PECULIARITIES OF BILLING AND CODING IN LTC
OCTOBER 14, 2011
PRESENTED BY
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Maine Medical Directors Association
Faculty Disclosures:

Dr. Baker has disclosed that he has no relevant financial relationship(s).
This presentation is based, in part, on educational sessions created collaboratively by

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Learning Objectives

- Review basic billing concepts
- Delineate coding situations that frequently result in incorrect billing
- Create a Medical Director's mentoring program for reducing compliance issues
Pre-Course Assessment
Session Outline

1. Systems
   1. CMS
   2. Medicare-Medicaid
   3. Carriers
      1. Medicare Claims Processing Manual

2. Billing Codes in Long Term Care: Routine Care
   1. Codes
   2. Location of services (POS)
Session Outline

3. Special Requirements and Important Concepts: Nursing Homes
   1. POS, SNF vs. NF, time, AI modifier,
   2. Medical Necessity
      1. regulatory visits
      2. E/M visits
   3. Face to face
   4. Initial vs. subsequent
Session Outline

4. Special Situations: Nursing Homes
   1. NPPs
   2. Split Billing, Gang visits, Incident-to services
   3. Telephone calls (telehealth 2011)
   4. Care Plan Oversight
   5. Family conferences
   6. Hospice
   7. Prolonged services
   8. Consultations
SYSTEMS
The Center for Medicare and Medicaid Services

Administratively a part of the Department of Health and Human Services

Responsible for

- everything to do with Medicare
- State requirements for Medicaid (but how the money is spent by the States is up to them, within guidelines)
<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
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<tbody>
<tr>
<td>Primarily =&gt;65</td>
<td>Any age (need dependent)</td>
</tr>
<tr>
<td>Multiple components (A,B,D esp.)</td>
<td>Single system</td>
</tr>
<tr>
<td>A = hospital, SNF costs</td>
<td></td>
</tr>
<tr>
<td>B = physician, lab, x-ray, therapy</td>
<td></td>
</tr>
<tr>
<td>D = drugs</td>
<td></td>
</tr>
<tr>
<td>Standardized by CMS</td>
<td>State specific</td>
</tr>
</tbody>
</table>
Carriers

- Business entities that take money from CMS and pay it to providers for services provided to Medicare beneficiaries
  - generally speaking, must follow rules put forth by CMS (Medicare Claims Processing Manual, Transmittals)
  - may make local determinations on some issues
Incredibly huge and complex

Defines process and procedures for everything related to Medicare claims (billing and payment)

We are mostly concerned with Chapter 12: Physician/Practitioner Billing

But also with Chapter 11: Hospice

Some other chapters have bits and pieces applicable to this topic
Finding the Manual online

- [ ] www.cms.hhs.gov/Manuals
  - click on Internet Manuals Only (left panel)
  - click on Publication 100-04
  - click to read/download any desired Chapters
List of Online Manuals

100   Introduction
100-01 Medicare General Information, Eligibility and Entitlement Manual
100-02 Medicare Benefit Policy Manual
100-03 Medicare National Coverage Determinations (NCD) Manual
100-04 Medicare Claims Processing Manual
100-05 Medicare Secondary Payer Manual
100-06 Medicare Financial Management Manual
100-07 State Operations Manual
100-08 Medicare Program Integrity Manual
100-09 Medicare Contractor Beneficiary and Provider Communications Manual
Chapter 12 - Physician/Practitioner Billing

Chapter 13 - Radiology Services
Chapter 14 - Ambulatory Surgical Centers
Chapter 15 - Ambulance
Chapter 16 - Laboratory Services from Independent Labs, Physicians, and Providers
Chapter 17 - Drugs and Biologicals
Medicare Claims Processing Manual

To download the Manual – Chapter 12


See Manual references to selected topics as we proceed through this presentation.
Billing Codes in Long Term Care: Routine Care
## Nursing Homes

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<tr>
<th>Code</th>
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<td>99318</td>
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<td>Annual</td>
<td>30</td>
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</table>

* Initial: “Initial Nursing Facility Care, per day
** Subsequent: “Subsequent Nursing Facility Care, per day”
The American Medical Association’s **Current Procedural Terminology (CPT)** 2006 **new patient codes 99324 – 99328 and established patient codes 99334 – 99337** (new codes beginning January 2006), for Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services, are used to report evaluation and management (E/M) services to residents residing in a facility which provides room, board, and other personal assistance services, generally on a long-term basis. **These CPT codes are used to report E/M services in facilities assigned places of service (POS) codes 13 (Assisted Living Facility), 14 (Group Home), 33 (Custodial Care Facility) and 55 (Residential Substance Abuse Facility)**. Assisted living facilities may also be known as adult living facilities.
Special Requirements and Important Concepts: Nursing Homes
Session Outline

3. Special Requirements and Important Concepts: Nursing Homes
   1. POS, SNF vs. NF, time, AI modifier,
   2. Medical Necessity
      1. regulatory visits
      2. E/M visits
   3. Initial vs. subsequent
POS, SNF vs. NF

- Place of Service Code
  - 31 = SNF, 32 = NF

- SNF vs. NF: in a nursing facility, the resident is in a
  - SNF bed: when the resident is receiving Medicare Part A benefits (“skilled care”)
  - NF bed: when the resident is not receiving Medicare Part A benefits
All nursing home CPT codes, as required by Medicare, require a face-to-face visit by the provider. Additional “floor” time (chart review, discussion with staff, writing of notes and orders) are included in the time guidelines for each code.

Telephone calls, family conferences without the patient present, off-site work of any kind is not reimbursable.
Starting in 2010, the AI modifier (A-eye, not A-one) is to be added by the attending physician when billing for the initial comprehensive visit (99304, 99305, 99306).

Procedure for when the initial comprehensive visit is performed by a covering practitioner is not clear and is being clarified with CMS by AMDA.
Medical Necessity

- Medical Necessity is the overarching criterion required to bill for services provided.
SEC. 30.6.1 - Selection of Level of Evaluation and Management Service

A. Use of CPT Codes

“Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.”

“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 reported.”

AMDA White Paper
Medically Necessary Visits

“Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B”
Federally Mandated Visits

- Patient must be seen initially (within 30 days) and then at least every 30 days for the first 90 days, then at least once every 60 days thereafter
B. Visits to Comply With Federal Regulations (42 CFR 483.40)

“Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits. Following the initial visit by the physician, payment shall be made for federally mandated visits that monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.”

“Beginning January 1, 2006, the new CPT codes, Subsequent Nursing Facility Care, per day, (99307 – 99310) shall be used to report federally mandated physician E/M visits and medically necessary E/M visits.”
30.6.13 - Nursing Facility Services

B. Visits to Comply With Federal Regulations (42 CFR 483.40)

“Carriers shall not pay for more than one E/M visit performed by the physician or qualified NPP for the same patient on the same date of service.”

i.e. one payment for mandatory visit combined w/ medically necessary visit

“Medicare Part B payment policy does not pay for additional E/M visits that may be required by State law for a facility admission or for other additional visits to satisfy facility or other administrative purposes.”
B. Visits to Comply With Federal Regulations (42 CFR 483.40)

“E/M visits, prior to and after the initial physician visit, that are reasonable and medically necessary to meet the medical needs of the individual patient (unrelated to any State requirement or administrative purpose) are payable under Medicare Part B.”
The long-term care regulations at Section 483.40 require that residents of SNFs receive initial and periodic personal visits. These regulations insure that at least a minimal degree of personal contact between a physician or a qualified NPP and a resident is maintained, both at the point of admission to the facility and periodically during the course of the resident's stay.

Initial vs. Subsequent Care

- Every time a patient is admitted to a nursing facility, an Initial Visit must be done.
- Initial visit codes are used even if the patient is an established patient of the provider performing the visit.
Initial vs. Subsequent Care

- Initial Visit: the comprehensive history and examination, writing of orders and development of the care plan
  - performed upon admission to the nursing facility
  - 99304, 99305, 99306
  - attending physician appends “AI” modifier
  - must be done by physician in SNF
  - must be performed within 30 days of admission
Initial vs. Subsequent Care

- **Subsequent Visit:**
  - all other E/M visits (even if performed prior to the Initial Visit being done)
  - includes federally mandated visits
  - 99307, 99308, 99309, 99310
  - may be shared with Non-Physician Providers (NPPs) as allowed by Federal and State regulations and scope of practice
  - includes 99315, 99316, 99318
Special Situations: Nursing Homes
Non-Physician Practitioners (NPPs)

- Nurse Practitioners
- Physician Assistants
- Nurse Clinical Specialists
30.6.13 C Visits by Qualified Nonphysician Practitioners

- State Regulations, State Scope of Practice

  - “All E/M visits shall be within the State scope of practice and licensure requirements where the visit is performed and all the requirements for physician collaboration and physician supervision shall be met when performed and reported by qualified NPPs.”

  - “General physician supervision and employer billing requirements shall be met for PA services in addition to the PA meeting the State scope of practice and licensure requirements where the E/M visit is performed.”
Federally Mandated Visits

SNF (31)

“Following the initial visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.”
The long-term care regulations at Section 483.40 require that residents of SNFs receive initial and periodic personal visits. These regulations insure that at least a minimal degree of personal contact between a physician or a qualified NPP and a resident is maintained, both at the point of admission to the facility and periodically during the course of the resident's stay.
Federally Mandated Visits

NF (32)

Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.
30.6.13 C Visits by Qualified Nonphysician Practitioners

- “Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.”
<table>
<thead>
<tr>
<th>Facility</th>
<th>Order to Admit</th>
<th>Admission Treatment Orders</th>
<th>Initial Comprehensive Visit</th>
<th>Other Required Visits</th>
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<td>N</td>
<td>N</td>
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<tr>
<td>NP &amp; CNS not a facility employee</td>
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<td>N</td>
<td>N</td>
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<tr>
<td>PA regardless of employer</td>
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<td>Other Medically Necessary Visits</td>
<td>Other Medically Necessary Orders</td>
<td>Certification/Recertification</td>
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<tr>
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</table>
Billing Conundrums

- Split Visits
- Incident To Services
- Gang Visits
- Telephone calls
- Care Plan Oversight
- Family Conferences
- Telehealth Services
30.6.13 **Split/Shared Visits**

- **Definition**
  - 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.
  - The physician and the qualified NPP must be in the same group practice or be employed by the same employer.
  - **Can** be used for hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non-facility clinic visits, and prolonged visits associated with these E/M visit codes.

- **Nursing Facility**
  - A split/shared E/M visit **can not** be reported in the SNF/NF setting.
30.6.13 Incident To Services in the Nursing Home

- Where a physician establishes an office in a SNF/NF, the “incident to” services and requirements are confined to this discrete part of the facility designated as his/her office.

- “Incident to” E/M visits, provided in a facility setting, are not payable under the Physician Fee Schedule for Medicare Part B.
“Claims for an unreasonable number of daily E/M visits by the same physician to multiple patients at a facility within a 24-hour period may result in medical review to determine medical necessity for the visits.”

Not quantified
Telephone calls, Care Plan
Oversight, Family Conferences

- Medicare does not pay for these services provided in the nursing facility
  - exception: family conference wherein the patient is present
- New in 2011: payment for telehealth services
Effective January 1, 2011, the Centers for Medicare & Medicaid Services approved the addition of subsequent nursing facility care services (99307–99310) to the list of Medicare telehealth services with the limitation of one telehealth subsequent nursing facility care service every 30 days. The initial visit and Federally-mandated periodic visits [as defined by 42 CFR §483.40(c)] should be conducted in-person and may not be furnished through telehealth. Medicare beneficiaries are eligible for telehealth services only if they are in an originating site (skilled nursing facilities are an authorized originating site) located in a rural health professional shortage area or in a county outside of a Metropolitan Statistical Area.

As a condition of payment, an interactive audio and video telecommunications system must be used that permits real-time communication between a physician or practitioner at the distant site and the beneficiary at the originating site.
The Ubiquitous Area of Confusion

- Hospice
Chapter 11 – HOSPICE

- 40 - Billing and Payment for Hospice Services Provided by a Physician
  - 40.1 - Types of Physician Services
    - 40.1.1 - Administrative Activities
    - 40.1.2 - Patient Care Services
    - 40.1.3 - Attending Physician Services

- 50 - Billing and Payment for Services Unrelated to Terminal Illness
Chapter 11 – HOSPICE

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Chapter 11 – HOSPICE

- 40.1 - Types of Physician Services
  - 40.1.1 - Administrative Activities

- Payment for physicians’ administrative and general supervisory activities is included in the hospice payment rates.
- These activities include participating in the establishment, review and updating of plans of care, supervising care and services and establishing governing policies.
- These activities are generally performed by the physician serving as the medical director (of the Hospice) and the physician member of the interdisciplinary group (IDG).
- Nurse practitioners may not serve as or replace the medical director or physician member of the IDG.
Chapter 11 – HOSPICE

- 40.1 - Types of Physician Services
  - 40.1.2 - Patient Care Services

- Payment (to Hospices) for physicians or nurse practitioner serving as the attending physician, who provide direct patient care services and who are hospice employees or under arrangement with the hospice, is made in the following manner:

- Hospices establish a charge and bills the FI (MAC) for these services.
Chapter 11 – HOSPICE

40.1 - Types of Physician Services

40.1.3 - Attending Physician Services

- an “attending physician” means an individual who:
  - Is a doctor of medicine or osteopathy or
  - A nurse practitioner; and
  - Is identified by the individual, at the time he/she elects hospice coverage, as having the most significant role in the determination and delivery of their medical care.
Chapter 11 – HOSPICE

40.1 - Types of Physician Services

40.1.3 - Attending Physician Services

In order to bill Medicare as an “attending physician:”
Not employed nor receives compensation by Hospice
Professional services only (not technical)
Can be in addition to the services of hospice-employed physicians
The professional services of a non-hospice affiliated attending physician for the treatment and management of a hospice patient’s terminal illness are not considered “hospice services.”
Chapter 11 – HOSPICE

40.1 - Types of Physician Services

40.1.3 - Attending Physician Services

In order to bill Medicare as an “attending physician:”

Services are reasonable and necessary for the treatment and management of a hospice patient’s terminal illness.

Services not furnished under a payment arrangement with the hospice.

Must be coordinated with any direct care services provided by hospice physicians.

These services are coded with the GV modifier: “Attending physician not employed or paid under agreement by the patient’s hospice provider.”
40.1 - Types of Physician Services

40.1.3 - Attending Physician Services

Can NOT bill Medicare as an “attending physician:”

When services related to a hospice patient’s terminal condition are furnished under a payment arrangement with the hospice by the designated attending physician, the physician must look to the hospice for payment.

In this situation the physicians’ services are hospice services and are billed by the hospice to its FI (MAC).
Chapter 11 – HOSPICE

- 40 - Billing and Payment for Hospice Services Provided by a Physician
  - 40.1 - Types of Physician Services
    - 40.1.1 - Administrative Activities
    - 40.1.2 - Patient Care Services
    - 40.1.3 - Attending Physician Services

- 50 - Billing and Payment for Services Unrelated to Terminal Illness
Chapter 11 – HOSPICE

50 - Billing and Payment for Services Unrelated to Terminal Illness

Any covered Medicare services not related to the treatment of the terminal condition for which hospice care was elected, and which are furnished during a hospice election period, may be billed by the rendering provider to the carrier for non-hospice Medicare payment.

These services are coded with the **GW modifier**: “service not related to the hospice patient’s terminal condition”
Hospice - Summary

- Care not related to terminal illness
  - Bill Medicare – modifier GW

- Care related to terminal illness
  - MD not associated with hospice
    - Bill Medicare – modifier GV
  - MD associated/employed with hospice
    - Bill Hospice / Contract

- POS: not site-specific
Prolonged Services
• Time

“In those evaluation and management services in which the code level is selected based on time, prolonged services may only be reported with the highest code level in that family of codes as the companion code.”
• Time face to face, continuous or not, beyond the typical time plus 30 minutes, of the visit code

• Documentation not required to be sent w/ bill, but is required in record as to duration and content of svc

• 99354-99355 – office, outpatient setting

  99356-99357 – inpatient and NH

  • 99356 – First 30 min of prolonged service

  • 99357 – each additional 30 minutes beyond the first hour
# Threshold times for prolonged visit codes (99356, 99357)

<table>
<thead>
<tr>
<th>Code</th>
<th>Typical Time for Code</th>
<th>Threshold Time to Bill Code 99356</th>
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<td>99318</td>
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<td>60</td>
<td>105</td>
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</table>
Prolonged Services
Without Face-to-Face Service

30.6.15.2
99358-99359

- Medicare does not pay for these codes
- Payment included in face to face services
- Can not bill patient
Consultations

- Revised regulations as of January, 2010
Consultations
99241-99255

• 30.6.10 - Consultation Services
Consultations — Gone With the Wind

Consultation codes no longer recognized by CMS effective 1/1/10 (except telehealth codes)

Fiscal Effect

- Increase the work relative value units (RVUs) for new and established office visits
- Increase the work RVUs for initial hospital and initial nursing facility visits
- Incorporate the increased use of these visits into the practice expense (PE) and malpractice calculations
- Increase the incremental work RVUs for the codes that are built into the 10-day and 90-day global surgical codes
Revised Consultation Policy

- Inpatient hospital setting and nursing facility setting

- “All physicians (and qualified nonphysician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221 – 99223) or nursing facility care codes (99304 – 99306).”

- AMDA clarified language re: initial evaluation in SNF and NPP: MLN MATTERS SE 1010

- 30.6.10 - Consultation Services
“Physicians may bill an initial NF care CPT code for their first visit during a patient’s admission to a NF in lieu of the CPT consultation codes these physicians may have previously reported, when the conditions for billing the initial NF care CPT code are satisfied.

The initial visit in a skilled nursing facility (SNF) and nursing facility must be furnished by a physician except as otherwise permitted as specified in CFR Section 483.40(c)(4).

The initial NF care CPT codes 99304 through 99306 are used to report the initial E/M visit in a SNF or NF that fulfills federally-mandated requirements under Section 483.40(c)”
Initial E/M service that could be described by a CPT consultation code not meeting the requirements for reporting an initial NF care CPT code

- May bill a subsequent NF care CPT code in lieu of the CPT consultation codes they may have previously reported.
- Otherwise, the subsequent NF care CPT codes 99307 through 99310 are used to report either a federally-mandated periodic visit under Section 483.40(c), or any E/M service prior to and after the initial physician visit that is reasonable and medically necessary to meet the medical needs of the individual resident.
Revised Consultation Policy

- Principal physician of record is identified in Medicare as the physician who oversees the patient’s care from other physicians who may be furnishing specialty care.

- Only the principal physician of record shall append modifier “-AI”, Principal Physician of Record, in addition to the E/M code.

- Follow-up visits in the facility setting shall be billed as subsequent hospital care visits and subsequent nursing facility care visits.
DOCUMENTATION

• “Conventional medical practice is that physicians making a referral and physicians accepting a referral would document the request to provide an evaluation for the patient.

• In order to promote proper coordination of care, these physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician.

• This is not to be confused with the specific documentation requirements that previously applied to the use of the consultation codes.”
How to Help!!
Role of the Medical Director

- Education, education, education!
  - Auditor? *Mais non!*
  - Learning facilitator? *Mais oui!!*
- Provide learning sessions for your medical staff
  - Use this information
Role of the Medical Director

- Educational program(s): content
  - codes and appropriate uses
  - initial versus subsequent care
  - correct use of NPPs
  - what can’t be billed
  - billing for services provided to patients who have elected the Medicare Hospice benefit
Role of the Medical Director

- Why?
  - better charts/better documentation
  - better care/improved understanding of requirements
  - decrease compliance risk/reduce chance of erroneous billing that might be construed as fraud
Post-Course Assessment
WHEW !!!

Thanks!
The “attending physician of record” for a patient in a SNF or NF must be a physician.

- True
- False
The “attending physician of record” for a patient receiving the Medicare Hospice benefit must be a physician.

- True
- False
The “initial visit” for a patient in a SNF or NF is the first time that the patient is seen after admission.

- True
- False
An initial visit is required every time a patient comes in to (is “admitted” to) a SNF or NF.

- True
- False
The new (2011) telehealth billing is available to all practitioners.

- True
- False
Under Federal regulations, a physician (M.D. or D.O.) is never required to visit a patient in a NF.

- True
- False