Internal Medicine Coding Alert

Follow New Rule to Score 100 on Shared Hospital Services

You can now use the physician's provider number to bill for same-day, face-to-face services provided to a hospital patient by both a nonphysician practitioner (NPP) and a physician and get 100 percent Medicare reimbursement for the shared encounter.

This major change in the rules for shared billing of hospital E/M services, which was spelled out in Transmittal 1776 and took effect Oct. 25, 2002, facilitates the use of NPPs as physician extenders in the hospital. Many internal medicine practices will find that this change allows them to better allocate resources, improve productivity, and boost reimbursement, says **James R. Blakeman,** senior vice president for practice management at Healthcare Business Resources, a billing and practice management firm in Bala Cynwyd, Pa.

Change Reduces Paperwork Burden

Previously, Medicare rules required you to use 99499 (Unlisted E/M service) for billing shared services provided by an NPP and a physician to a hospital patient on the same day because no CPT code describes a partial E/M service. The rules also required you to submit documentation describing which portions of the services were provided by the NPP and which were provided by the doctor and then allow the carrier to determine the payment amount based on that breakdown.

"It was a lot of work for practices and for carriers," says **Dennis Grindle, CPA,** a partner in healthcare consulting at Seim, Johnson, Sestak & Quist LLP in Omaha, Neb.

Few offices used the cumbersome procedure because it often delayed payment, Grindle says. Instead, most just billed the services of one provider the physician or the NPP. "Now you can combine the two visits and bill under the physician's number," Blakeman says.

Reimbursement Is Greater

Your reimbursement will increase 15 percent for those services that you previously billed under the NPP's number and which now meet the requirements for billing under the physician's number. This change applies to services provided to hospital inpatients, outpatients and emergency department patients. The difference in reimbursement for the subsequent hospital care code 99232 is about $8, with 85 percent reimbursement at $45.53 and 100 percent reimbursement at $53.57 nationally, not adjusted for region, according to the 2002 Medicare fee schedule.

In practices that make wide use of NPPs, this change may help balance out the expected 4.4 percent decrease in Medicare reimbursement for 2003, Blakeman notes.

CMS' change is a direct response to complaints about the paperwork required to bill for shared services, says **Brett Baker,** third-party payment specialist for the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) in Washington, D.C.

"The thrust of the complaints came from the physician community, but CMS realized it was extra work for the carriers as well," Baker says.

NPPs Can Provide Initial Care

The new shared-hospital-services policy will be especially helpful for large internists' offices, which typically use many

NPPs, such as physician assistants (PA) and nurse practitioners. Practices may use NPPs to see patients in the morning, with the physician making rounds in the afternoon to a number of hospital patients, Blakeman says.

"If the internist will take the extra few minutes to see the patient, you can get the full 100 percent," Blakeman says.

You should note that NPPs may bill under the physician's number when they see new patients and established patients with new problems in the hospital as long as the physician also has a face-to-face encounter on that day with the patient. There is no restriction against NPPs making the initial patient visit in the hospital setting, Baker notes.

That's a key difference from the office environment where incident-to rules provide that NPPs must bill under their own numbers and receive 85 percent reimbursement if they instead of the physician perform the initial evaluation of a patient or an established patient with a new problem.

How to Code Shared Services

Here's a scenario where you might bill under the physician's number for shared hospital services. The internist admits a patient to the hospital. The next day, the PA sees the patient in the early morning, reviews her history, does a brief examination and writes some orders. In the afternoon, the physician makes rounds and also has a face-to-face encounter with the patient.

"The physician has to document that he had face-to-face contact with the patient and describe the portion of the services that he or she provided," Baker says.

You then combine the two visits to determine the correct level of hospital service to code and bill under the physician's identification number. Note, however, that you cannot bill the shared hospital services under the physician's number in the example above if the physician didn't make the afternoon round and see the patient on the same day as the NPP. Instead, in that scenario, you would have to bill under the NPP's identification number and accept 85 percent of the Medicare fee schedule amount as reimbursement.

Use NPPs Only When Appropriate

Although NPPs can be helpful to internists in managing their hospital patients' health, they should not provide care in some situations, Blakeman says. For example, if a patient is critically ill or has complications, the physician generally will want to see the patient, Blakeman says.

"Midlevels are not physician replacements; they are physician extenders," Blakeman notes. "Medical necessity does come into play here."

The new rules do not change the requirements for billing shared services in the office setting. As long as you meet incident-to requirements, you can bill under the physician's identification number. (See "Five Keys Open the Door to Incident-To Billing in the Office" below for incident-to requirements.)

Use 99499 for Special Cases

Transmittal 1776 notes that you should still use 99499, the unlisted-procedure code, in isolated cases when the physician or NPP provides a service not captured by a specific CPT code. For example, you should use 99499 if the physician performs only a patient history during an encounter or if a physician and an NPP provide a shared office-based E/M service that does not meet the incident-to criteria for instance, because the NPP took the patient history on a new patient, Baker says. In those cases, you must provide a description of the service with the claim, and the carrier has discretion to determine an appropriate payment, Baker says.

Note: You can view CMS Transmittal 1776 on the Web at http://cms.hhs.gov/manuals/pm_trans/R1776B3.pdf.