THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER HOUSTON

MEDICAL SERVICE RESEARCH AND DEVELOPMENT PLAN
UT NON-PHYSICIAN PRACTITIONERS

BILLING AND DOCUMENTATION GUIDELINES

2010

Table of Contents

THE UNIVERSITY OF TEXAS - HOUSTON
MEDICAL SERVICE RESEARCH AND DEVELOPMENT PLAN/
UT NON-PHYSICIAN PRACTIONERS

NPP BILLING AND DOCUMENTATION GUIDELINES

Non-Physician Practitioners recognized by Trailblazer (Texas Medicare)

Includes, but is not limited to the following providers:

- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Certified Nurse Specialist (CNS)
- Certified Nurse Midwives (CNM)
- Clinical Social Workers (CSW)
- Clinical Psychologists

INTRODUCTION: Written documentation in the clinical patient chart is of primary importance for communication among clinical care providers. Documentation must be contemporaneous, comprehensive and complete in order to facilitate and coordinate clinical care. Increasingly, written documentation is also used for other purposes, including medical-legal review, support for clinical research and quality assurance.

Importantly, written documentation provides support for charges submitted by NPPs for payment for medical services. The following guidelines are intended to help faculty understand issues relating to billing and clinical documentation. **For billing purposes, MSRDP/UTP expects NPPs to follow billing and documentation guidelines to meet the requirements of Medicare.** Payers differ in funding source (e.g., Federal, State, Commercial, Private), in payment structure (e.g., fee for service, discounted fee for service, capitation), in process (e.g., Primary Care Provider, Precertification, etc.) and in documentation requirements. It is important that MSRDP/UTP members be attentive to written documentation, and recognizes that good documentation not only improves care, but also improves the ability of MSRDP/UTP to collect for services and reduces NPP medical-legal exposure.

While the complete guidelines for each individual payer billed by MSRDP/UTP are beyond the scope of this document, it is important that each MSRDP/UTP member be familiar with documentation guidelines in general, and with the specific requirements of his/her most frequent payers. As Medicare and Medicaid are each frequent payers for the overall practice plan, this document will discuss these payers in some detail. Unless otherwise directed by the MSRDP Board, non-physician practitioners MUST follow the Medicare guidelines as specified below. **In selected settings preapproved by the MSRDP Board,** where another payer is essentially the only payer, that payer's guidelines should be used. Generally, documentation at the level required for Medicare should meet the requirements of most payers, and shall be used by non-physician practitioners.

MEDICARE GUIDELINES

I. Medical Necessity

Medicare pays for services which are reasonable and medically necessary for the diagnosis and/or treatment of an illness or injury or a malfunctioning body member.

To be considered reasonable and medically necessary, items and services must have been established as:

1. safe and effective;

2. consistent with the symptoms and/or diagnosis of the illness or injury under treatment;

3. consistent with generally accepted professional medical standards (e.g., not experimental or investigational or procedures where an assistant at surgery is ordinarily not necessary);

4. not furnished primarily for the convenience of the patient, the attending physician, or other physician or supplier; and

5. furnished at the most appropriate level of care.

Services and items considered to be not reasonable and medically necessary include those that are:

1. not generally accepted in the medical community as safe and effective in the setting and for the condition for which it is used;

2. not proven to be safe and effective based on authoritative evidence;

3. experimental;

4. not medically necessary in the particular case;

5. furnished at a level, duration or frequency that is not medically appropriate;

6. not furnished in accordance with accepted standards of medical practice; or

7. not furnished in a setting appropriate to the patient's medical needs and conditions.

For purposes of this section, **physician** means physician or *other practitioner* (i.e., PA, NP, CNS, nurse midwife, and clinical psychologist) authorized by the Act to receive payment for services "incident to" his/her own services.

A. Non-Physician Practitioners – Billing Options

A.1 - Direct billing – PAs, NPs, CNSs, certified nurse midwives, clinical psychologists, clinical social workers, physical therapists and occupational therapists all have their own benefit categories and may provide services without direct physician supervision and bill directly for these services. When their services are provided as auxiliary personnel and under direct physician supervision, they may be covered as "incident to" services, in which case, the "incident to" requirements would apply.

A.2 - "Incident to" billing – For office/clinic (POS 11) services of an NPP to be covered as "incident to" the services of a physician, the services must meet all the requirements for coverage specified within the "incident to" criteria. For example, the services must be an integral, although incidental, part of the physician's personal professional services and they must be performed under the physician's *direct* supervision. "Incident-to" does not apply to Hospital settings (see below).

A.3 - Shared/Split billing – Applies to Hospital Inpatient (POS 21), Hospital Outpatient (POS 22), and Emergency Department (POS 23) settings. When sharing an E/M service with a physician, Shared/Split guidelines apply. All requirements must be met in order to report these services.

B. "Incident to" physician services

B.1 - Requirements for "incident to"

- The services are commonly furnished in a physician's office.
- The physician must have initially seen the patient.
  - Incident to services may only be provided by the NPP when the patient and the problem being addressed are "established".
  - New patients and new problems must be addressed by the Physician first.
- There is direct personal supervision by the physician of auxiliary personnel, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician.
- The physician has an active part in the ongoing care of the patient.

B.2 - Auxiliary personnel - Auxiliary personnel means 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 of the legal entity that employs or contracts with the physician. Likewise, the supervising physician may be an employee, leased employee or independent contractor of the legal entity billing and receiving payment for the services or supplies.

B.3 - Supervision requirements –

General Supervision - General Supervision - means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.

Direct Supervision – means the physician *must be present* and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed, but there in the office.

Personal Supervision - means a physician *must be in attendance in the room* during the performance of the procedure.

B.4 - Documentation requirements –
For "incident to" services that are billed and undergoing medical review, documentation sent in response to the carrier's request should clearly show the link.

***Evidence of the link may include*:**
B.4.1. Co-signature or legible identity and credentials (i.e., MD, DO, NP, PA, etc.) of both the practitioner who provided the service and the supervising physician on documentation entries.
B.4.2. Some indication of the supervising physician's involvement with the patient's care. *This indication could be satisfied by:*

- Notation of supervising physician's involvement (the degree of which must be consistent with clinical circumstances of the care) within the text of the associated medical record entry.

Or,

- Documentation from other dates of service (e.g., initial visit, etc.) other than those requested, establishing the link between the two providers.

Failure to provide such information may result in denial of the claim for lack of documentation from the billing provider.

C. Shared/Split visits -

C.1 - Office/Clinic Setting – Please refer to "Incident to" guidelines above in section B.

C.2 - Hospital Inpatient/Outpatient/Emergency Department - When a hospital inpatient/hospital outpatient or emergency department E/M service is shared between a physician and an NPP from the same group practice, and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's provider number. However, if there was *no face-to-face encounter* between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record), *the service may only be billed under the NPP's provider number*.

Examples of Shared Visits:
A. If the NPP sees a **hospital inpatient** in the morning and the physician (from the same group practice) follows later with a face-to-face visit with the patient on the same day, the physician or the NPP may report the service. Both providers must document and sign their contribution to the service.

B. In an office setting, the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met, the physician reports the service. If the "incident to" requirements are not met, the service must be reported using the NPP's name and NPI number.

C.3 - Skilled and Non-Skilled Nursing Facilities - Any E&M service reported with an SNF/NF place of service must be performed by the billing physician/NPP. Split/shared E&M visits cannot be reported in the SNF/NF settings.

D. Resident and Student Documentation

Several UT Non-Physician Practitioners have their own patient clinics where they perform and report their own services directly. NPPs do not fall under the GME Guidelines. As such, NPPs may not supervise Residents in their clinics. The only portion of the Resident's documentation that may be used for NPP billing may be the reference to the Resident's ROS and Past, Family, and Social History. All other elements of the E/M service must be performed and documented by the Non-Physician Practitioner for billing purposes. Procedures and E/M services performed by the Resident in absence of a Teaching Physician's supervision are not billable.

Medicare does not reimburse for any service performed by a *student*. Medical students and Non-Physician Practitioner students (NP/PA) may only contribute the same portions of the history as outlined above for Residents. All other elements of the visit must be performed and documented by the Non-Physician Practitioner.

E. Scribing, Transcribing, and Shared/Split Documentation

E.1 – Scribing –

A scribe is a human recorder. The scribe documents exactly as the physician tells them to without personally contributing any medical judgment, observation, or clinical insight to the medical record. Billing NPPs are prohibited from Scribing according to the UT Scribe Policy.

E.2 - Transcribing –

When performing in a transcriptionist capacity, you will need to sign the dictation with a transcriptionist recorder signature, and task to your supervising physician. Transcriptionists *do not* participate in the service, they dictate from the physician's handwritten, dictated, or verbal instruction.

E.3 – Shared/Split Documentation –

Only applies to E/M services in the hospital setting. Each provider must document their own portion of the E/M service occurring on the same date. Each entry needs to be signed and dated by the author.

MEDICAID GUIDELINES

II. Nurse Practitioner (NP) and Certified Nurse Specialists (CNS) –

Services performed by NPs and CNSs are benefits if the services meet the following criteria:

- Are within the scope of practice for APNs, as defined by Texas state law.
- Are consistent with rules and regulations promulgated by the Texas BON or other appropriate state licensing authority.
- Are covered by Texas Medicaid when provided by a licensed physician (MD or DO).
- Are reasonable and medically necessary as determined by HHSC or its designee.

Procedures billed by an NP or CNS may be reviewed retrospectively for appropriateness. Independently enrolled NPs and CNSs with a valid Medicare provider number are eligible to receive payment of deductible and coinsurance amounts as appropriate on Medicare crossover claims.

III. Physician Assistants (PA)

To enroll in Texas Medicaid, a PA must be licensed and recognized as a PA by the Texas Medical Board.

Enrollment as an individual provider is not mandatory. PAs currently treating clients and billing under the supervising physician's provider identifier can continue this billing arrangement.

All PA services must be delivered according to protocols developed jointly within the scope of practice and state law governing PAs.

Procedures billed by PAs may be reviewed retrospectively for medical necessity. Independently enrolled PAs with a valid Medicare provider number are eligible to receive payment of deductible and coinsurance amounts as appropriate on Medicare crossover claims.

Medicaid Claims for PA services must include modifier **U7** on the claim details to indicate that the client was treated by a PA.

V. Licensed Clinical Social Workers (LCSW)

MEDICAID GUIDELINES:

LCSW counseling services are a benefit for clients suffering from a mental, psychoneurotic, or personality disorder, when performed in the office (place of service [POS] 1), home (POS 2), skilled nursing facility (SNF) (POS 4), outpatient hospital (POS 5), nursing facility (POS 8), or other location (POS 9). When billing for contracted LCSW counseling services provided to Medicaid clients who are 20 years of age or younger and reside in a residential treatment facility, providers should use POS 9 (other location).

LCSWs must not bill for services provided by people under their supervision, including services provided by students, interns, or licensed professionals under their supervision *(this LCSW rule also applies to Medicare patients).* Only the licensed LCSW and Medicaid-enrolled practitioner providing the service may bill Medicaid. LCSWs that are employed by or remunerated by another provider may not bill Medicaid directly for counseling services if that billing would result in duplicate payment for the same services.

Procedure codes 90806, 90847, and 90853 are allowable for services provided by an LCSW on an hourly basis. When billing or providing family counseling services (procedure code 90847), note the following requirements for Medicaid reimbursement:

- The client must be present when family counseling services are provided.
- Family counseling is only reimbursable for one family member per session.

According to the definition of "family" provided by HHSC Household Determination Guidelines, only specific relatives are allowed to participate in family counseling services. These guidelines also address the roles of relatives in supervision and care of children with Temporary Assistance for Needy Families (TANF). The following specific relatives are included in family counseling services:

- Father or mother
- Grandfather or grandmother
- Brother or sister
- Uncle, aunt, nephew, or niece
- First cousin or first cousin once removed
- Stepfather, stepmother, stepbrother, or stepsister

When billing for family, group, or individual counseling services, the time spent with the client must be reflected on the claim form as follows:

- 30 minutes are billed as 0.5 hour.
- 60 minutes are billed as 1 hour.
- 90 minutes are billed as 1.5 hours.
- 120 minutes are billed as 2 hours.

The time indicated on the claim form must be the time actually spent with the client.

Each individual practitioner is limited to performing a combined total of 12 hours of behavioral health services per day.

Claims submitted with a prior authorization number are not exempt from the 12-hour limitation.

Refer to: "Benefits and Limitations" for details about the 12-hours-per-day behavioral health services limitation. (Medicaid Manual)

Outpatient behavioral health services are limited to 30 encounters/visits per client, per calendar year (January 1 through December 31) regardless of provider, unless prior authorized. This limitation includes encounters/visits by all practitioners. School Health and Related Services (SHARS) behavioral rehabilitation services, mental health/mental retardation (MHMR) services, laboratory, radiology, and medication monitoring services are not counted toward the 30-encounter/visit limitation. An encounter/visit is defined as each hour of therapy, psychological, and/or neuropsychological testing rendered per hour, per provider. Clients should receive no more than four hours of therapy per day. Each Medicaid client is limited to 30 encounters/visits per calendar year.

It is anticipated that this limitation, which allows for 6 months of weekly therapy or 12 months of biweekly therapy, is adequate for 75 to 80 percent of clients. Clinicians should plan therapy with this limit in mind. However, it may be medically necessary for some clients to receive extended encounters/visits. In these situations, prior authorization is required. *A provider who sees a client regularly and anticipates that the client will require encounters/visits beyond the 30-encounter/visit limit must submit the request for prior authorization before the client's 25th encounter/visit.*

It is recognized that a client may change providers in the middle of the year, and the new provider may not be able to obtain complete information on the client. In these instances, prior authorization may be made before rendering services when the request is accompanied by an explanation as to why the provider was not able to submit the prior authorization request by the client's 25th encounter/visit.

All authorization requests for an extension of outpatient psychotherapy sessions beyond the annual 30-encounter/visit limitation are limited to ten encounters/visits per request and must be submitted on the Extended Outpatient/Counseling Request Form. Requests must include the following:

- Client name and Medicaid number
- Provider name and provider identifier
- Clinical update, including specific symptoms, response to past treatment, and treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency of encounters/visits)
- Number and type of services requested, and the dates based on the frequency of encounters/visits that the services will be provided

All areas of request must be completed with the information required by the form. If additional room is needed, providers may state "see attached," but the attachment must contain the specific information required in that section of the form.

Refer to: "Request for Extended Outpatient Psychotherapy/Counseling Form" (Medicaid Manual)

Prior authorization is not granted to providers who have been seeing a client for an extended period of time or from the start of the calendar year and who have not requested prior authorization before the 25th encounter/visit. *It is recommended that a request for extension of outpatient behavioral health services be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided*.

The number of encounters/visits authorized is dependent on the client's symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. *The request for additional encounters/visits must include new documentation that addresses the client's current condition, treatment plan, and the therapist's rationale supporting the medical necessity for these additional encounters/visits.* Prior authorization for an extension of outpatient behavioral health services is granted when the treatment is mandated by the courts as a court-ordered service. A copy of the court order for outpatient treatment signed by the judge must accompany prior authorization requests.

Mail or fax the request to:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Providers can submit requests for extended outpatient psychotherapy/counseling through the TMHP website.

Refer to: "Prior Authorization Requests through the TMHP Website" for additional information, including mandatory documentation and retention requirements.

The following services are not covered by Medicaid (except where specifically indicated in other sections):

- Music or dance therapy
- Services provided by a licensed chemical dependency counselor (LCDC), psychiatric nurse, mental health worker, or a psychologist assistant
- Thermogenic therapy, recreational therapy, psychiatric daycare, and biofeedback
- Hypnosis
- *Adult activity* and *individual activity* (these types of services would be payable only if guidelines of group therapy are met and are termed group therapy)

Documentation requirements as outlined below under (LPC).

VI. Licensed Professional Counselors (LPC)

To enroll in Texas Medicaid, whether as an individual or as part of a group, an LPC must be licensed by the Texas Board of Examiners of Professional Counselors. LPCs are covered as Medicaid-only providers; therefore, enrollment in Medicare is not a requirement. LPCs can enroll as part of a multi-specialty group whether or not they are enrolled in Medicare. Providers that hold a temporary license are not eligible to enroll in Medicaid.

LPCs cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

Documentation Requirements - Services that are not supported by required documentation in the client's record are subject to recoupment.

Clients for whom services are billed must have the following documentation included in their records and the documentation must comply with these standards:

- All entries must be clearly documented and legible to individuals other than the author.
- All entries must be dated (month/day/year) and signed by the performing provider.
- Notations of the beginning and ending session times
- All pertinent information regarding the client's condition to substantiate the need for services, including but not limited to the following:
    - Diagnosis
    - Behavioral observations during the session
    - Narrative description of the counseling session
    - Narrative description of the assessment, treatment plan, and recommendations

IV. Genetic Counseling

Basic contract requirements are as follows:

- The provider's medical director must be a clinical geneticist (doctor of medicine [MD] or doctor of osteopathy [DO]) who is licensed by the Texas Medical Board and who is board eligible/certified by the American Board of Medical Geneticists (ABMG).
- The provider must use a team of professionals to provide genetic evaluative, diagnostic, and counseling services. The team rendering the services must consist of professional staff including a clinical geneticist (MD or DO) and at least one of the following: nurse, social worker, medical geneticist (Ph.D.), or *genetic counselor*.

Upon DSHS approval, TMHP issues a provider identifier number and a performing provider identifier for the provision of genetic services.

A provider cannot be enrolled if his or her license is due to expire within 30 days; a current license must be submitted.

V. Certified Registered Nurse Anesthetist (CRNA)

Medically necessary services performed by a CRNA are benefits if the services are within the scope of the CRNA's practice as defined by state law; are prescribed, supervised by, and provided under the direction of a supervising physician (MD or DO), dentist, or podiatrist licensed in the state in which they practice; or are provided under one of the following conditions:

- No physician anesthesiologist is on the medical staff of the facility where the services are provided (e.g., rural settings).
- No physician anesthesiologist is available to provide the services, as determined by the policies of the facility in which the services are provided.
- The physician performing the procedure requiring the services specifically requests the services of a CRNA.
- The eligible client requiring the services specifically requests the services of a CRNA.
- The CRNA is scheduled or assigned to provide the services according to policies of the facility in which the services are provided.
- The services are provided by the CRNA in connection with a medical emergency.

Texas Medicaid does not reimburse the CRNA for equipment, drugs, or supplies-they are the responsibility of the facility where the CRNA services are provided. If the equipment, drugs, and supplies are covered and reimbursable by Texas Medicaid, payment is considered for the Medicaid-enrolled facility. The basis and amount of reimbursement depends on the reimbursement methodology used by Texas Medicaid for the services and providers involved.

Counseling

Counseling includes prognosis, recurrence risks, family planning implications, and the options available to family members who are at increased risk for giving birth to individuals with the same condition. A counseling procedure code should be submitted if counseling is the only service provided.

NPP REFERENCES:

- CR 5288, located at ***http://www.cms.hhs.gov/Transmittals/downloads/R87BP.pdf***

- *Medicare Benefit Policy Manual*, Chapter 15 (Covered Medical and Other Health Services), Sections 50.3 (Incident To Requirements for Coverage of Drugs and Biologicals That Are Not Usually Self-Administered), 60 (Services and Supplies Furnished Incident To a Physician's/NPP's Professional Service), 60.1 (Incident To Physician's/NPP's Professional Services in Office or Physician/NPP Owned and Operated Clinic), 60.2 (Services of Nonphysician Personnel Furnished Incident To Physician's Services), and 60.3 (Incident To Physician's/NPP's Services in Physician/NPP Owned and Operated Clinics) as an attachment to that CR.

- 'Incident to', Shared and Scribed Services Documentation Errors (12/15/2009) http://www.trailblazerhealth.com/Tools/Notices.aspx?ID=13440&DomainID=1

- http://www.cms.hhs.gov/Manuals/IOM/list.asp
- MLN Matters Number :MM5288 http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5288.pdf
- Incident to Policy Update – CMS CR 5288
- 2010 Medicaid Manual – http://www.tmhp.com/Manuals/TMPPM/Output/Frameset.html
    - NP/CNS - http://www.tmhp.com/Manuals/TMPPM/Output/Frameset.html
    - PA - http://www.tmhp.com/Manuals/TMPPM/Output/Frameset.html
    - LCSC - http://www.tmhp.com/Manuals/TMPPM/Output/Frameset.html
    - LPC - http://www.tmhp.com/Manuals/TMPPM/Output/Frameset.html
    - Genetic Counseling - http://www.tmhp.com/Manuals/TMPPM/Output/Frameset.html
    - CRNA - http://www.tmhp.com/Manuals/TMPPM/Output/Frameset.html

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ACKNOWLEDGEMENT OF MSRDP/UTP PRACTICE GUIDELINES

I, the undersigned Non-Physician Practitioner, by signing this document, acknowledge receipt of a copy of the Medical Service Research and Development Plan (MSRDP)/ UT NPP (UTP) Guidelines. Furthermore, I acknowledge that the MSRDP/UTP Guidelines were discussed with me and I had the opportunity to ask questions regarding the portions of the MSRDP/UTP Guidelines that required clarification. Medical Service Research and Development Plan/UT Non-Physician Practitioner (NPP) representatives answered all of my questions regarding the MSRDP/UTP Guidelines to my satisfaction.

I understand that MSRDP/UTP personnel will generate billing claims on my behalf for professional services that I render as an NPP. The billing claims will be based upon documentation provided by me. I understand that any false claims, false statements, false documents, undocumented services or improperly documented services, or any concealment of a material fact regarding professional services rendered by me may be prosecuted under applicable federal and/or state law and the knowing submission of false claims may subject me to criminal charges, civil penalties, and/or forfeitures.

I agree to conduct my medical practice within the context of the MSRDP/UTP Guidelines. Furthermore, I acknowledge I understand that all professional services I render must be documented in the patient's medical record according to the MSRDP/UTP Guidelines, appropriate hospital/institutional by-laws, and applicable federal/state regulations.

_____ _____

Non-Physician Practitioner (PRINT) Department

_____ _____

Signature Date

Approved, MSRDP CEC: May 18, 2010