“Incident to” Community Paramedic Services Coding and Billing by the Clinic

Level 1 Established Patient Code

One option for the reimbursement of CP services in or for a physician clinic is the use of Level 1 established patient visit code 99211. This code is defined by the CPT guide as an “office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or another qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.” The guidelines for this level of service are not as extensive as the other levels. Basic guidelines are that the patient must be established to the practice and/or physician. To bill for this service, it must be incidental to the services of a physician as discussed above. Payers have varying rules around how often the patient must see a physician while on the plan of care, the visit must be face to face with the non-physician practitioner and evaluation and management (E&M) service must be provided. Reviewing the patient history or assessing a physical issue or condition would be required. Therefore, Level 1 visits are often conducted by nurses in practice, but Medicare does not have a guideline that requires this to be an RN. Some guidance suggests that the person delivering care must be a licensed health care professional. A CP should meet this requirement. If a level 1 service is provided and documented, it can be billed under the supervising physician’s billing number (NPI).

In-Home Visit

Medicare regulations allow for the billing of in home encounters for physicians and, in some cases, non-physician health care practitioners such as nurses or CPs. An in-home visit could be conducted with a licensed health care professional and a physician and be billed under the physician number. This is likely impractical for most CP visits; however, it may apply to those cases where the physician/CP is operating a mobile clinic. However, under the “incident to” billing rules for Medicare, a patient in a rural area that has no access to home health services could be billed for a Level 1 visit in the home even when the physician is not present. Of course, a physician’s supervision, but not physical presence or proximity, is required. This option may not be available for urban CPs where home health services are available, but it may be a possibility for remote rural paramedic services. Again, note the discussion under the “incident to” guidelines for care in a patient home that may allow CPs in the state of Minnesota to bill for their services due to the CMS established exception for personnel authorized by state law.

Annual Wellness Visit

Although the Annual Wellness Visit (AWV) is not technically governed by the “incident to” regulations because it is a separate benefit category, the direct supervision requirement still applies. health care professionals working under the direct supervision of a physician could also perform the AWV individually or as a team. The AWV is a preventive visit available to eligible beneficiaries and may be billed by HCPCS codes G0438 - annual wellness visit, including PPPS,

first visit; and G0439 - annual wellness visit, including PPPS, subsequent visit. It is available to beneficiaries not within the first 12 months of eligibility for Medicare Part B and who have not had an Initial Preventive Physical Examination (IPPE) or AWV in the last 12 months.

The AWV includes the following:

- Review (and administration if needed) of a health risk assessment,
- Establishment (or update) of the individual's medical/family history,
- Establishment (or update) of a list of current providers and suppliers that are regularly involved in providing medical care to the individual,
- Measurement of the individual's height, weight, body mass index (or waist circumference, if appropriate), blood pressure (BP), and other routine measurements as deemed appropriate, based on the individual's medical and family history,
- Detection of any cognitive impairment that the individual may have,
- Review of an individual's potential risk factors for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations,
- Review of the individual's functional ability and level of safety, based on direct observation of the individual, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations,
- Establishment (or update) of a written screening schedule for the individual, such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force (USPSTF) and Advisory Committee of Immunizations Practices (ACIP), and the individual's health risk assessment, health status, screening history, and age-appropriate preventive services covered by Medicare,
- Establishment (or update) of a list of risk factors and conditions of which primary, secondary, or tertiary interventions are recommended or underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits,
- Furnishing of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management or community-based lifestyle interventions to reduce health risks and promote self- management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition, and,
- Any other element(s) determined appropriate by the Secretary through the national coverage determinations process.

Transitional Care Management

A CP may also be used to provide services covered by the transitional care management codes, CPT codes 99495 and 99496. These codes can be used in the 30 days following discharge from hospital visits including inpatient stay, observation stay, partial hospitalization or SNF/nursing home stays or a community mental health center. The discharge must be to the patient's home, domiciliary, rest home or assisted living. These codes cannot be used after discharge from an emergency room visit only or other outpatient settings. In order to bill using these codes the services must be:

1. Provided during the first 30 days;
2. The health care provider must accept responsibility for the post-discharge care; and,
3. The patient must have a condition requiring decision making that is moderate or high complexity.

This follow up does not have to be done face-to-face; although it should be noted that a face-to-face visit with a physician, certified nurse mid-wife, clinical nurse specialist, nurse practitioner, or physician's assistant is required. Licensed clinical staff members may perform certain follow-up services. Covered services for licensed clinical staff include communication with the patient, caretaker, family, with a home health agency or similar community. Another covered service is patient education related to independent living and activities of daily living, including medication management and helping the patient find community services or other health care services. The non-face-to-face services may be provided under general physician supervision, meaning that they do not have to be provided with the supervising physician physically available on an immediate basis. Therefore, they may be done outside the physician practice provided they meet the other requirements of "incident to" billing.

Other requirements for these codes are as follows:

99495: communication with the patient/caregiver within 2 business days of discharge, face-to-face visit within 14 calendar days of discharge and moderately complex medical decision making

99496: communication within 2 business days, face-to-face visit within 7 calendar days of discharge and highly complex medical decision making.

Chronic Care Management

Medicare established the Chronic Care Management (CCM) code (CPT 99490) as a payable CPT code at the same time as the transitional care management codes starting January 1, 2015, and was similarly intended to pay physician practices for more care coordination and management. The intent is to improve care for patients and reduce hospitalizations and, thereby, the total cost of care. Medicare describes billable chronic care management services as "at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

1 Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,

2 Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,

3 Comprehensive care plan established, implemented, revised, or monitored.

It should be noted that the chronic care management code cannot be billed at the same time as the transitional care management codes. Also, only one practitioner can receive this payment per month per qualifying traditional Medicare patient.

Medicare requires that the CCM be initiated by a face-to-face encounter with the billing practitioner (physician, clinical nurse specialist, nurse practitioner, or physician assistant) that qualifies as an E/M visit, an AWV, or an Initial Preventive Physical Examination (IPPE). The practitioner also must inform the patient of the availability of the CCM service and get the patient's consent in the form of a written agreement. Because this service requires cost sharing with the patient, the patient must be made aware of the cost of this service in the agreement. Medicare also requires the agreement to cover how the patient is able to access the CCM services, how the patient's information may be shared, and how to terminate the service.

In contrast to most billing for "incident to" services, billing for these services is allowed under general physician supervision rather than direct physician supervision. This means the physician does not need to be immediately available physically and service can be provided outside the clinic provided the other requirements of "incident to" billing is met.

The requirements of the services provided in order for the CCM service to be billable are extensive and Medicare provides a helpful table in its Chronic Care Management MLN article available online. Some of the major requirements include using a certified EHR system to record patient information such as medications, demographics, clinical problems, and medication allergies. Also the EHR system must be used to create a patient care plan that can be shared with anyone involved in the delivery of the CCM services as well as the patient. Patients must also have 24/7 access to the care management services by contacting a member of the care team that has access to the patient's care plan. Medicare also requires that the patient be able to get "successive routine appointments" with a member of the care team. Finally, the patient's care must be managed through assessments of the patient's needs, the provision of preventive care services, medication reconciliation, the management of patient transition between health care providers (such as post discharge from an ED visit), and the coordination of care between all care providers including home and community based services.