Mid-Level Providers / NPP's

- Physician Assistants (PA) and Nurse Practitioners (NP), are referred to as Non Physician Practitioners (NPP) by Medicare
- Any services for which Medicare will pay a physician are also covered when performed by a NPP.
- However, the services of the NPP are reimbursed at 85% of the Medicare allowable.

Mid-Level Providers / NPP's

- The only way to avoid the 15% discount for E&M services is to have the E&M shared between the NPP and the attending physician.
- When the NPP and the MD share in the performance of the E&M service, the claim can be filed under the attending physician's ID number and the service will be reimbursed at 100% of Medicare allowable.

Mid-Level Providers / NPP's

- This policy allows for an E&M service to be billed as a shared service under the MD's ID number as long as the attending physician has a face to face encounter with the patient and the NPP and MD are part of the same group

Mid-Level Providers / NPP's

Face to face encounter

- The physician must have contact with the patient and not simply review and/or co-sign the patient's medical record.
- A social salutation alone does not constitute a face-to-face portion or "physician work" of an E/M service."
- The MD must perform and document some portion of the elements of the E&M service (history, physical exam, or medical decision making) in whole or part.

Mid-Level Providers / NPP's

- **A generic attestation will not suffice as documentation to support a shared service.**
- *"I have personally seen and examined the patient independently, reviewed the PA's Hx, exam and MDM and agree with the assessment and plan as written"*
- To qualify as a shared visit, both the physician and the PA must each personally perform part of the visit, and both the physician and the PA must document the part(s) that he or she personally performed.

Mid-Level Providers / NPP's

- Patient presents with *(insert chief complaint)* for *(insert duration)*. My exam shows *(insert relevant exam of affected system or area)*. I reviewed the PA's note and agree with PA's findings and plan.
- For example: *Patient presents with chest pain for 2 hours. My exam shows heart rate normal, regular rhythm, breath sounds are normal, clear throughout. I reviewed the PA's note and agree with PA's findings and plan*

Mid-Level Providers / NPP's

- If there is no EDMD involvement in the encounter it is perfectly acceptable for the service to be reported by the PA/NP.
- The EDMD should not participate in the encounter solely for the purpose of boosting reimbursement.
- EDMDs involvement in the encounter should be driven by medical necessity and the chart should reflect their participation to ensure accurate reimbursement.

Mid-Level Providers / NPP's

- The changes from Transmittal 1776 and the rules regarding shared services only apply to E&M services. Procedures performed by NPP's should be billed under their ID number and paid at 85% of the Medicare allowable.
- "Please note this (Transmittal 1776) relates only to E/M services. There is no mention of procedures."
  Stephen D. Boren, MD, MBA, FACEP
  WPS Medical Director

Teaching Physicians & Residents

- There are four different scenarios in the ED that may involve residents and the EDMD should remember that all four have different performance and documentation requirements.
  - E&M services
  - Procedures
  - Interpretations
  - Critical Care

Teaching Physicians & Residents

- Scenario 1 - Resident performs E&M service in the presence of the teaching physician and the resident documents the service.
- The teaching physician must document that they were present during the performance of the critical or key portions of the service and that they were directly involved in the management of the patient.
- The teaching physician's note should reference the resident's note.
  - *I was present with the resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note.*

Teaching Physicians & Residents

- Scenario 2 - Resident performs E&M service in the absence of the teaching physician and documents the service.
- The teaching physician must independently perform the critical or key portions of the service and, as appropriate, discusses the case with the resident.
- The teaching physician must document that they personally saw the patient and performed critical or key portions of the service, and participated in the management of the patient. The teaching physician's note should reference the resident's note.
  - *I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note.*

Teaching Physicians & Residents

- For major procedures (lasting more than five minutes), the teaching physician must be physically present during the "key portion(s)" of the service and must be immediately available to furnish service during the entire procedure.
- The teaching physician must document the extent of his/her participation.
  - *"I was present for the key portions of the procedure performed by the resident"*

Teaching Physicians & Residents

- For minor procedures which take only a few minutes to complete, such as a simple suture, and involve relatively little decision making once the need for the operation is determined, the teaching physician must be present for the entire procedure in order to bill for the procedure.
  - *"Procedure performed by the resident under my direct supervision."*

Teaching Physicians & Residents

The attending physician documentation must provide substantive information including:

1. the time the teaching physician spent providing critical care,
2. that the patient was critically ill during the time the teaching physician saw the patient,
3. what made the patient critically ill, and
4. the nature of the treatment and management provided by the teaching physician.

Teaching Physicians & Residents

- CMS example of acceptable TP documentation for E&M involving resident.
  - "I saw the patient with the resident and agree with the resident's findings and plan."
- CMS example of **unacceptable** TP documentation for critical care involving Resident.
  - "I came and saw (the patient) and agree with (the resident)".

Teaching Physicians & Residents

INTERPRETATIONS

- If a resident signs the report, the teaching physician must indicate that they personally reviewed the image and the resident's interpretation and either agrees with it or edits the findings.

Teaching Physicians & Residents

Moderate Sedation

- The time documented must be the teaching physician's personal intra-service time.
- Cannot include time spent by the resident in the absence of the teaching physician.
- Time must be documented by the teaching physician.

Scribes in the ED

- A scribe accompanies the doctor into each patient encounter to transcribe the doctor's dictation into the medical record.
- A scribe must document verbatim what is being said by the physician.
- The scribe cannot document any of their own findings.
- The scribe's documentation should identify the scribe and the physician.

Scribes in the ED

- When using an electronic medical record, the scribe must have their own username and password to access the system.
- Entries in the EMR must be identified has having been made by the scribe.
- The physician must review and verify the scribe documentation and attest to its accuracy in addition to also signing the chart.

JCAHO on Scribes

- Signing (including name and title), dating of all entries into the medical record—electronic or manual.

– The role and signature of the scribe must be clearly identifiable and distinguishable from that of the physician or licensed independent practitioner or other staff.
  - Example: "Scribed for Dr. X by name of the scribe and title" with the date and time of the entry

JCAHO on Scribes

- The physician or licensed independent practitioner must authenticate the entry by signing, dating and timing (for deemed status purposes) it. The scribe cannot enter the date and time for the physician.
- Although allowed in other situations, a physician signature stamp is not permitted for use in the authentication of "scribed" entries-- the physician must actually sign or authenticate through the clinical information system.

JCAHO on Scribes

- <u>The authentication must take place before the physician and scribe leave the patient care area.</u>
- Authentication cannot be delegated to another physician or licensed independent practitioner.

JCAHO on Scribes

- The scribe's note should include:
  - The name of the scribe and acceptable signature.
  - The name of the physician providing the service.
    - *Documentation by Maggie Greene acting as scribe for Rick Grimes, MD.*
    - Scribe signature, date & time.
- The physician's note should indicate:
  - Affirmation that the physician personally performed the services documented.
  - Confirmation he/she reviewed and confirmed the accuracy of the information in the medical record.
  - Acceptable physician signature.
    - *I have reviewed the documentation recorded by the scribe and it accurately reflects services performed by me.*
    - MD signature, date & time.

Feel Free to Contact Me

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