Internal Medicine Coding Alert

Part B Coding: Part B Update: You Are Not Bound to Accept Each and Every New Medicare Patient

MACs clarify doubts over "incident to" and "shared/split" services question.

You are not in minority when you find the number of Medicare rules to be overwhelmingly vast. Missing out on one or the other regulation and their updates is natural while negotiating the hassles of your daily practice. Fortunately, many of the Part B payers have come to the rescue and provided specific information to providers to help navigate the Medicare billing and coding arena.

We have brought you the inside news from dozens of webinars and have combed through scores of MAC question-and-answer sessions to get to the bottom of several pressing issues. We've got the potentially surprising answers to three frequently-asked Medicare questions straight from the sources.

Contract With Medicare Does Not Mean You Cannot Limit New Medicare Patients

One question on the minds of many practices in this era of tightening Medicare reimbursements is whether you can limit the number of new Medicare patients your practice is willing to accept. Some clinicians believe that if they contract with Medicare, they're required to see every Medicare patient who calls the office. But the reality is that you can just say no when it comes to new patients.

A caller to WPS Medicare's December 2015 "Ask the Contractor" call noted that so many surgeons in her area had opted out of Medicare that her solo practice has been inundated with new Medicare patients from within a 120-mile radius, and they were becoming overwhelmed. "Is it possible to actually close the practice at least for a period of time to new Medicare patients?" she asked.

The answer, she was pleased to hear, was yes. "Medicare does not restrict who you choose to see as your patient," said WPS Medicare's **Paula Reed** during the call. "It's up to you whether you accept a Medicare patient or not accept a Medicare patient. However, once you do accept a Medicare patient, for that patient you must submit the claim."

In other words, you can put a cap on the number of Medicare patients you're willing to bring into the practice but if you do bring them in, you're subject to all of the claims submission and patient care rules that Medicare contractually imposes. "On an individual basis you really have the right to choose who you see and who you do not see," Reed said. "It's only once you see them that you are subject to Medicare laws."

"However, be sure to consult with the legal team before doing this to ensure that there are no other regulatory or medico-legal issues that could arise from this action," cautions **Carol Pohlig, BSN, RN, CPC, ACS**, Senior Coding & Education Specialist at the Hospital of the University of Pennsylvania.

Individual Payers Can Decide Who Performs AWV

Many practices still wonder whether registered nurses (RNs) and licensed practical nurses (LPNs) can document and bill for annual wellness visits (AWVs, billed with G0438 for initial visit and G0439 for the annual visits thereafter).

The answer will depend on your MAC's regulations, but you're in the clear if you're with Noridian Medicare, said **Karly**

Lundquist during Noridian's Annual Wellness Visit presentation in January 2016. "We do get a lot of questions on what an RN and LPN can document and perform for services" she said. "They can record the data for the AWV and they may also perform the services as long as they are under the direct supervision of the physician and as long as their state licensure allows them to perform the services."

She reminded listeners that Medicare pays for an AWV for beneficiaries who are no longer within 12 months of the effective date of their first Medicare Part B coverage period, and have not received either an IPPE or an AWV within the past 12 months. In addition, Lundquist outlined just how to report both the AWV and another evaluation performed at the same time.

"If, during the visit, several medical conditions are brought up, it may be appropriate to bill an E/M visit in addition to the AWV," she said. "The appropriate level of E/M should be reported and documented, and the 25 modifier (Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) appended," she added.

Be Within 'Speaking Loudly Distance' for Incident to Services

If the OIG reports are any indication, medical practices incorrectly bill for incident to services round the clock. From the supervising physician being out of the country during the visit to the receptionist performing the service, reviewers have seen it all. Many practices wonder exactly what it takes to stay on the right side of the incident to laws when the physician is in the building, but not nearby. Luckily, clarification is on the way.

The regs: Under incident to rules, the physician is in charge of the patient, and the non-physician practitioner is acting as a physician extender as opposed to acting under their own license, said WPS Medicare's **Ellen Berra** during the MAC's "Incident to and Shared/Split Services Question and Answer Teleconference." The services must be provided under direct supervision and the physician should be immediately available should the need arrives, meaning the supervising physician is in the office suite, or "within speaking loudly distance," she said. "Not within 'shouting distance,' not just available by telephone or by walkie talkie, not on a different floor□but really within that designated office space."

The person providing the incident to services must have an employment relationship either with the physician or with the group that employs the physician, Berra added. "It can be a direct employee, a leased employee, a contracted employee□but it does have to have that relationship with the entity that's employing the physician or be employed by the physician himself," she said.

Oh, by the way: You should also watch for "oh by the way situations," Berra said. For instance, a patient comes for a follow-up for diabetes or congestive heart failure with the non-physician practitioner, and the physician has previously created the plan of care for that diagnosis. "But as the visit is wrapping up, the patient says, 'Oh, by the way, I have this rash on my elbow.' The new rash on the elbow then moves this service out of incident to," Berra says. "At this point, you must bill the service under the non-physician practitioner's provider number because it no longer meets the guidelines."

In addition, in situations where the non-physician practitioner changes the plan of care, incident to guidelines don't apply. "If the physician says the patient needs to be on this medicine for this amount of time, but then the non-physician practitioner decides to change the dosage or switch to a different medication, that means the service is no longer incident to," Berra said. "The NPP has now changed the plan of care and they are now the one making the decisions for that patient; therefore, you would bill under their provider number for the services."