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Incident To

CMS has revised and clarified the guidelines for Services and Supplies Furnished Incident To a Physician's/NPP's Professional Service. These guidelines become effective June 2, 2008.

As stated in the guidelines, services may be provided by auxiliary personnel 'incident to' a physician or non-physician practitioner (NPP) service. An example would be a nurse providing an injection. Services may also be provided by NPPs 'incident to' physician services. In both cases in order to be covered as 'incident to' the services and/or supplies must be:

- Covered and payable (reasonable and necessary as described in the Program Integrity Manual);
- An integral, although incidental, part of the physician's/NPP's professional service
 - Preceded by a related physician/NPP service;
 - Authorized by a physician/NPP;
 - Furnished under the care of a physician/NPP during the course of diagnosis and treatment of an illness or injury; and
 - Furnished under the direct supervision of a physician/NPP; and
- Commonly rendered without charge or included in the physician's/NPP's bill;
- Of a type that is commonly furnished in physician/NPP offices;
- An expense, or represent an expense, incurred by the physician/NPP or by the legal entity billing for the services;
- Furnished by auxiliary personnel under direct supervision (the physician/NPP must be in the same office suite and immediately available if needed);
- Appropriately documented.

The guidelines make it clear that the physician/NPP must:

1. *provide* the initial evaluation or service;
2. *authorize* the 'incident to' service;
3. *actively participate* in the continuing care of the patient.

The *authorization* may be documented in the plan. It is not required to be in any specific form but must convey the intention of the physician/NPP that a subsequent service is requested.

Active participation by the physician/NPP must be demonstrated by documentation indicating review of the record and/or periodic services to the patient for the same condition at a frequency consistent with the patient's needs.

Documentation requirements.

- The 1995 and 1997 Evaluation and Management Documentation Guidelines apply to all E/M services including those performed 'incident to'.
- The identity of the individuals who authorized, supervised and rendered the service shall be identifiable in the medical record.
- Documentation shall be available for medical review and indicate:
 - Reference to the initial problem and
 - Authorization for the service.

The complete guidelines may be found in Transmittal CR 5288 at

<http://www.cms.hhs.gov/Transmittals/downloads/R87BP.pdf>

Changes/additions are printed in red italics.

Prolonged Services

CMS has also revised and clarified the guidelines for Prolonged Services With Direct Face-to-Face Patient Contact (codes 99354-99357). A summary of the requirements may be found in a Medicare Learning Network article at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5972.pdf>

Prolonged services codes are used when the prolonged service is at least 30 minutes in addition to the companion E/M service code. Prolonged services of less than 30 minutes are not separately reported.

Prolonged services code 99354 or 99356 is used to report the first hour of prolonged services depending on the place of service. Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour depending on the place of service.

Prolonged services codes are not paid unless they are accompanied by the appropriate companion code. The companion E/M codes for 99354 are:

- Office or other outpatient visit codes (99201-99205, 99212-99215),
- Office or other outpatient consultation codes (99241-99245),
- Domiciliary (assisted living), rest home, custodial care services codes (99324-99328, 99334-99337),
- Home services codes (99341-99345, 99347-99350).

The companion E/M codes for 99355 (each additional 30 minutes, office/outpatient) are 99354 (first hour, office/outpatient) and one of its required E/M codes.

The companion codes for 99356 are:

- Initial hospital care and subsequent hospital care codes (99221-99223, 99231-99233),
- Inpatient consultation codes (99251-99255),
- Nursing facility codes (99304-99318).

The companion codes for 99357 (each additional 30 minutes, inpatient) are 99356 (first hour, inpatient) and one of its required E/M codes.

Only face-to-face time between the physician and patient may be counted when selecting a code. In E/M services in which the code level is selected based on counseling and/or coordination of care time, prolonged services may only be reported with the highest code level in the family of codes as the companion code.

In addition to documenting as required by the 1995 and 1997 Documentation Guidelines, the physician must appropriately and sufficiently document that s/he personally furnished the direct face-to-face time with the patient as specified in CPT definitions. The start and end times of the visit should also be documented as well as the date of service.

Tables with threshold times for the use of each code are available in the article and in the Medicare Carrier Manual.