Avoiding Medicare Fraud part 2

Abstract

In 1997, Congress authorized payments to nurse practitioners (NPs) for Medicare-provided services. NP services are now reimbursed at 85% of the physician fee schedule. As this source of reimbursement was realized, so was a new area of liability for NPs. Failure to follow billing rules can result in payment denial, repayment of fees already paid, mandated educational activities, fines, fraud prosecution, loss of Medicare-billing ability, and loss of employment. Appropriate billing entails adhering to guidelines for selecting procedure codes and proper medical documentation. This article identifies high-risk areas for NPs who bill Medicare and provides resources for accessing additional information.

Editor's note: This article is part 2 of a two-part series on avoiding Medicare fraud. Part 1 appeared in last month's issue.

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Collaboration Requirement

Medicare law requires NPs to collaborate with a physician. Medicare law defines collaboration as "a process in which a nurse practitioner has a relationship with one or more physicians to deliver health care services, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as defined by the law of the State in which the services are performed."[9] The physician supervision requirement excludes diagnostic tests payable under the physician fee schedule and performed by an NP or clinical nurse specialist authorized to perform such tests under applicable state laws.[10]

"Incident to" Billing

Medicare allows physicians to bill for services provided by nonphysicians, as if the services were actually provided by a physician. This process, termed "incident to" billing, continues to cause confusion. The definition of "incident to" services is "services 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." The term is applicable only to the Medicare program.

"Incident to" billing was intended to allow physicians to bill for services performed in their offices by ancillary staff. For example, "incident to" rules allow a physician to bill for services of a technician who performs an electrocardiogram as if the service was provided by the physician. Services billed "incident to" will be paid at the full physician's fee schedule rate.

"Incident to" rules allow a physician to bill an NP's ser-

vices under the physician's number under specific conditions. To bill NP services as "incident to," the NP service must be rendered under a physician's direct personal supervision. The NP must be an employee of a physician or physician group. Services must be "furnished during a course of treatment where a physician performs an initial service and subsequent services of a frequency which reflect the physician's active participation in and management of a course of treatment."[11] Direct personal supervision in the office setting does not mean that a physician must be in the same room as an NP. However, a physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the NP is performing services.

MEDICARE ALLOWS physicians to bill for services provided by nonphysicians, as if the services were actually provided by a physician. This process, termed "incident to" billing, continues to cause confusion. "Incident to" rules allow a physician to bill an NP's services under the physician's number under specific conditions. To bill NP services as "incident to," the NP service must be rendered under a physician's direct personal supervision.

An NP may bill for services provided by ancillary staff if parallel conditions are met. A practice may bill some of an NP's services under the NP's number and some of the NP's services under a physician's number. The current wording of the rules for billing "incident to" are problematic for NPs and their physician employers. The phrase "Physicians perform an initial service and subsequent services of a frequency which reflect the physician's active participation in and management of a course for treatment," which describes the circumstances under which a nonphysician's services may be billed incident to a physician's services, may be interpreted in two ways. A clinician is likely to interpret "initial service" to mean "new patient visit." A nonclinician may interpret "initial service" as any new course of care for an established patient. Similarly, "susbequent services of a frequency which reflect the physician's active participation" could be interpreted in various ways. Until the HCFA provides clarification, "incident to" billing is risky.

NPs are advised to bill under their number when the following occurs: when an NP conducts a new patient visit, when an NP initiates a course of treatment for an established patient, when a physician is not physically within the office suite, or when NP services are provided in a hospital, home, or nursing home. However, the following exceptions may apply: (1) NP services may be billed "incident to" if a physician accompanies the NP to a home visit or (2) NP services may be billed "incident to" if the services are provided in an office within a skilled nursing facility, a physician pays rent for the office, and a physician is present in that office when the NP is providing the services billed.

If someone—perhaps a patient who notices that his bill is from a physician when his visit was with an NP—reports an irregularity to a Medicare carrier, the HCFA may initiate an investigation that includes a review of the office schedules. When a physician is not scheduled to work and an NP bills for services "incident to," then the HCFA will be able to prove that bills were submitted fraudulently.

Documentation

Payers may require documentation to validate the site of service, the medical necessity and appropriateness of services provided, and that services have been accurately reported. For documentation, payers require a copy of the progress note, which is traditionally written by the provider and kept in the patient's medical record (see Table 3).

Physician services are reimbursed according to a fee schedule published each year by the HCFA. Fees correspond to procedure codes. The HCFA bases its fees on CPT, a coding system developed and copyrighted by the American Medical Association.

The HCFA recently developed and revised *Evaluation and Management Documentation Guidelines*, which indicate the amount of documentation required for each of the five levels of evaluation and management visits. The guidelines, which were published in 1995 and revised in 1997 and June 2000, are available on the HCFA Web site http://www.hcfa.gov. The HCFA is pilot-testing the proposed guidelines that were published last year. The target date for formal adoption of new guidelines is 2002. Meanwhile, the HCFA's status report accompanying the 2000 revision states, "During the study period and until new documentation guidelines are implemented, contractors will be instructed to continue review of medical records according to the 1995 and 1997 documentation guidelines using whichever documentation guidelines are more beneficial to the physician."

Choosing CPT Codes

NPs must base their choice of procedure code on the amount and complexity of evaluation and management services provided. Evaluation and management services include history taking, physical examination, medical decision making, coordination of care, and counseling. Although coordination of care is required, there is no upgrade of the procedure code for the provision of coordination of care. Similarly, counseling is expected and required; however, counseling is a factor in reimbursement only when more than 50% of the visit is spent on counseling. If more than 50% of the provider's time with a patient is devoted to counseling, then the level of visit billed may be based on time spent, rather than documentation of history, examination, and medical decision making. *Current Procedural Terminology* should be consulted for the procedure codes that correspond to the number of minutes spent counseling.

Counseling includes providing diagnostic results, impressions, or recommended diagnostic studies; discussing prognosis; discussing risks and benefits of treatment options; providing instructions for treatment or follow-up; discussing the importance of compliance with treatment options; discussing how to reduce risk factors; and educating patients and families.

Unless a visit fits this definition of a counseling visit, the HCFA guidelines and CPT base choice of procedure codes on three aspects of medical work: history taking, physical examination, and medical decision making. A comparison of the requirements for documentation of history taking and examination from the 1995, 1997, and 2000 guidelines for visit levels 1 to 5 are provided in Table 4. NPs should follow the 1995 or 1997 guidelines until the 2000 version has been tested and finalized.

Table 3

HCFA General Requirements for Documentation

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include the chief complaint and/or reason for the encounter and relevant history; physical examination findings and prior diagnostic test results; assessment, clinical impression, or diagnosis; a plan for care; the date of care; and a verifiable, legible identity of the health care provider who provided the service.
3. If not specifically documented, the rationale for ordering diagnostic and other ancillary services should be apparent.
4. To the greatest extent possible, past and present diagnoses and conditions, including those in the prenatal and intrapartum period that affect the newborn, should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to treatment, changes in treatment, planned follow-up care and instructions, and diagnosis should be documented.
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by medical record documentation.
8. Addendums to medical records should be dated the day the information is added to the medical record and not the day the service was provided.
9. Services should be documented at the time, or soon after, they are provided in order to maintain accurate medical records.
10. Medical record confidentiality should be maintained consistent with medical ethics and legal requirements.

History Taking

Under the guidelines, providers must base their selection of visit level (1 to 5) on the number of history elements they have documented. The guidelines address three components of history taking: history of present illness (HPI); review of systems (ROS); and past, family, and social history (PFSH). A provider documenting HPI would count each symptom descriptor as an element of history. For example, if the chief complaint is foot pain, then one element of history of present illness is foot pain duration. A second element is the quality of foot pain. A provider who has documented at least three elements of HPI would meet the criteria for a level 4 visit. A provider who has documented only one element of HPI would meet the criteria for a level 3 visit.

Examination

The HCFA guidelines define elements of examination in various ways, depending on the version. The 1997 guidelines that are currently used provide detailed descriptions of examination elements. For example, if the chief complaint is foot pain, one element of examination is inspection and palpation of the foot and another element is range of motion. The proposed 2000 guidelines state, "The extent of examination performed and documented is dependent upon clinical judgment and the nature of the presenting problem." The proposed 2000 guidelines then direct the provider to base the choice of visit level billed on the number of body areas or organ systems examined and documented. The

body areas are head, neck, chest, abdomen, genitalia, back, and each extremity. The organ systems are ophthalmologic, otolaryngologic, cardiovascular, respiratory, endocrine, gastrointestinal, genitourinary, musculoskeletal, integumentary, neurologic, psychiatric, hematologic/lymphatic, allergic, and immunologic.

Medical Decision Making

Quantifying medical decision making has been problematic for the HCFA. For example, the 1997 guidelines attempted to categorize the difference between a level 3 and a level 4 visit: A visit falls at level 3 if there are two or more self-limited or minor problems, one stable chronic illness, or one acute uncomplicated illness or injury. A visit falls at level 4 if one of the following exists: one or more chronic illnesses with mild exacerbation, progression, or adverse effects of treatment; two or more stable chronic illnesses; a new problem with an uncertain prognosis (such as a breast lump); an acute illness with systemic symptoms; or an acute complicated injury (head injury with brief loss of consciousness).

The American Medical Association strongly objected to such quantification. In the revised June 2000 HCFA guidelines, guidance on translating medical decision making into a procedure code is general. The guidelines indicate that the more severe the problem, the higher the level of visit; the more diagnoses on the differential, the higher the level of visit; the more data reviewed, the higher the level of visit; the more tests ordered or interventions ordered, the higher the level of visit; and the more extensive the treatment plan, the higher the level of visit. The provider should document all that are appropriate to the visit: the severity of the problem, the amount of data to be obtained and reviewed, the diagnoses and differential diagnoses, diagnostic tests ordered, interventions and/or treatment plans, risk of significant complications, and morbidity and/or mortality. NPs should follow the requirements of the 1995 or 1997 HCFA guidelines and CPT until the final guidelines are released.

New Patients versus Established Patients

A new patient is defined as a patient who has not been seen at the practice in the past 3 years; all other patients are considered established. If seeing a new patient, the provider must meet documentation requirements regarding history, examination, and medical decision making. In contrast, if seeing an established patient, the provider must meet the

Table 4

Documentation Guideline Comparison for Visit Levels 1 to 5

Level 1: Documented Elements Required to Bill

	1995	1997	2000
History of present illness	0	0	0
Review of systems	0	0	0
Past, family, and social history	0	0	0
Physical examination	0	0	0

Level 2: Documented Elements Required to Bill

	1995	1997	2000
History of present illness	1	1	1
Review of systems	0	0	0
Past, family, and social history	0	0	0
Physical examination	Not specified*	1	1

Level 3: Documented Elements Required to Bill

	1995	1997	2000
History of present illness	1	1	1
Review of systems	1	1	1
Past, family, and social history	0	0	1
Physical examination	Not specified†	6	1

Level 4: Documented Elements Required to Bill

	1995	1997	2000
History of present illness	4	4	4
Review of systems	2	2	3
Past, family, and social history	1	1	2‡
Physical examination	Not specified§	12	3

Level 5: Documented Elements Required to Bill

	1995	1997	2000
History of present illness	4	4	4
Review of systems	10	10	9
Past, family, and social history	2‖	2‖	2‡
Physical examination	8	18	9

* Number of elements not specified; guidelines state, "limited examination of affected body area."

† Number of elements not specified; guidelines state, "limited examination of affected body area or organ system."

‡ For new patient visits, three elements of past, family, and social history are required: one element from past, one element from family, and one element from social history.

§ Number of elements not specified; guidelines state, "extended examination of affected body area."

‖ For new patient visits, three elements of past, family, and social history are required: one element from past, one element from family, and one element from social history. For hospital, home, emergency, consultation, domiciliary or skilled nursing facility services, the guidelines should be consulted.

Medicare Billing Recommendations for NPs

1. Obtain an individual Medicare provider number and bill under your own number, unless following "incident to" rules.
2. Learn the documentation guidelines.
3. Learn which procedures Medicare covers relevant to your practice area; inform patients that they must pay for noncovered services.
4. Review transmittals from the local Medicare carrier and the Health Care Financing Administration (HCFA) at least once a month.
5. Audit your own documentation on a regular basis.
6. If billing under a physician's number, follow the "incident to" rules.
7. When providing hospital evaluations, substantiate medical necessity of stay in the medical record every day.
8. Substantiate medical necessity of office visits or procedures in each progress note.
9. Use checklists for extended evaluations.
10. If your practice would like to bill your work in a manner that is not addressed by the rules or guidelines, ask for a written advisory opinion from the practice's or hospital's compliance officer, the Medicare carrier, the appropriate office at the HCFA, or a private attorney who specializes in Medicare reimbursement.

Additional resources

1. HCFA Web site: http://www.hcfa.gov.
2. Office of Inspector General Web site: http://www.hhs.gov/oig.
3. American Medical Association: Physicians' current procedural terminology. Chicago, Ill.: American Medical Association.
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7. Holmes D: Practical guide to medical billing. U.S. Department of Commerce, Technology Administration. 703-605-6000 (report number PB98-114374).
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requirements of two of the three components of medical work (for example, history and examination, or history and medical decision making).

Expected Distribution of Visit Codes

Table 4 illustrates that level 5 visits and level 1 visits are going to be few and far between. Government agencies expect that a provider's bills will form a bell curve. For most providers, level 3 is the most common visit. Level 2 and level 4 visits are also common. The HCFA has prosecuted physicians whose billing is skewed toward the higher level codes and who lack supporting documentation. Providers who see patients with complex conditions should survive an audit if documentation supports the bills.

■ Conclusion

The rules for billing Medicare are extensive, complex, and in some areas, open for interpretation; general recommendations are provided in Table 5. The HCFA has clarified expectations in the past few years and will continue to do so. Commercial payers are likely to adopt the Medicare rules. NPs must apply the Medicare rules appropriately so that the services performed are acknowledged and the appropriate payments are captured, but fraud is avoided. Reimbursement has become a core content area—of equal importance to the clinical content areas—for NPs.

REFERENCES

9. 42 USCS §1395x(aa)(6).
10. Federal Register. Final rule, November 2, 1999;59416.
11. Medicare Carrier's Manual. §2050.1.B.

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