CODING & DOCUMENTATION

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Countersigning notes for incident-to services

Q Does Medicare require that I countersign all notes for services provided "incident-to"?

A No, but read on. The Medicare program does not require your signature on services provided incident-to and billed under your name and identification number. However, Medicare's regional administrative contractors offer differing instructions on signature requirements. Some do not require a signature other than that of the person performing the service. Others require countersigning but only when incident-to services are provided by auxiliary staff other than qualified health care professionals such as nurse practitioners. Yet others require the supervising physician's signature on all records. It is necessary to check the policy of the Medicare contractor in your region. State laws for physician signatures may also apply and may vary according to the type of professional providing the service (e.g., countersigning may be required for incident-to services provided by physician assistants but not nurse practitioners), so you should check on these as well.

In any case, you should be able to provide documentation to support your direct supervision of the incident-to service provider (i.e., that you or another supervising physician were available in the office suite at the time of service) and the plan of care that the incident-to service provider is carrying out. If another physician in the practice provided direct supervision rather than you, that physician must report the service with you listed on the claim as the referring/ordering provider.

Same-day, same-group hospital care

Q Can two physicians of the same group practice but different specialties bill separately for subsequent hospital care services they provided to a patient on the same date of service when one is the attending physician and consults the other?

A Yes, if both services were medically necessary and the requirements for each level of service were met, physicians of the same group practice but different medical specialties may separately report services provided on the same date. An initial inpatient consultation would be reported with a code in the 99251-99255 series to payers that recognize consultation codes or as initial hospital care to Medicare, which does not recognize consultation codes. If the physician who was consulted assumed an active role in managing a condition that required his or her expertise, that would be concurrent care. Concurrent care must be medically necessary and nonduplicative (i.e., each physician is managing a different aspect of the patient's care) to be paid.

Note that if the two physicians were of the *same specialty* and same group practice, the two services would be reported as one with the code that appropriately represents the combined services.

Transporting lab specimens

Q Can I bill code 99000 for transporting laboratory specimens from a patient's home to a hospital laboratory for analysis?

A Since the descriptor for code 99000 specifically covers transporting specimens "from the office to a laboratory," I would not advise using it to report transportation from a patient's home to a laboratory. Instead, consider using 99001, which describes "Handling and/or conveyance of specimen for transfer from the patient in other than an office to a laboratory (distance may be indicated)." Codes 99000 and 99001 are intended to be reported when the physician incurs costs for the handling or transportation of a specimen (e.g., courier service fees). These codes may also be used to reflect the work involved in the preparation of a specimen prior to sending it to the laboratory. This work may include centrifuging a specimen, separating serum, labeling tubes, packing the specimens for transport, filling out lab forms, and supplying necessary insurance information and other documentation.

Please be aware that some payers do not cover 99000 or 99001. For instance, Medicare designates both codes as "bundled" services, which means that Medicare considers payment for them to be bundled into the payment made for other services that Medicare covers. Check with your payers to learn whether they have similar policies. ➤

About the Author

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Admission to observation care

Q Can I bill for admitting a patient to observation care if the review of systems (ROS) I performed does not meet the requirement for 99218?

A Code 99218 represents initial observation care, per day, for the evaluation and management of a patient and requires these three key components: a detailed or comprehensive history, a detailed or comprehensive examination, and medical decision-making that is straightforward or of low complexity. According to Medicare's "Documentation Guidelines for Evaluation and Management Services," an "extended" ROS inquires about the system directly related to the problem(s) identified in the history of present illness (HPI) and a limited number of additional systems; the patient's positive responses and pertinent negatives for two to nine systems should be documented. If the documented ROS does not meet the definition of an extended ROS, then you technically cannot report 99218. Coders and auditors should remember that the ROS elements may be documented as a distinct portion of the history or in combination with the HPI. Any documentation of the patient's response to questions regarding signs or symptoms should be counted as ROS, although some payers may not allow the same element of documentation to be counted as HPI and ROS.

You should determine if the payer has a policy advising how to report initial observation care that is less than comprehensive. You may need to report the appropriate office or other outpatient visit code (99201-99215), since patients in observation are technically still outpatients of the hospital. Another option is to report subsequent observation care, which only requires two of three key components and the lowest level of which involves only a problem-focused interval history.

If you are not comfortable with those options, the alternative is to use the unlisted E/M code, 99499. Verify the payer's instructions for reporting code 99499 because this may be prohibited in cases where a code within the subcategory of service adequately describes the elements of service provided. It will be necessary to send supporting documentation with the claim if you choose this option. FPM

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