirements
 - Oxygen Therapy Supplies: Complying with Documentation and Coverage Requirements
 - Positive Airway Pressure (PAP) Devices: Complying with Documentation and Coverage Requirements (Pocket)
 - Percutaneous Fetal Tissue Examination (PFTMA) (Pocket)
- Complying with Medicare Signature Requirements
- Inpatient Rehabilitation Therapy Services: Complying with

CMS: Booklet for Teaching Physicians



The image shows the cover of a booklet titled "Guidelines for Teaching Physicians, Interns, and Residents". The cover features the Medicare Learning Network logo and the text "DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services". Below the title, there are two photographs: one showing two women in a clinical setting, and another showing a group of people, including a doctor and students, in a classroom or meeting.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network
Official CMS Information for Medicare Fee-for-Service Providers

FACT SHEET
Guidelines for Teaching Physicians, Interns, and Residents

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/gdelinesteachgresfctsh.pdf>

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FY 2014 & CY 2014 Payment System Updates

- Hospital Inpatient Prospective Payment System (HIPPS) Final Rule
 - Changes to Inpatient Admission Criteria (required physician documentation)
- Hospital Outpatient Prospective Payment System (HOPPS) Proposed Rule
 - Inpatient Only List (Physician orders)
 - E/M Codes for Facility billing (provider based clinics)
- Medicare Physician Fee Schedule (MPFS) Proposed Rule
 - Proposed changes to "incident-to"
 - Complex Chronic Care Management Services (CCCMS)
 - Table 72 Proposed Estimated Impact on Total Allowable Charges by Specialty

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Questions?

Additional Handouts Available:
<http://elinkunz.com/>

Thank you!

Elin Baklid-Kunz
ekunz@bellsouth.net

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Attached Article

AAPC Coding Edge

August 2008

Hot Topic:

Medicare's Split/Shared Visit Policy

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American Academy of Professional Coders

CODING

August 2008

edge

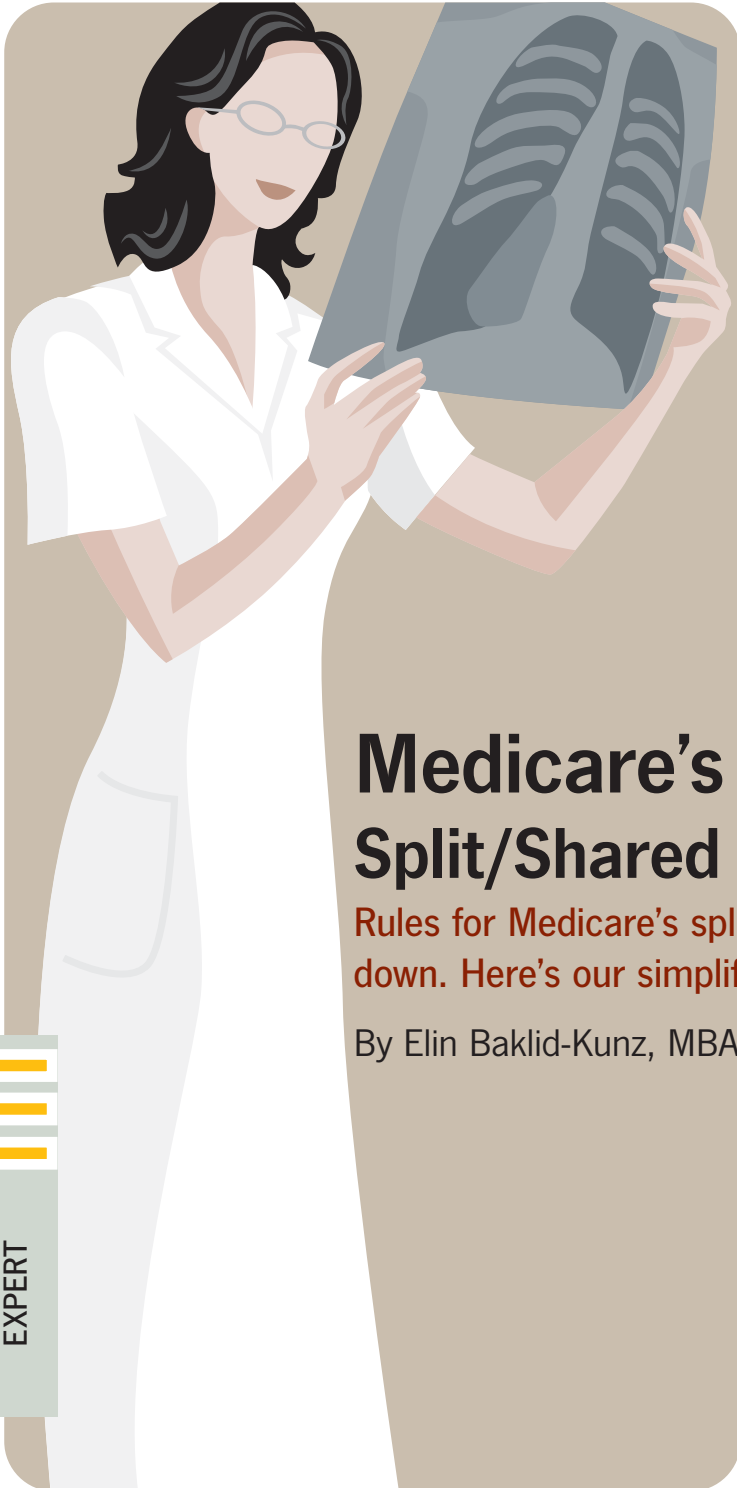


Get Ready for Big ICD-9-CM Changes

Kerin Draak, MS, APNP, CPC, CPC-E/M



Plus: Orlando Conference • Echocardiology • Addiction Coding • OIG Investigation • Orthopaedic Changes



Medicare's Split/Shared Visit Policy

Rules for Medicare's split/shared visit policy can be a lot to choke down. Here's our simplified interpretation to make it easier to digest.

By Elin Baklid-Kunz, MBA, CPC, CCS



EXPERT

On Oct. 25, 2002, the Center for Medicare & Medicaid Services (CMS) issued Transmittal 1776 giving non-physician practitioners (NPPs) and their supervising physicians increased latitude for hospital and office billing of evaluation and management (E/M) services. The instructions found at www.cms.hhs.gov/transmittals/downloads/R1776B3.pdf allowed NPPs and physicians who work for the same employer/entity to share patient visits on the same day by billing the combined work under the physician's provider number for 100 percent of the Medicare physician fee schedule (MPFS) reimbursement—although the NPP may have done the majority of the work.

Medicare defines NPPs as physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs).

These instructions are referred to as Medicare's Split/Shared Visit Policy. The policy is one of three billing options for NPPs:

- NPPs own provider number receiving 85 percent of the MPFS amount
- Incident-to the physician receiving 100 percent of the MPFS
- Split/shared service receiving 100 percent of MPFS

Billing using the NPP's provider number is easy but can cause confusion about Medicare's Split/Shared Visit Policy when it relates to new patient office or other outpatient visits (CPT® 99201–99205).

Medicare's Split/Shared Visit Policy

The definition of split/shared visits can be found in the CMS Internet Only Manual (IOM): Medicare Claims Processing Manual Publication 100-04, chapter 12, section 30.6.1.H Split/Shared E/M Visit:

“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.”

Different Rules for Different Settings

The split/shared E/M visit policy applies only to selected settings: hospital inpatient, hospital outpatient, hospital observation, emergency department, and office and non-facility clinics. A split/shared E/M visit cannot be reported in the skilled nursing facility (SNF) or nursing facility (NF) setting.

When a non-hospital outpatient clinic or physician office E/M visit is split or shared between a physician and a NNP, the E/M encounter may be billed under the physician's name and provider number if the patient is an established patient and the incident-to rules are met. (Note: Medicare clarifies that incident-to billing is not allowed for new patient visits).

Let's look at an example. An established patient visits. The NPP performs the history and physical exam and the physician performs the medical decision-making. The “incident-to” requirements are met. In this same example, if the physician and the NPP shared the visit and it does not meet incident-to rules, the entire visit is billed under the NPP's provider number.

When a hospital inpatient, hospital outpatient, or emergency department E/M visit is split or shared between a physician and a NPP from the same group practice, the E/M visit may be billed under the physician's name and provider number if the physician provides any face-to-face portion of the E/M encounter (also applies to same day as the NPP's portion) and the physician personally documents in the patient's record the physician's face-to-face portion of the E/M encounter with the patient. (Co-signatures are NOT sufficient).

An example of an E/M visit that may be billed under the physician's name and provider number is hospital rounds at different times of the day on the same date of service. In a provider-based physician office (i.e., hospital outpatient department) or the emergency room, an example is a new or established patient visit where the NPP performs the history and physical exam, and the physician is the medical decision-maker.

Rule Applies ONLY to Selected E/M Visits

The split/shared E/M visit rule applies only to selected E/M visits such as these in the hospital settings:

Because incident-to criteria can be applied only in the office and non-facility clinic, the patient must be established.

- hospital admissions (99221-99223)
- follow-up visits (99231-99233)
- discharge management (99238-99239)
- observation care (99217-99220, 99234-99236)
- emergency department visits (99281-99285)
- prolonged care (99354-99357)
- hospital outpatient departments (provider-based visits) (99201-99215)

In a physician office setting, use codes 99211-99215 for an established patient with an established plan of treatment. Incident-to requirements must be met.

Remember: Split/shared visits do not apply to consultations (99241-99255), critical care services (99291-99292) or procedures.

Relationship to Incident-to

To bill a split/shared visit in the physician office setting, the visit must meet incident-to rules. For the services of a NPP to be covered as incident-to the services of a physician, the services must meet all the requirements for coverage specified in the CMS IOM: Medicare Benefit Policy Manual Publication 100-02, chapter 15 §60-61:

- The service or supplies are an integral, although incidental, part of the physician's or practitioner's professional services
- The services or supplies are of a type that are commonly furnished in a physician's office or clinic
- The services or supplies are furnished under the physician's/practitioner's direct supervision
- The services or supplies are furnished by an individual who qualifies as an employee of the physician, NPP or professional association or group that furnishes the services or supplies
- The service is part of the patient's normal course of treatment, during which a physician personally performs an initial service and remains actively involved in the course of treatment

According to the Medicare Benefit Policy Manual, incident-to apply only to non-institutionalized settings (i.e., not hospital or SNF settings); section 60.1B of the Medicare Claims Processing Manual states:

“For hospital patients and for SNF patients who are in a Medicare covered stay, there is no Medicare Part B

coverage of the services of physician-employed auxiliary personnel as services incident to physicians' services under 279H§1861(s)(2)(A) of the Act. Such services can be covered only under the hospital or SNF benefit and payment for such services can be made to only the hospital or SNF by a Medicare intermediary.”

Can New Patients Office or Other Outpatient Visits (99201–99205) be Split/Shared?

Because incident-to criteria can be applied only in the office and non-facility clinic, the patient must be established. A hospital outpatient clinic/office is considered a hospital or facility setting, and not a non-institutional setting. Incident-to regulations do not apply and New Patient Office or Other Outpatient Visits (99201–99205) can be reported as a split/shared visit in the hospital outpatient clinic/office (POS 22). The physician must perform some aspect of the E/M service with the patient face-to-face and both the NPP and the physician must personally document what he/she performed.

Remember: Exclude the NPP's salary and benefits from the hospital's cost report when the NPP performs professional services. If the NPP does both facility and professional services, keep time sheets so the expense for professional services can be excluded from the facility's cost report.

In a provider-based clinic/office, the cost for the hospital staff is reported in the facility's cost report and reimbursement for the service is received through the facility payment. If the NPP performs professional services, remember to exclude the NPP's salary and benefits from the cost report. If the NPPs perform both hospital and professional services, keep track of the time spent on professional services so this component can be excluded from the cost report.

The cost report manuals are paper based manuals found at:

www.cms.hhs.gov/Manuals/PBM/list.asp

(publication 15: Provider Reimbursement, Provider Reimbursement Manual Part 1

chapter 21: Cost Related to Patient Care, section 2108: Reimbursement For Services by Provider-Based Physicians)

Provider-based regulations can be found in Transmittal A03-030, CR 2411, April 18, 2003: www.cms.hhs.gov/transmittals/downloads/A03030.PDF

Documentation of Split/Shared Visits

Documentation for split/shared visits should follow the documentation guidelines for any E/M Service, and you must follow these documentation requirements:

- Each physician/NPP should personally document in the medical record his/her portion of the E/M split/shared visit.
- The physician's documentation must clearly indicate that a face-to-face visit took place. (i.e., documenting an exam component to substantiate the physician had a face-to-face visit with the patient, is recommended.)
- Documentation must support the combined service level reported on the claim.
- Auxiliary staff may document the review of systems, past family history, and social history. The physician and NPP must personally review this documentation and confirm and/or supplement it in the medical record.

If the physician does not personally perform and document a face-to-face portion of the E/M encounter with the patient, then the E/M encounter is not billed under the physician's name and provider number and is billed only under the NPP's name and provider number.

If the physician's participation is only reviewing the patient's medical record, the service is billed under the NPP's name and provider number. Payment will be made at the appropriate physician fee schedule based on the provider number entered on the claim.

Acceptable Physician Documentation

Because teaching physician services involving residents is somewhat analogous to split/shared visits, these examples from the CMS material on teaching physician services (CMS Pub.100-4, Chapter 12, Section 100.1.1.A General Documentation Instruction and Common Scenarios), help establish acceptable documentation for split/shared visits:

- "I performed a history and physical examination of the patient and discussed his management with the NPP. I reviewed the NPP note and agree with the documented findings and plan of care."

The physician must perform some aspect of the E/M service with the patient face-to-face and both the NPP and the physician must personally document what he/she performed.

- "I saw and evaluated the patient. I reviewed the NPP's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."
- "I saw and evaluated the patient. Agree with NPP's note but lower extremities are weaker, now 3/5; MRI of L/S Spine today."

Examples of unacceptable documentation by a physician:

- "Agree with above," followed by legible countersignature or identity.
- "Rounded, Reviewed, Agree," followed by legible countersignature or identity.
- "Discussed with NPP. Agree," followed by legible countersignature or identity.
- "Seen and agree," followed by legible countersignature or identity.
- "Patient seen and evaluated," followed by legible countersignature or identity.
- A legible countersignature or identity alone.

Such documentation is not acceptable as it is not possible to determine whether the physician was present, evaluated the patient, and/or had any involvement with the plan of care.

Scribing is Not a Billable Service

A scribe's role is to document in the medical record a physician's visit with the patient. In a hospital setting, a scribe makes rounds with the physician and documents the visit. Scribing is not a billable service and is not always straightforward. For example, it is no longer considered scribing if the NPP adds an opinion to the progress note.

If your hospital or office uses scribes, establish a protocol that clearly outlines scribes to not render any opinions and to provide an accurate transcription of physicians' comments. Watch out for scribes who improve documentation to facilitate optimization of the claim to maximize revenue.

Guidelines for scribes published by First Coast Service Option, the Part B carrier for Florida and Connecticut in the third quarter 2006 Part B update (www.floridamedicare.com/Part_B/Medicare_B_Update/Archive/106399.pdf) are:

- If a nurse or NPP acts as a scribe for the physician, the individual writing the note, history, discharge summary, or any entry in the record; should note “written by X, acting as scribe for Dr. Y.” Dr. Y should co-sign, indicating the note accurately reflects work and decisions made.
- It is inappropriate for an employee of the physician to make rounds and write entries in the record, and then for the physician to make rounds several hours later and note “agree with above,” unless the employee is a licensed, certified provider (PA, NP) billing Medicare for services under his/her own name and number.
- Scribes should record entries upon dictation by the physician, and should clearly document the level of service provided at that encounter. This requirement is no different from other encounter documentation requirements.
- Medicare pays for medically necessary and reasonable services, and expects the person receiving payment to deliver services and create the record. There is no carrier Part B incident-to billing in the hospital setting (inpatient or outpatient). The scribe should only write what the physician dictates and does, acting independently there is no payment for this activity.

Understand Private Payer Differences

There is a distinction between Medicare regulations and private payers’ policies. Medicare rules do not necessarily impact private payers. Some payers may defer to state law, so understand your state’s scope of practice. Follow the requirements set out by private payers. Some hospitals query private payers to see what their rules are. An alternative to querying the private payers is to send the private plans a certified letter advising the hospital’s procedures plan for billing NPP service, unless the plan advises the hospital otherwise, in writing. When querying payers about policies, ask how to report services such as critical care and consultations.

Most private payers do not issue numbers to NPPs and request that billing occur under a supervising physician. Some payers may only ask to follow state law when NPPs deliver care. For such cases, it might be appropriate for the NPP to provide care without a physician face-to-face encounter in the emergency room and bill the private payer under the physician’s number.

Follow Medicaid’s State Rules

Medicaid also has different rules from Medicare when it comes to NPPs. Check your local state Medicaid Web site for your state’s rules. Medicaid pays NPPs on a separate fee schedule and has a separate limitation and coverage book for NPPs.

In Florida, NPP services under the direct supervision of a physician may be billed using the physician’s provider number instead of the NPPs provider number with some exceptions. Florida Medicaid direct supervision means the physician is on the premises when the services are rendered and he/she reviews, signs, and dates the medical record.

Get on Target with Split/Share Visits Compliance

In January’s incident-to article, Robert Pelaia Esq., CPC identified incident-to billing as completely transparent to the payer. This transparency exists for split/shared visit billing as well. When a claim for a split/shared visit is received for reimbursement, it looks just like a claim for a physician service and the provider usually gets paid for the claim even if it did not comply with the split/shared visit policy. Although transparent to the payer, non-compliance with the split/shared visit policy could be an easy target for Recovery Audit Contractors (RACs) when the permanent RAC program starts. In the revised scope of work released on Nov. 7, 2007, E/M codes were added to the services list that RAC can review. The RAC will also have hospital and provider specific medical record request limits and they may only send the provider one review result per claim. This may lead to auditors checking for multiple issues before sending denial letters. Because the RACs have the complete medical record and the claims submitted, it will be very easy to identify a progress note documented by the NPP and merely signed by the physician.

With the permanent RAC program near, now is a good time to review a few internal progress notes for compliance with the split/shared visit policy. You may discover your physicians are not aware of the face-to-face requirement for billing split/shared visits, do not realize incident-to rules do not apply in emergency room and provider-based offices, or are using the split/shared visits for consultations. ■



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Letters to the Editor

Documenting Counseling Discussion is Time Well Spent

Dear *Coding Edge*,

I am confused with the E/M and consultation verbiage in August's article "Orlando Report: High Stakes for High-Risk Pregnancy." The second sentence indicates to use time when greater than 50 percent of your patient encounter is involved in counseling then goes on to indicate they "cannot" be billed as such "I spent 40 minutes with the patient of which greater than 50 percent of the time was spent counseling the patient about ..."

It is my understanding that when billing on time you need to indicate time spent in counseling and coordination of care and indicate that more than 50 percent of the encounter was spent counseling. Please advise.

Aurelia Barraco, CHC, CPC

Dear Aurelia,

Consultations "can" be billed by time provided that greater than 50 percent of the time was spent in counseling or coordination of care. It is appropriate to document what was discussed. It is not enough to just say "I spent X amount of time counseling the patient. Some auditors will look for total time spent and counseling time.

Peggy Stilley, CPC, CPC-OBGYN, ACS-OB

Split Guidance on Shared Visits

Dear *Coding Edge*,

I read Elin Baklid-Kunz excellent article, "The Skinny on Medicare's Split/Shared Visit Policy," in the August issue. There was one section that I was hoping to clarify. The second bullet under Documentation of Split/Shared Visits states:

- The physician's documentation must clearly indicate that a face-to-face visit took place. (i.e., documenting an exam component to substantiate the physician had a face-to-face visit with the patient, is recommended.)

This seems to contradict the first bullet under Acceptable Physician Documentation:

- "I performed a history and physical examination of the patient and discussed his management with the non-physician practitioners (NPP). I reviewed the NPP note and agree with the documented findings and plan of care."

The acceptable physician documentation is not specific to the patient—the statement could apply to any patient. We have residents and NPPs and struggle with our compliance education to keep TP guidelines and shared visit guidelines separate. We educate our physicians perform-

ing split/shared visits that they may agree with the NPP's note; however, they must document some element of the visit to show a face-to-face visit. For example, "Patient seen and agree with above, less abdominal pain today, proceed with endoscopy," followed by a legible physician signature.

Thank you,

Marianne Lockwood, CPC, CPC-H, RCC

Dear Marianne,

I agree with you that TP and shared visits guidelines are different. However, some of our physicians want to see what the manual says, and there are no examples in the CMS manuals for shared visits.

We give them the TP examples as acceptable documentation. However, our recommendation to our physicians is to clearly indicate that a face-to-face visit took place by writing "patient seen and evaluated" and we recommend that they document an exam component. In an audit, this would justify that they had a face to face with the patient. We prefer an exam component where they have to touch the patient. For example, lungs clear. We feel less has to be documented for shared, but start out with TP guidelines since these are more restrictive. I personally feel we will be getting more specific guidance from CMS on this issue, especially if this ends up being a Recovery Audit Contractor (RAC) issue, which it very easily could.

Our biggest issue has been making sure the physicians document that the patient was seen, rather than just agree with above. If they write agree with above without documenting that the patient was seen or evaluated, we don't give them credit in an internal audit. We also explain that if they document the medical decision making (MDM) without documenting the patient was seen, and an outside audit could determine the patient was not seen, as the MDM could have been done based on the NPPs note.

I also have checklists for auditing these services to give physicians' staff to help keep track of this.

Elin Baklid-Kunz, MBA, CPC, CCS

Coding Edge Readers,

There was a typographical error in August's "Medicare's Split/Shared Visit Policy," article on page 15, paragraph 5. There is no IOM 100-04, 12, 30.6.1H. The reference should be IOM 100-04, chapter 12, 30.6.13H. We apologize for any inconvenience this may have caused.

Sincerely,

Coding Edge