FREQUENTLY ASKED QUESTIONS FROM PHYSICIAN TRAINING SESSIONS 2007

Q. **Can physicians and nurse practitioners combine documentation to bill a higher level of service for a consultation?**

No. According to the CMS Manual 100-4, Chapter 12, Section 30.6.10, a **consultation** should not be performed as a split/shared E/M visit.

Q. **How do we bill as the attending physician for Hospice patients?**

When a Medicare beneficiary elects hospice coverage he/she may designate an attending physician, not employed by the hospice, in addition to receiving care from 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."

These attending physician services are billed to the Medicare carrier, provided they were not furnished under a payment arrangement with the hospice. The attending physician codes services with the **GV modifier** when billing his/her professional services furnished for the treatment and management of a hospice patient's terminal condition. Payment will be made to the attending physician or beneficiary, as appropriate, based on the payment and deductible rules applicable to each covered service.
If another physician covers for the designated attending physician, the services of the substituting physician are billed by the designated attending physician under the reciprocal or locum tenens billing instructions. In such instances, the attending physician bills using the **GV modifier** in conjunction with either the **Q5 or Q6 modifier**. Services unrelated to a hospice patient's terminal illness may be billed with the **GW modifier** - "Service not related to the hospice patient's terminal condition.

Q. **Is only one initial consult per provider/specialty per hospitalization? In the case of a trauma patient who may be hospitalized for an extended period of time, is it appropriate (for a provider to bill an initial consultation then does not follow the patient, but is consulted again at a later date) to bill a subsequent initial consultation?**

The Initial Inpatient Consultation may reported only **once** per consultant per patient facility admission. The follow-up care shall be reported using the subsequent hospital care codes. Effective January 1, 2006, the follow-up Inpatient Consultation codes (99261-99263) were deleted. In the hospital setting, following the initial consultation service, the Subsequent Hospital Care codes (99231-99233) should be reported for additional follow-up visits. (MCM Chapter 12, Section 30.6.10)

Q. **How can we bill for additional time we have spent with a patient? Prolonged Services?**

The code range for prolonged services is **99354-99357** (Prolonged physician services in the outpatient or inpatient setting requiring direct face-to-face patient contact beyond the usual service). The prolonged care codes would not be used unless the time allotted to the evaluation and management (E/M) code billed has been surpassed by 30 minutes. The code that most appropriately describes the care and treatment given to the patient should be selected. This would include the history, examination, and level of medical decision-making. In the case of prolonged office services, time spent by office staff with the patient, or time the patient remains unaccompanied in the office cannot be billed. In the case of prolonged hospital services, time spent waiting for test results, for changes in the patient's condition, for end of a therapy, or for use of facilities cannot be billed as prolonged services. The medical record must support the billing for prolonged services by documenting the duation and content of the evaluation and management code billed and that the physician has personally furnished at least 30 minutes of direct service after the typical time of the evaluation and management service had been exceeded by at leas

Q. **Can we bill for a Discharge Service on the day a patient dies?**

The CMS Coverage Issues Manual, Cov. 50-19, Pronouncement of Death, states, "According to established legal principles, an individual is not considered deceased until there has been official pronouncement of death. An individual is, therefore, considered to have expired as of the time he/she is pronounced dead by a person who is legally authorized to make such a pronouncement, usually a physician. Reasonable and necessary medical services rendered up to, and including, pronouncement of death by a physician are covered diagnostic or therapeutic services." EG. The SNF Discharge Day Management Service may be reported using CPT code 99315 or 99316, depending on the code requirement, for a patient who has expired, but only if the physician or qualified NPP personally performed the death pronouncement. (MCM 30.6.13.I)

Q. **What is the reimbursement comparison for ventilator management + E/M service vs. Critical Care?**

Ventilator management (94002-94004) cannot be billed with an E/M service. The reimbursement rates according to the 2007 Medicare fee schedule are the following:

Ventilator Management: 94002-$81.95, 94003-$59.62, 94004-$43.43
Critical Care Services: 99291-$202.32, 99292-$101.27

Q. **Where can we obtain a copy of general multi-system & specialty examinations?**

The complete Documentation Guidelines can be found at: http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp

Q. **Where can we obtain a copy of the table of risk?**

The complete Documentation Guidelines can be found at: http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp. The Table of Risk can be found on page 50 of the 1997 Guidelines.

Q. **What is Care Plan Oversight? Can we receive additional reimbursement?**

Care plan oversight is the supervision of patients under care of a home health agency (HHA) or hospice, requiring complex or multidisciplinary care modalities involving regular physician development and/or revision of care plans. Coverage is extended for patients requiring an unusual intensity of work. According to Medicare, a Physician who supervises a patient receiving Medicare-covered services provided by a participating home health agency (G0181-Medicare, 99375-other carriers) or hospice (G0182-Medicare, 99378-other carriers) or nursing facility (99380-other carriers) (patient not present), requiring complex and multidisciplinary care modalities and spends at least 30 minutes or more during a calendar month would be eligible to bill for Care Plan Oversight. (LMRP EM003E02)

The reimbursement rates according to the 2007 Medicare fee schedule are the following:
G0181-$106.86
G0182-$111.74

Q. What is the reimbursement comparison of the different levels of Initial inpatient services? Subsequent hospital visits?

The reimbursement rates according to the 2007 Medicare fee schedule are the following:
Initial Inpatient Visit: 99221-$82.53, 99222-$115.46, 99223-$168.70
Subsequent Hospital Visit: 99231-$34.54, 99232-$61.96, 99233-$88.54

Q. For Teaching Physicians, when should the GC modifier be used?

The **GC modifier** must be entered by the physician for Teaching Physician services rendered in compliance with all the requirements outlined in 100-04, Ch. 12, Section 100.1.1.C of the Medicare Carriers Manual. Physicians billing for Teaching Physician services using this modifier are certifying that they have been present during the key portion of the service and were immediately available during the other parts of the service.

Q. For Teaching Physicians, when should the GE modifier be used?

There are Evaluation and Management (E/M) services that a resident can perform without the presence of a teaching physician under the primary care exception. These services should be billed with the **GE modifier**, the services that can be billed with the GE modifier are limited to specific E/M codes. Per CMS IOM 100-04, Ch. 12, Section 100.1.1.C:
http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf,

Teaching Physicians providing E/M services with a Graduate Medical Education (GME) program granted a primary care exception may bill Medicare for lower and mid-level E/M services provided by residents. For the E/M codes listed below, teaching physicians may submit claims for services furnished by residents in the absence of a teaching physician:

New Patient - 99201, 99202, and 99203
Established Patient - 99211, 99212, and 99213

Effective January 1, 2005, the following code is included under the primary care exception: G0344 - Initial preventive physical examination; face-to-face visit services limited to new beneficiary during the first 6 months of Medicare enrollment."

Q. **Where can we obtain the Teaching Physician Physician Guidelines?**

The guidelines for Teaching Physicians, Interns, and Residents provides information about payment for physician services in teaching settings and general documentation guidelines. The guidelines can be obtained at:

http://www.cms.hhs.gov/mlnproducts/downloads/gdelinesteachgresfctsht.pdf

Q. **What are we to bill when a patient is admitted and discharged on the same date?**

Providers may not bill for both an admission (99221-99223) and discharge visit (99238-99239) on the same day. For an inpatient admission and discharge of less than 8 hours on the same calendar date, CPT codes 99221-99223 should be used for the admission service and the hospital discharge day management should not be billed. When patients are admitted as a hospital inpatient or an observation care patient for a period of 8 or more hours, but less than 24 hours, the admission and discharge should be billed using CPT codes 99234-99236. (LMRP EM007E01)

Q. **What is the correct way to document counseling/coordination of care when it dominates more than 50% of the encounter for the Evaluation and Management (E&M) service?**

A. According to the Medicare Resident and New Physician Guide, 7th Edition, Chapter 6, http://www.cms.hhs.gov/MLNProducts/MPUB/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1184005, in the case where counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), the time is considered the key or controlling factor to qualify for a particular level of E&M service.

If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of the time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.

This documentation should be available to the carrier upon request.

OUTPATIENT QUESTIONS/ANSWERS

Q. **What is Certification/Recertification of Medicare-Covered home health services?**

Physician's services involved in physician certification (and recertification) of Medicare-covered home health services may be **separately coded and reimbursed.** These services include creation and review of a plan of care and verification that the home health agency initially complies with the physician's plan of care. The physician's work in reviewing data collected in the home health agency's patient assessment would be included in these services.

The physician services for **initial certification (G0180)** of Medicare-covered home health services are **billable once for a certification period**. This may be billed when the patient has not received Medicare-covered home health services for at least 60 days. (This means that the patient has not received services for 60 days and does not mean that 60 days has elapsed since the previous certification). Physician services for **recertification (G0179)** of Medicare-covered home health services may be billed after a patient has received services for at least 60 days when the physician signs the certification after the initial certification period. (LMRP EM004E01)

Q. Can we be reimbursed for Smoking and Tobacco Use Cessation Counseling for Medicare patients?

Medicare Part B covers two levels of counseling, intermediate and intensive, for smoking and tobacco use cessation. The coverage is limited to beneficiaries who use tobacco and have disease or adverse health effect found by the U.S. Surgeon General to be linked to tobacco use or who are taking certain therapeutic agents whose metabolism or dosage is affected by tobacco use. Patients must be competent and alert at the time that service are provided. Two attempts are covered each year and each attempt may include a maximum of four intermediate or intensive sessions. A maximum of 8 sessions in a 12-month period is covered. The are two G codes for billing the levels of smoking and tobacco use cessation counseling: **G0375**-Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes. **G0376**-Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes. (Medlearn Article-MM3834)

Q. When can we bill for the Preventive Pap Smear and Pelvic Exam-G0101 & Q0091 for Medicare patients?

A screening Pap smear and a screening pelvic examination (**G0101**)(including clinical breast examination) and the obtaining of the Pap Smear (**Q0091**) are covered by Medicare Part B. HCPCS code G0101 may be billed with an E/M visit if the E&M visit is significant and separately identifiable from the G0101 service. When both services occur at the same encounter, modifier 25 should be utilized on the claim appended to the significant separately identifiable E/M code, and the procedure codes should be shown as separate line items on the claim.
(LMRP-LB001W06)