MPC, Inc.
November

Series of "You Asked & They Answered" Novitas JH
Series One : FAQ's for "Billing" & "Time"

CELEBRATING 25 YEARS OF EXCELLENCE

MEDICAL PRACTICE CONSULTANTS, INC.

The Medicare contractors FAQ page is devoted to Frequently Asked Questions (FAQs) and their answers on a wide spectrum of topics. Check back often, they are in a constant state of update.

It is vital to understand that the FAQ page is only one excellent source of determine your contractors interpretation as well as CMSs principles for a wide variety of regulations. Understanding the value it brings is based on a clear understanding of the definitions.

Definition of a "Question":

- A sentence in an interrogative form, addressed to someone to get information in reply.
- A problem for discussion or under discussion; a matter for investigation.
- A matter of some uncertainty or difficulty; problem.
- A subject of dispute or controversy.

Definition of "FAQ – Frequently Asked Questions":

- "A document that provides answers to a list of typical questions that users might ask regarding a particular subject"

Definition of "Asked & Answered":

- "One of the objections which an attorney might make to a question raised by his or her opposing attorney within a trial is the objection of "asked and answered." This objection would normally be raised after the opposing attorney asks a question which has already been answered in some capacity."

PAY CLOSE ATTENTION TO THE FAQs. IT MAY BE THE ONLY PLACE YOU WILL FIND THE CONTRACTORS INTERPRETATION!

The following contain only a partial sample of the Novitas JH FAQ recently published.

FAQ's for Billing

1.) Why do claims only reject or deny for one reason and not for everything that is missing or wrong?

- Medicare Part B claims process through the standard Multi-Carrier System. The standard system uses a series of edits and audits to help determine whether claims are eligible for payment. The standard system has been programmed to reject or deny a claim based on the first edit or audit that it does not pass. It does not continue to process against the rest of the edits and audits.

2.) What date of service should I report when completing a diagnostic interpretation on a different date from the actual test?

- We recognize that providers do not always perform the professional component on the same date as the technical component. Many providers prefer to submit a claim with a date of service that reflects the date the professional component was performed, while others prefer to use the date of the technical component as the date of service for their professional component.

Happy Thanksgiving

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FAQ's for Billing cont.

** There is no policy from CMS that requires billing to be one way or the other. Since there is no specific policy, regulation, or other mandate from CMS on this issue, we will leave which date of service is billed for the professional component up to the provider.**

3.) What must be included in my medical record documentation when administering medication(s)?

- Medical record documentation should include the name of the medication, the dosage and the route of administration. The site of the injection should also de documented as well as any patient reactions to the medication and signature of the person administering the medication. Documentation must be maintained in the patient's chart to support the medical necessity of the injection given. When a portion of the drug is discarded, the medical record must clearly document the amount administered and the amount wasted.

4.) Can we collect the co-insurance from our Medicare patients on the date of service when we know the patient does not have co-insurance coverage?

- Yes, you may collect the co-insurance on the date of the service from patients who advise you that they do not have co-insurance coverage.

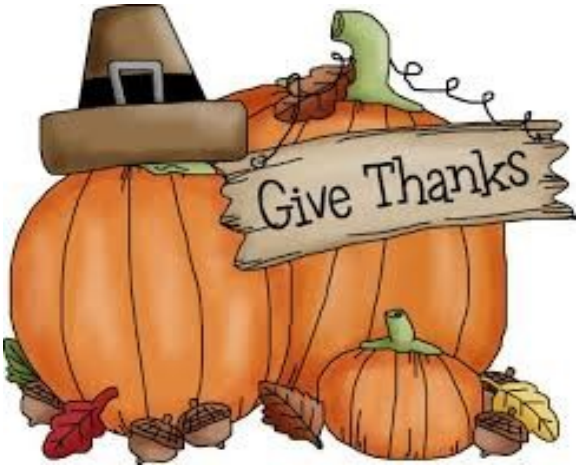
5.) How do we bill if both a physician and non-physician practitioner sees the patient in the office during the same encounter?

- When an evaluation and management service is a shared/split encounter between a physician and a non-physician practitioner (nurse practitioner, PA, clinical nurse specialist, or clinical nurse midwife), the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient. If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the non-physician's national provider identifier (NPI), and payment will be made at the appropriate physician fee schedule payment."

FAQ's for Time

1.) My patient visits are primarily counseling and coordination of care. How do I bill for this type of patient visit?

- When counseling and/or coordination of care dominate more than 50% of the time a physician spends with a patient during an E/M service then time may be considered as the controlling factor to qualify the E/M service for a particular level of care, then a number of factors must be in the patient's medical record. The following must be in the patient's medical record in order to report an E/M service based on time:
- The total length of time (start and stop times) of the E/M visit;
- Evidence that more than half of the total length of time of the E/M visit was spent in counseling and coordination of care; and
- The content of the counseling and coordination of care provided during the E/M visit.



Medical Practice Consultants, Inc.

For the last 25 years Medical Practice Consultants (MPC) has distinguished itself as one of the leading healthcare business consulting firms in the Southwestern and Midwestern states of the United States. Our team credentials include:

- Certified Medical Insurance Specialist (CMIS)
- Advanced Coding Specialist for Evaluation/ Management services (ACS –EM)
- Certified Healthcare Auditor (CHA)
- Certified Public Accountant (CPA)
- Certified Professional Medical Auditor (CPMA)
- Certified Medical Terminology (AAPC)
- Certified Anatomy (AAPC)
- Certified Hospital Health Service Management (HHSM)

MPC offers a comprehensive understanding of the complete reimbursement process, documentation, coding, and the ability to challenge and prevail in claim appeals with CMS carrier and program integrity contractors; The knowledge and ability to audit E/M services with attention to the tough scrutiny from the RAC and payer audits; The skills to assist an organization in ensuring they are documenting appropriately to support the E/M levels billed to achieve proper reimbursement and avoid costly denials; and the qualifications to assist organizations with determination of problematic root causes found in the healthcare organization with the performance of gap analysis to assist the organization on corrective actions.