

Cleaning Up the Low Hanging Fruit to Protect Your Physician Practices

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Objectives

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- Learn about the “low hanging fruit” in most physician practices that can open the door to potential fraud and abuse.
- This session will provide overviews of high risk areas for physician practices and how to determine your risks.
 - Incident-To
 - × Non-Physician Provider Students / Medical Students
 - 99211
 - Anticoagulation Clinics
 - Locum Tenens
 - Supervision of Diagnostic Testing
- Learn the steps to take to effectively minimize the risks to your organization and physicians through simple and effective education, auditing and refunding processes.

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Billing “Incident To” Physician’s Professional Services

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- **Allows certain services performed in the physician’s office/clinic by someone other than the physician to be**
 - Billed under the physician’s provider number
 - Paid at 100% of the physician fee schedule

- **The “Services” provided by the physician’s auxiliary staff and Non-Physician Practitioner (“NPP”) must meet certain criteria and rules established by Medicare.**
 - Not all Insurance Payers (e.g. Commercial & Medicaid) use the same rules or allow Incident-To billing.

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“Incident To” Definition

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Incident to a physician’s professional services means that the services are furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness.

Source: Medicare Benefit Policy Manual (Internet Only Manual) Chapter 15, Section 60.1 – Incident To Physician’s Professional Services (Rev. 1, 10-01-03) B3-2050.1

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“Incident To” Definition

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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 services
 - ✦ The **initial service** must be done by the physician.
 - The NPP and/or Auxiliary staff may only complete and document the ROS and PFSH. The physician must complete the Chief Complaint, History of Present Illness, Examination, Assessment, and Plan of Care.
 - ✦ A **plan of care** must be **established by physician and followed**.
 - New problems and changes to the treatment plan – the physician must see the patient first and modify the plan of care before the NPP can provide follow-up care and bill “Incident To”
 - ✦ There must be **subsequent services** by the physician of a **frequency** that **reflects** the physician’s **continuing active participation** in and management of the course of treatment.

Source: Medicare Internet Only Manual Chapter 15, Section 60 - Services and Supplies Furnished Incident To a Physician’s/NPP’s Professional Service

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“Incident To” Definition, Continued

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- Furnished by the physician **or** by auxiliary personnel under the physician’s **direct supervision**.
 - ✦ Auxiliary personnel
 - Any individual who is acting under the supervision of a physician, regardless of whether the individual is an **employee, leased employee, or independent contractor** of the physician, or the legal entity that employs or contracts with the physician.
 - W2 or 1099 Nurses, Technicians, Therapists, Aides
 - Under the control of the physician
 - Must **represent an expense** to the physician, group practice, or legal entity.

Source: Medicare Internet Only Manual Chapter 15, Section 60 - Services and Supplies Furnished Incident To a Physician’s/NPP’s Professional Service

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Involvement of Other Persons in “Incident To”

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- **Residents/Fellows** may not supervise “incident to”.
- **Students (Medical & Non-Physician Provider)** services can not be billed “Incident To”
 - Students are not paid W2 or 1099 “employees”
 - ✦ Exception - stipends paid to students by the practice.

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Documentation to Support “Incident To”

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- **Documentation**
 - ✦ Must clearly document who performed the “Incident To” service and
 - ✦ The physician’s presence in the office suite during the service/procedure with a note by the NPP and/or Auxiliary staff

Dr. Jones was immediately available and provided direct supervision in the office during the patient’s visit today. Vicki Dwyer, APRN/CNS

- AND the signature of the physician providing direct supervision.

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99211 - Definition

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“Office or other outpatient visits for the evaluation and management of an established patient, that may not require the presence of a physician.

Usually, the presenting problem(s) are minimal.

Typically, 5 minutes are spent performing or supervising these services.”

Source: American Medical Association cpt® Standard

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Billing 99211

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- **Requires a face-to-face patient encounter.**
- **May be performed by ancillary staff and billed as if the physician personally performed the services.**
 - **Must meet Incident-to requirements.**
- **Must be REASONABLE & NECESSESARY**
- **The documentation of each patient encounter:**
 - **Must have reason for the encounter and elements of evaluation and management**
 - ✦ **Historical information and/or physical data**
 - ✦ **Medical decision-making, provision of patient education, etc.**

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Documenting a 99211

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- **The documentation of each patient encounter:**
 - Services performed by ancillary staff and billed incident-to the physician should demonstrate the “link” between the non-physician service and the precedent physician service.
 - Must contain the date of the service, legible identity and credentials of both the individual who provided the service and the supervising physician.

99211 Billing

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- **99211 should NOT be used to bill:**
 - Solely for the writing of prescriptions (new or refill) when no other E/M is necessary or performed
 - Routine blood pressure checks that have no impact on patient’s care.
 - When drawing blood for laboratory analysis or when performing other diagnostic tests, whether or not a claim for the venipuncture or other diagnostic study test is submitted separately.
 - Routinely when administering medications, whether or not an injection (or infusion) code is submitted on the claim separately.
 - For performing diagnostic or therapeutic procedures (especially when the procedure is otherwise usually not covered/not reimbursed or payment is bundled with payment for another service), whether or not the procedure code is submitted on the claim separately.
 - Phone calls to patients.

99211 in the Anticoagulation (Coumadin) Clinic

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- **Appropriate Use of 99211 in addition to the laboratory blood draws for warfarin management:**
 - If it's determined the patient's medication needs adjustment, the INR is not therapeutic, or if the patient has symptoms that need to be addressed.
 - ✦ Assessing and documenting the patient in-person for signs and symptoms of bleeding or adverse effects to anticoagulant therapy.
 - ✦ Assessing the patient for changes in health status that may account for fluctuations in lab results.
 - ✦ A new anticoagulant patient where education is required regarding dietary modifications, medicine restrictions, etc.
 - ✦ A new caregiver accompanies the patient so education is needed to ensure compliance
 - Documentation of the services provided by the physician or nurse, discussion of symptoms, side effects, patient observations etc. are considered supportive of the 99211 service.

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99211 "Dos" for Anticoagulation Management

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- Documenting the patient's indication for anticoagulant therapy, current dose, protime and INR results
- Assessing the patient in-person for signs and symptoms of bleeding/adverse effects to anticoagulant therapy
- Assessing the patient for changes in health status that may impact or account for fluctuations in lab results (for example, new or changed medications that may cause a drug interaction with the anticoagulant therapy)
- Providing medically necessary education as needed based on the patient's individual circumstances
- Documenting the identity of the ancillary staff performing this service "incident to" the supervising physician
- Documenting the identity of the billing physician who was notified of results, gave orders, and provided direct supervision

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99211 "Don'ts" for Anticoagulation

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- **Billing for 99211**
 - when the in-person encounter with the patient was only for the diagnostic test
 - for telephone care, i.e. instructions on changing dose, assessment, and/or education
 - when the only documentation would be vital signs, the patient's current and future dose of anticoagulant, and when lab work is to be repeated
 - when direct physician supervision is not met or is not by the physician treating the patient's medical problem requiring anticoagulant therapy (i.e. as seen in some "Coumadin® clinic" scenarios)
 - based on the delivery of repetitive education that does not serve the medical needs of the individual patient

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99211 in the Anticoagulation (Coumadin) Clinic

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- **Do Not Bill** a 99211 in the Anticoagulation Clinic when The **INR** is **within the therapeutic range**, and
 - The documentation does not support a need for adjustment of warfarin dosage, or
 - The documentation does not support that the patient is symptomatic, or
 - The documentation does not support the presence of a new medical co-morbidity or dietary change.
 - When the purpose of the visit is for refilling the current prescription
 - When lab work must be repeated.
 - When **direct supervision** is not met or is not met by the physician treating the patient's medical problems requiring anticoagulant therapy.

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Locum Tenens Definition

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- A physician who serves temporarily as a substitute (or a “place-holder”) for a regular physician is absent most commonly due to illness, pregnancy, vacation, or continuing medical education, but occasionally for a physician who has left a physician group or an employer.
 - The substitute physician generally has no practice of their own and moves from area to area as needed to provide these temporary services.
 - The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent contractor rather than of an employee.

Use of Modifier Q6 for “Locum Tenens”

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- **Regular Physician** is the physician that is normally scheduled to see a patient and may include specialists but not Non-Physician Providers.
- **Q6** is a billing modifier added to the claim for services furnished by a locum tenens physician. When this modifier is added to the CPT code, Medicare pays the regular physician (under the regular physician’s NPI) for services provided by a Locum Tenens.

Medicare Rules for Locum Tenens

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- Medicare Payment Procedure:
 - A patient's regular physician may submit the claim, and (if assignment is accepted) receive the Part B payment, for covered visit services (including emergency visits and related services) of a locum tenens physician who is not an employee of the regular physician and whose services for patients of the regular physician are not restricted to the regular physician's offices, if:
 - ✦ The **regular physician is unavailable to provide the visit services**;
 - ✦ The Medicare beneficiary has arranged or seeks to receive the visit services from the regular physician;
 - ✦ The **regular physician pays the locum tenens** for his/her services on a per diem or similar fee-for-time basis;

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Medicare Rules for Locum Tenens

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- Medicare Payment Procedure:
 - ✦ The substitute physician does not provide the visit services to Medicare patients **over a continuous period of longer than 60 days*** subject to the exception for military personnel; and
 - ✦ The **regular physician identifies the services as substitute physician services meeting the requirements of this section by entering HCPCS code modifier Q6** (service furnished by a locum tenens physician) after the procedure code.
 - ✦ When Form CMS-1500 is next revised, provision will be made to identify the substitute physician by entering his/her unique physician identification number (UPIN) or NPI when required to the carrier upon request.

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Medicare Rules for Locum Tenens

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- **Medicare Payment Procedure:**
 - Physicians who are members of a group but who bill in their own names are generally treated as independent physicians for purposes of applying the Locum Tenens requirements for payment for locum tenens physician services.
 - ✦ Compensation paid by the group to the locum tenens physician is considered paid by the regular physician for purposes of those requirements.
 - ✦ The term “regular physician” includes a physician who has left the group and for whom the group has hired the locum tenens physician as a replacement.

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Definition of a “Continuous Period”

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- **Begins** with the first day on which the covering physician (Locum Tenens) performs the covered visit services to Medicare Part B patients of the regular physician, and **ends** with the last day the covering physician (Locum Tenens) performs services to these patients before the regular physician returns to work.
- This **period continues without interruption** on days on which no covered visit services are provided to patients on behalf of the regular physician or furnished on days which no covered visit services are provided by the covering physician on behalf of the regular physician.

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Example of 60-day Continuous Period

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- The regular physician goes on vacation on June 30, 2016 and returns to work on September 4, 2016. A substitute physician (Locum Tenens) provides services to Medicare patients of the regular physician on July 2, 2017, and at various times thereafter, including September 2, 2017. The **continuous period** of covered visit services begins on **July 2 and runs through September 2, a period of 63 days**
 - The regular physician may bill and receive payment for services the substitute physician provided on his/her behalf from July 2 through August 30.
 - Since the **September 2 services occur after 60 days**, the **regular physician is not entitled to bill and receive payment for them**. The substitute physician must bill for these services in his or her own name.

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What if the Regular Physician will be Absent More than 60 Days?

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- At the end of the 60 continuous days the regular physician can:
 - Contract with a **different** substitute physician.
 - **Return to work for 1 day** then renew the contract with the existing substitute physician.
 - **Hire** the substitute physician as an independent contractor, credential them and bill under their own NPI.

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Locum Tenens Questions

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- Can a Locum Tenens substitute for more than one physician at a time in our group?

Per CMS, locum tenens physician is the substitute for a physician who is absent. Once entered into, the locum tenens physician **should not substitute for a different absent physician**. It is the expectation that the locum tenens will see only those patients that requested the regular physician for which the locum is substituting. This would **include a new patient**

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Locum Tenens Questions

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- Does locum tenens apply to a deceased provider?
- **No**, Medicare only permits payment for services furnished prior to a physician's death. When a physician becomes deceased, his/her billing number, NPI and enrollment are deactivated and cannot be used after the date the physician passes away, therefore, a locum tenens arrangement would not be permitted for a deceased provider.

10.12.2015

Locum Tenens Questions

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- Can we hire a Locum Tenens to build or supplement staffing?

No, per Medicare, a **locum tenens** physician is **meant only for the temporary absence of a regular physician** or when a regular physician has left a group practice.

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NPP Supervision of Diagnostic Testing

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- Nurse Practitioners, Clinical Nurse Specializes, and Physician Assistants may not function as “supervisory physicians”, however they may perform diagnostic tests under their own statutory benefits and state requirements for physician supervision.
- “Section 410.32(b) of the Code of Federal Regulations requires that, with certain exceptions, **diagnostic tests** covered under §1861(s) (3) of the Social Security Act and **payable under the physician fee schedule have to be performed under the supervision of an individual meeting the definition of a “physician”**.”

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NPP Supervision of Diagnostic Testing

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- Pub 100-02 Medicare Benefit Policy, Section 40.4 – Definition of Physician/Practitioner:
 - For purposes of this provision, the term “**physician**” is limited to doctors of medicine; doctors of osteopathy; doctors of dental surgery or of dental medicine; doctors of podiatric medicine; and doctors of optometry who are legally authorized to practice dentistry, podiatry, optometry, medicine, or surgery by the State in which such function or action is performed; no other physicians may opt out.
 - Also, for purposes of this provision, the term “**practitioner**” means any of the following to the extent that they are legally authorized to practice by the State and otherwise meet Medicare requirements: Physician assistant; Nurse practitioner; Clinical nurse specialist; Certified registered nurse anesthetist; Certified nurse midwife; Clinical psychologist; Clinical social worker; *Registered dietitian; or Nutrition Professional*

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NPP Supervision of Diagnostic Testing

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- This policy applies to technical components (TCs) (including TCs billed globally with the professional component (PC) of the procedure) and other diagnostic procedures, which do not have relative value units reflecting physician work. These supervision requirements do not apply to diagnostic tests furnished in hospitals.
- Documentation maintained by the billing provider must be able to demonstrate that the required physician supervision is furnished.
 - Services that are not performed under the appropriate supervision are not considered reasonable and necessary and, therefore, are not covered under Medicare.

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NPP Supervision of Diagnostic Testing

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• Limited License Practitioners

- Nurse practitioners, clinical nurse specialist, and physician assistants are **not defined as physicians**. Therefore, they **may not function as supervising physicians under the diagnostic tests benefit**.
- However, when performing diagnostic tests, they are not required to meet the physician supervision requirements defined here.
- Instead, they may perform diagnostic tests pursuant to State scope of practice laws and under the applicable State requirements for physician supervision or collaboration.

• 'Incident To' Benefits

- Because the diagnostic tests benefit set forth in §1861(s)(3) of the Act is separate and distinct from the incident to benefit set forth in §1861(s)(2) of the Act, **diagnostic tests need not meet the incident to requirements**.

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Identifying the Low Hanging Fruit

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• Conduct investigatory audits

- Pull all 99211, Incident-To, Locum Tenens, etc. billed over a designated month period.
 - ✦ Appears there could be a problem
 - Root Cause Analysis
 - Education & Training
 - System Issues
- Follow the 60-day Overpayment rule to Quantify and Refund.
 - ✦ Identify
 - ✦ Quantify
 - ✦ Refund
- Conduct Follow-up Audits

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**EXAMPLES
AND
DISCUSSION**

QUESTIONS?

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Thank You!

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