UC DAVIS HEALTH

New Provider Billing Compliance Training

v220701

New Provider Billing Compliance Training

The UC Davis Health Compliance Plan requires every new provider who will bill professional charges to complete education on billing compliance within 30 days of hire.

This module is an overview of the Billing and Coding Compliance component of the Compliance Program.

Providers will find more information and resources on Billing & Coding Compliance at:

https://health.ucdavis.edu/compliance/billing_coding/policies_resources/

Presentation Goals

Introduction to UC Davis Health Compliance Department
Overview of Medical Billing Guidelines:
- General Billing Guidelines
- Advanced Practice Providers
- Other Medicare Eligible Providers
- Moonlighting Criteria
- Scribes
- Medical Students
- Teaching Physician and Resident Definitions
- Teaching Physician Requirements

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UC Davis Compliance Department

The objective of the UC Davis Health Compliance Department is to promote and ensure that UC Davis Health's affairs are conducted in accordance with all applicable laws, regulations, and policies.

The Compliance Department serves as a resource providing information on:

- General Compliance
- Research Compliance
- Billing and Coding Compliance
- Privacy

UC Davis Health Billing & Coding Compliance

The Billing and Coding Compliance website contains links to UC Davis Health Policies & Procedures (P&P) to assist with complying with rules and regulations:

https://health.ucdavis.edu/compliance/billing_coding/policies_resources/

- P&P 1259: Physician Assistant (PA) Services: Guidelines for Professional Billing
- P&P 1260: Nurse Practitioner (NP) Services: Guidelines for Professional Billing
- P&P 1905: Drug Documentation and Billing
- P&P 1920: Coding Rules for Evaluation and Management Services and Preventive Services
- P&P 1922: Compliance Monitoring, Auditing, Review and Reporting Standards
- P&P 1924: Evaluation and Management Consultation Guidelines
- P&P 1925: Billing for Fellows and Cost Report Accounting
- P&P 1928: Teaching Physician Guidelines for Professional Fee Billing
- P&P 1930: Scribe Notes
- P&P 2305: Approved Abbreviations
- P&P 2307: Medical Record Documentation Standards

Medical Billing Guidelines – General Billing Guidelines

To ensure that professional billing accurately reflects the services rendered, general billing guidelines apply to all providers:

- Services must be medically necessary and rendered by qualified health care professionals in accordance with the professional's scope of practice.
- Unless directed otherwise by a payor, services must be billed under the name of the rendering provider. They may not be billed under a provider that only co-signs the note of a provider awaiting enrollment with a payor.
- Assignment of CPT, HCPCS, and ICD-10 codes is based on the medical record documentation and payor specific guidelines.

Medical Billing Guidelines - Advanced Practice Providers

Advanced Practice Providers (APPs) include:

- Certified Registered Nurse Anesthetists (CRNA)
- Clinical Nurse Specialists (CNS)
- Nurse Practitioners (NP)
- Physician Assistants (PA)

In addition to the general billing guidelines, the following may be applicable to services furnished by APPs:

Medicare Incident-to Billing

Medi-Cal Non-physician Medical Practitioner (NMP) billing guidelines

Medical Billing Guidelines - Medicare Incident-to Billing

Incident-to billing of professional services - billing services provided by APPs or auxiliary personnel under the name and billing number of the supervising physician.

Requirements:

1. The service must be provided in a physician's office, not in a hospital-based setting.
2. A physician must initially see the patient and initiate care.
3. A physician in the same group must be present in the office suite when the incident-to service is provided.

Medical Billing Guidelines - Medicare Incident-to Billing

Requirements continued:

4. The APP or auxiliary personnel and the billing physician must be employed by the group entity billing for the service.
5. A physician in the same group must actively participate in and manage the patient's course of treatment.
6. The incident-to service must be the type of service usually performed in the office setting and must be part of the normal course of treatment.

The APP or auxiliary personnel providing the service should document the name of the supervising physician.

Medical Billing Guidelines - Medi-Cal Non-Physician Medical Practitioner (NMP)

Physician Assistants (PAs)

- PAs may enroll in Medi-Cal but are never an independent Medi-Cal provider.
- PAs may not directly bill and receive payment from Medi-Cal. Instead, payment is made to the PA's employer. The supervising physician's provider number must be entered as the rendering physician on each applicable claim line. The PA's name, provider number and type of NMP-PA is included in the "remarks" section of the claim.

Nurse Practitioners (NPs)

- NPs may enroll in Medi-Cal but only Certified Nurse Practitioners (CNPs) are permitted to enroll as independent Medi-Cal providers.
- NPs (other than CNPs) may not directly bill and receive payment from Medi-Cal. Instead, payment is made to the NP's employer. The supervising physician's provider number must be entered as the rendering physician on each applicable claim line. The NP's name, provider number and type of NMP-NP is included in the "remarks" section of the claim.
- NP billable services are limited to those list in the Medi-Cal NMP manual and must be billed with modifier "SA".

Medical Billing Guidelines - Medi-Cal Non-Physician Medical Practitioner (NMP)

Certified Nurse Practitioners (CNPs)

- CNPs may enroll in Medi-Cal as independent providers.
- CNPs can bill only for services within their scope of practice. All CNP services are reimbursed at 100% of the amount paid to physicians for the same service.
- CNP providers billing for services with their own provider numbers must not use the nurse practitioner modifier “SA”.
- When billing for services with their own provider numbers, CNPs may use any modifier (except “SA”) appropriate with the procedure code billed.

Other Medicare Eligible Providers

The following practitioners may also enroll in Medicare, however, the ability to bill for their professional services is dependent on their employer (e.g., hospital or physician group), where services are rendered (e.g., hospital setting versus medical office), and their scope of practice:

- Clinical Social Worker
- Occupational Therapist in Private Practice
- Physical Therapist in Private Practice
- Qualified Audiologist
- Speech Language Pathologist in Private Practice
- Registered Dietitian or Nutrition Professional

Other Medicare Eligible Providers

If employed by the hospital, steps must be taken to ensure that the expenses associated with rendering professional billable services (e.g., salary and benefits) are not reported on the Medicare and Medicaid cost reports.

Services provided to hospital inpatients by these providers are not billable as professional services to Medicare.

The general billing guidelines apply to these providers as well:

- Services must be medically necessary and rendered by qualified health care professionals in accordance with the professional's scope of practice.
- Unless directed otherwise by a payor, services must be billed under the name of the rendering provider. They may not be billed under a provider that only co-signs the note of a provider awaiting enrollment with a payor.
- Assignment of CPT, HCPCS, and ICD-10 codes is based on the medical record documentation and payor specific guidelines.

Moonlighting Criteria

Moonlighting refers to a resident or fellow working as an independent physician, outside the scope of the resident's training program.

Outpatient and inpatient services rendered by a resident at UCDH that are not related to the GME program in which the resident participates are covered as physician services when the all of the following criteria are met:

1. The services are identifiable physician services;
2. The resident is fully licensed in the State;
3. The services performed can be separately identified from those services that are required as part of the approved GME program;
4. The physician is credentialed and privileged by UCDH in accordance with the Medical Staff Administration Policy and Procedure "Moonlighter Privileges"; and
5. There is a signed written agreement approved by the Department Chair.

Scribes

A scribe is a person employed or contracted by UCDH to document “word for word” a service being performed by a UC Davis Health healthcare provider without applying any clinical insight or observation.

NPs and PAs cannot act as scribes as their job descriptions do not allow it; however, NPs and PAs may utilize scribes if approved by their departments.

A scribe’s note must accurately reflect the services provided on a specific date of service. It must be a dated, signed note that includes the following elements:

- Identifies them as a scriber of the service and identifies their credentials;
- Attests that the notes are written/recorded contemporaneously in the presence of the physician performing the service;
- Identifies the physician.

Use of the Scribe Statement SmartPhrase assists with fulfilling these requirements.

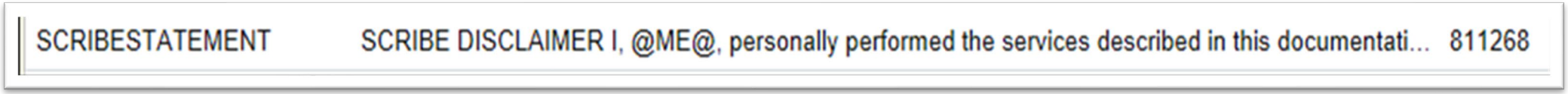
SCRIBE	SCRIBE STATEMENT I, @ME@, am personally taking down the notes in the presence of Dr. ***....	811267

Scribes

The billing provider is ultimately responsible for the content of the scribed note.

The billing provider must attest that the scribed note is accurate after assuring any corrections and/or modifications have been made. For example: “I personally performed the services described in this documentation as scribed by (scribe name) in my presence, and it is both accurate and complete.

There is also a SmartPhrase for use by providers that assists with fulfilling these requirements:



Students

Medical Student

- A person attending medical school who has not received their doctorate and is not considered a resident.
- Any contribution of a medical student to the performance of a billable service (other than taking a Review of Systems or Past Family Social History in the case of an Evaluation and Management service) must be performed in the physical presence of a physician or performed jointly with a resident.

Medical, physician assistant, and nurse practitioner students may document in the medical record; however, the billing provider must personally perform (or re-perform) the physical exam and medical-decision-making activities of the E&M being billed and verify the student documentation to use it instead of redocumenting the work.

The SmartPhrase "MEDSTUDENTLINKINGLANGUAGE" may be used to document the billing provider's attestation of presence and personal performance of the required elements when using student documentation:

"I was physically present with the medical student during the examination of the patient. I personally examined this patient and developed the assessment and plan. I verified the student's documentation and made changes as appropriate. The documentation accurately reflects my findings of the patient's history and exam, and my assessment and plan."

Teaching Physicians and Resident Definitions

Teaching physicians include:

- Any physician (other than a resident) who involves residents in the care of his or her patients;
- Faculty physician;
- Attending physician;
- An individual enrolled in an ACGME-approved or ABMS-approved residency program may be considered a teaching physician when moonlighting criteria are satisfied.

Residents include:

- All residents and fellows in an American College of Graduate Medical Education (ACGME) or American Board of Medical Students (ABMS) approved program.
- A physician who is not in an approved GME program, but who is authorized to practice only in a hospital, for example, individuals with temporary or restricted licenses, or unlicensed graduates of a foreign medical school.

Teaching Physicians – Payors

Policies differ in application based on payors.

- Examples of State and Federal Payors:
  - Medicare
  - Medi-Cal
  - CCS
- Examples of Non-State and Non-Federal Payors (Commercial payors):
  - Blue Cross
  - Health Net
  - Cigna

Teaching Physicians – E&M – State & Federal Payor Requirements

Evaluation and Management (E&M) services billed by teaching physicians require that the medical record demonstrate:

- The teaching physician performed the service or was physically present during the key or critical portions of the service when performed by a resident;
- The participation of the teaching physician in the management of the patient.

Medi-Cal requires the teaching physician to personally document their presence and involvement in the management of the patient.

The Centers for Medicare and Medicaid Services (CMS) allows the teaching physician's presence during E&M services to be documented in the medical record by physicians, residents, or nurses; however, UC Davis Health requires that the teaching physician personally document their presence through linking language.

Teaching Physicians – Other Services - State & Federal Payor Requirements

Majority of surgical, high-risk, or other complex procedures:

- Teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.

Complex or high-risk procedures for which national Medicare policy, local policy, or the CPT description indicate that the procedure requires personal (in person) supervision of its performance by a physician:

- Teaching physician must be personally present throughout the procedure.
- Includes services such as interventional radiologic and cardiologic supervision and interpretation codes, cardiac catheterization, and cardiovascular stress tests.

Teaching Physicians – Other Services - State & Federal Payor Requirements

Single surgery:

- When the teaching physician is present for the entire surgery, his or her presence may be documented by the physician, resident or operating nurse.

For two overlapping surgeries:

The teaching physician must:

- Be present for the critical or key portions of both operations.
- Personally document that he/she was physically present during the key or critical portions.
- When not present and participating in another procedure, must arrange for another qualified surgeon to assist should the need arise.

Billing global surgical package:

- Teaching physician is responsible for preoperative, operative and post-operative care.
- Teaching physician determines which post-operative visits are key and require his/her presence.

Teaching Physicians – Other Services - State & Federal Payor Requirements

For minor procedures that only take a few minutes (5 minutes or less):

- The teaching physician must be present for the entire procedure in order to bill.

Time-based codes:

- Teaching physician must be present for the period of time used to determine the code.

Endoscopy procedures:

- Teaching physician must be present during the entire viewing.

Interpretation of diagnostic tests:

- When a resident prepares and signs the report, the teaching physician must document that he/she personally reviewed the image and the resident's interpretation and either agrees with it or edits the findings.

Teaching Physicians – Other Services - State & Federal Payor Requirements

Psychiatric services:

- Follows general teaching policy requirements.
- For certain psychiatric services, the teaching physician's presence may be met by concurrent observation of the service by the use of one-way mirror or video equipment.
- Audio-only equipment does not satisfy the presence requirement.
- Only a teaching physician, not a psychologist, may supervise a resident

Teaching Physicians – Other Services - State & Federal Payor Requirements

Anesthesia services:

- Rules vary based on the number of cases in which the teaching anesthesiologist is involved in concurrently.
- Teaching anesthesiologist rules apply when a teaching anesthesiologist is involved in one case with a resident, two concurrent cases with residents or two concurrent cases, one with a resident and one with another case paid under the medical direction rules.
- Teaching anesthesiologist or another anesthesiologist in the same group must be present during all of the critical or key portions and immediately available during the entire procedure.

Teaching Physicians – Other Services - State and Federal Payor Requirements

Maternity services:

- Teaching physician must be present for the delivery.
- In order to bill global obstetrical care (prepartum, delivery, and postpartum), teaching physician must be present for the minimum indicated number of visits when such a number is specified in the CPT code description.

Monthly capitated payment (MCP) for End Stage Renal Disease (ESRD):

- Patient visits furnished by residents may be counted toward the MCP visits if the teaching physician is physically present during the visit.
- Teaching physician may utilize resident's notes; however, the teaching physician must document his or her physical presence during the visit furnished by the resident and that he or she reviewed the resident's notes.

Teaching Physicians – Assistant Surgeons - State & Federal Payor Requirements

Assistant Surgeons

- Services of assistant surgeons are only billable when a qualified resident is not available to perform the surgery.

Documentation requirements:

- No available “Qualified Resident”
- Medical necessity and complexity of the surgery requiring an assistant surgeon
- Completion of the “Assistant Surgeon Certification Statement”

Teaching Physicians – Non-State & Non-Federal Payor Requirements

Evaluation and Management Services

- Attending physician must be available.
- If the service includes direct patient contact with review of the resident's work, the attending physician must document one of the following:
  - Own note describing the complete service provided; or
  - Some of the findings and linking language to incorporate the resident's findings, recommendations and plan into his/her own note; or
  - Linking language identifying his or her involvement with the resident on the management of the patient.

Teaching Physicians – Other Services - Non-State & Non-Federal Payor Requirements

Non-state or non-federal payers typically do not have presence requirements related to “key portions”; however, UCDH requires the attending physician to document presence for all payors as detailed below.

Single surgery:

- Attending physician must be promptly available to provide hands-on care as needed.
- If present for the entire procedure, their presence may be documented in the medical record by the physician, resident, or operating room nurse.
- If not present for entire procedure, attending physician must personally document their involvement in the critical or key portions of the procedure.

Two overlapping surgeries:

- Attending physician must be promptly available to provide hands on care as needed.
- Attending physician must personally document their involvement in the critical or key portions of the procedure.

Teaching Physicians – Non-State & Non-Federal Payor Requirements

Timed-based codes:

- The time spent by a licensed resident, fellow, and attending in providing direct patient care may be summed to determine the total time used to select the CPT code.
- When more than one physician is simultaneously providing the service, only the time of one may be counted.

Endoscopy procedures:

- The attending physician must be available.
- The attending physician must document their level of participation in the medical record.

Interpretation of diagnostic tests:

- The attending physician shall be available to provide assistance, direction, and to view all the data and respond to the resident.
- Charges shall not be submitted for an interpretation if the documentation shows simply a countersignature of the resident's interpretation by the teaching physician.

Teaching Physicians – Non-State & Non-Federal Payor Requirements

Psychiatric services:

- The attending must review the resident's work.
- The attending must demonstrate involvement by personal documentation.

Anesthesia:

- Attending anesthesiologist must be physically available.
- Attending anesthesiologist must document level of participation in the medical record.

Teaching Physicians – Non-State & Non-Federal Payor Requirements

Maternity:

- Attending must be available to provide hands-on care as needed.
- Minimum evidence of the attending physician's supervision must be demonstrated by documentation of their participation and management in the delivery.
- Countersignature alone will not support a billable service.

Monthly capitated payment (MCP) for End Stage Renal Disease (ESRD):

- UCDH has determined that the Medicare teaching physician documentation requirements apply to these services regardless of payor type.
- Patient visits furnished by residents maybe counted toward the MCP visits if the teaching physician is physically present during the visit.
- Teaching physician may utilize resident's notes, however, the teaching physician must document his or her physical presence during the visit furnished by the resident and that he or she reviewed the resident's notes.

Documentation

Medical Record Documentation

- Patient care is a priority for healthcare professionals whether the professional is a physician, advanced practice provider, therapist, or any of the many other types of medical professionals.
- Meeting ongoing patient needs is impossible without documenting each patient encounter completely, accurately, and in a timely manner.
- Meeting patient needs is the most important reason for documenting services.
- Another reason for comprehensive medical record documentation is the need to comply with Federal and State laws that require providers to maintain the records necessary to “fully disclose the extent of the services,” care, and supplies furnished to beneficiaries, as well as support claims billed.

Documentation

Medicare Participation Agreement

According to Medicare reimbursement regulations, a physician must sign an acknowledgement statement when joining a hospital medical staff. The statement is:

- Notice to Physicians: *Medicare payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable federal laws.*

The purpose of this statement is to ensure that the physician is aware of the serious consequences of misconduct in reporting diagnoses and procedures.

Evaluation and Management (E/M) Services Documentation

- Complete and accurate documentation of each patient encounter is essential for patient care and billing.
- Documentation should reflect the medically necessary service provided.
- Per the CMS Claims Processing Manual, Chapter 12, §30.6.1 - Selection of Level of Evaluation and Management Service:
  - Medical necessity of a service is the *overarching criterion* for payment in addition to the individual requirements of a CPT code.
  - It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.
  - The volume of documentation should not be the primary influence upon which a specific level of service is billed.

Documentation

Quality Clinical Documentation should be:

- Patient centered – Reflect the patient's current condition and trajectory of illness.
- Timely - Up-to-date and projecting the most current picture of the patient's status.
- Appropriately concise and relevant - Avoid note bloat, include information that is timely, pertinent and relevant to the patient's current condition.
- Accurate – The author is responsible for all documentation that is signed or cosigned whether the content is original, copied, pasted or imported.
- Compliant – Documentation must be in compliance with all existing department/service, hospital regulatory, legal and billing requirements.
- Appropriately reviewed by supervisor – Trainee notes must be appropriately reviewed in accordance with department/service policy and level of supervision required.

Summary

Federal and state payors have requirements that must be adhered to in order to bill professional services.

UC Davis Health has internal policies and procedures for all providers rendering services.

Additional information on compliant professional billing can be found in the following administrative policies:

1259 - Physician Assistant Services Guidelines for Professional Billing

1260 – Nurse Practitioner Services Guidelines for Professional Billing

1928 – Teaching Physician Guidelines for Professional Fee Billing

1930 – Scribe Notes

1920 – Coding Rules for Evaluation and Management Services and Preventive Services

1924 – Evaluation and Management Consultation Guidelines

Contacts for Questions

- For questions regarding the completion of this course, contact Compliance by email or phone at hs-compliancehelp@ucdavis.edu or (916) 734-8808
- For questions regarding computer difficulty, please contact the Help Desk at (916) 734-HELP.
- For medical coding information, please review the HIM Centralized Coding Leadership page at:
- https://intranet.ucdmc.ucdavis.edu/emr/projects/him_centralized_coding_leadership/index.shtml
- For compliance questions, submit a Compliance Inquiry Form (link on the Compliance website) at Compliance: https://health.ucdavis.edu/compliance/ ; or contact Billing Compliance at hs-codingbillingcompliance@ucdavis.edu or phone (916) 734-8808
- A compliance concern can be reported to the Compliance Hotline via phone at (800) 403-4744 or via the Hotline website: https://secure.ethicspoint.com/domain/media/en/gui/23531/index.html