Billing Guidance
Non-Physician Practitioners (NPPs)

Medicare Part B, Medi-Cal and certain other health payers reimburse for certain services provided by non-physician practitioners. Payer rules determine whether the service is billed in the name of the performing provider or the supervising physician. At UCSD, all Non-Physician Practitioners (NPP’s) must have a California License and be credentialed and privileged as follows – prior to treating patients:

- UCSD Health – Medical Staff: credentialed, license verification, privileged to practice medicine subject to scope of practice and state licensure; and
- UCSD Medical Group – Provider Relations: credentialed for billing with payer groups, National Provider Identifier (NPI) number, assignment of benefit (billing /collections) to UCSD Medical Group; and
- UCSD Health – Human Resources (HR): employment relationship, background screening, pre-employment physical / health screening, completion of on-boarding training, including: core compliance training, HIPAA privacy / information security, exclusion screening.

Credentialing with both the Medical Staff Administration Office and the Medical Group Provider Relations is **required** regardless of whether the NPP sees patients independently or will be submitting professional fee bills.

**General Billing Principles**

For purposes of professional fee billing, services provided to patients must be medically necessary, documented and authenticated in a timely manner by the performing provider in the patient’s medical record (or electronic health record). Documented services billed to the patient and other health payers are identified by accurate billing codes (CPT, HCPCS, modifiers, ICD9 or ICD10 diagnosis codes, and place of service codes) and accurate provider name and NPI number. In addition, services billed by non-physician practitioners may be subject to further restrictions based on: current state licensure, scope of practice or collaboration, UCSD H Medical Staff privileges, UCSD Medical Group credentialing, and when required or indicated by the payer or licensure – appropriate physician supervision and co-signature requirements.

Supervision requirements are generally set by state law, but may also be specified within payer manuals. Example: Medicare specifies supervision levels for different diagnostic procedures.

**Medical Necessity:** Medical necessity relates to activities which may be justified as reasonable, necessary for the health of the patient, and/or appropriate, based on evidence-based clinical standards of medical practice. Health insurance companies provide coverage only for health-related services that they define or determine to be medically necessary. Health payers including Medicare may issue both national and local coverage decisions that define specific coverage criteria for certain services to be a covered benefit. **There is a difference between clinical medical necessity and billing medical necessity.**

1. AMA defines medical necessity as: Services or procedures that a prudent physician would provide to a patient in order to prevent, diagnose or treat an illness, injury or disease or the associated symptoms in a manner that is:
   a. In accordance with the generally accepted standard of medical practice.
   b. Clinically appropriate in terms of frequency, type, extent, site and duration.
   c. Not intended for the economic benefit of the health plan or purchaser or the convenience of the patient, physician or other health care provider.

2. Medicare defines medically necessary under Title XVIII of the Social Security Act, Section 1862 (a)(1)(a): "No payment may be made under Part A or Part B for expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Refer to the CMS site to view coverage determinations: [http://www.cms.gov/medicare-coverage-database](http://www.cms.gov/medicare-coverage-database)
**Medical Record – Documentation Guidelines**

Medical record documentation guidelines apply to all providers (physicians and NPPs). Each encounter’s documentation should include sufficient information to describe the purpose of the visit, procedure or other services provided and be authenticated. Authentication identifies the author of the note, provider of service, signature and title (MD, MS, NP, P.A., RN, etc.) of the note’s author who provided the service.

Documentation considerations:

1. **Evaluation and Management (E/M) Visits:**
   a. History: Chief complaint (reason for encounter), history of present illness (HPI), review of systems (ROS), and the past, family, social history (PFSH).
   b. Exam: Physical examination findings, and results of prior diagnostic tests.
   c. Medical Decision Making and Plan of Care: Current assessment, clinical impression or diagnosis, and care plan.
   d. Time: Certain services, such as critical care coding, require documentation of total time spent in the patient’s care.

2. **Medical necessity** of an evaluation and management (E/M) service is generally expressed in two ways: frequency of services and intensity of service (CPT level). During an audit, Medicare’s determination of medical necessity is separate from its determination that the E/M service was rendered as billed. Medicare may deny or adjust E/M services that, in its judgment, exceed the patient’s documented needs – or is insufficient to support the billed code or lacks documentation regarding time, when required by the billed CPT code, such as critical care. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.

3. **Medical / Student Entries:** The only portion of a medical student’s note that may be used is the review of systems (ROS) and past, family, social history (PFSH). Medical student notes should be signed by the student and co-signed by a supervising licensed physician.

4. **Bylaws & Policies:** Refer to UC San Diego Health’s policies (Medical Staff Bylaws, Rules & Regulations, and MCPs) for additional information regarding medical record documentation.

**Other Resources**

A. **UCSD Health Sciences - Compliance Office Guidance**
   Call the Compliance Office for guidance documents on topics, such as:
   1. Comparison of Medicare’s “Incident To” vs. “Split/Shared” Visits
   2. “Copy / Paste” Guidelines: Appropriate Use of E.H.R. Functions
   3. Critical Care Billing
   4. Teaching Physician Billing Rules

B. **UCSD Health’s policies (MCPs), [http://mcpolicy.ucsd.edu](http://mcpolicy.ucsd.edu)**
   1. MCP 325.2, "Legal Medical Record"
   2. MCP 320.1, "Timely Preparation and Authentication of Medical Records"
   3. MCP 523.2, "Allied Health Practitioners (AHP): Authorization for Clinical Specialists to Provide Patient Care Services"
   4. MCP 562.3, "Use of Scribes for Clinical Documentation"

C. **Medicare**
   2. Advanced Beneficiary Notices (ABNs): “Advance Beneficiary Notices advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment for them. ABNs allow beneficiaries to make informed consumer decisions about receiving items or services for which they may have to pay out-of-pocket and to be more active participants in their own health care treatment decisions.” Training booklet, Aug.2014:
D. Medi-Cal

1. Medi-Cal refers to non-physician medical practitioners as “NMP”, sometimes referred to as mid-level providers, and follows California Title 22, CCR Section 51240 which addresses enrollment and supervision requirements for NMPs. Physician Assistants, Nurse Practitioners and Certified Nurse Midwives are all considered to be NMPs for purposes of Medi-Cal provider enrollment. [https://www.dhcs.ca.gov/provgovpart/Pages/Medi-CalEnrollmentofNon-PhysicianMedicalPractitioners.aspx](https://www.dhcs.ca.gov/provgovpart/Pages/Medi-CalEnrollmentofNon-PhysicianMedicalPractitioners.aspx)

2. Medi-Cal's provider bulletin ("non ph") provides specific details regarding P.As., NPs, Certified Nurse Midwife (CNM), as well as licensure, supervision, scope or practice, allowable CPT codes, and modifiers.

3. Use the appropriate modifier when billing for services under the supervising physician’s NPI number when the service was rendered by a NMP. When a NMP bills Medi-Cal directly (in his/her own name and NPI number), then the NMP modifier is not reported on the claim.

   a. Modifier U7, Physician assistant
   b. Modifier SA, Nurse practitioner rendering service in collaboration with a physician
   c. Modifier SB, Nurse midwife
   d. Modifier 99, Multiple modifiers

5. CPT code restrictions: Medi-Cal does not recognize critical care codes (99291-99292) for NPPs.

   [http://www.miec.com/Portals/0/pubs/MedicalRec.pdf](http://www.miec.com/Portals/0/pubs/MedicalRec.pdf)