Maximizing Reimbursement; New Practice, Old Patients

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Get coding guidance on billing for a family medicine group; patients being seen at a new practice; and more. 

Source: Physicians Practice

Maximizing Reimbursement

Q: I supervise a family medicine group that is trying to maximize its billings. We have a few questions that might lead to additional revenue:

Q1: We currently use the following CPT codes for colposcopies: 57452, 57454, 57455, and 57456. We own the equipment. Is there any other code that can be billed to cover the equipment costs?

A1: The equipment costs are included in the practice expense portion of the RVU. The procedure codes include this.

Q2: We have an autoclave for sterilization of equipment and supplies. Is there any way to be reimbursed for this or is it just part of practice expense?

A2: This is also part of the RVU practice expense component as above.

Q3: If a patient comes into office for a urine pregnancy test provided by a medical assistant, we currently bill 81025. Is there any other code we should be using? Should we bill for a Level 1 visit also?

A3: If the physician needs to "read" the test, and he makes a note with the test results (that day), you can bill a 99211 in addition to the lab. If a positive test leads to a full encounter with the physician, the appropriate level of E&M can be billed.

Q4: Is there a billable CPT for use of suture removal trays?

A4: A4550 is the code for surgical trays and the suture removal materials appear to fall under that. This is not reimbursed by all payers.

New Practice, Old Patients

Q: I recently left a job working with an urgent-care/family-practice center to work in a hospital-owned practice just a few miles away. If I see patients at my new office that I previously saw at the urgent-care facility I want to code them as new patients. Often, I am not aware that patients saw me at the previous facility unless they inform me, especially if I saw them for a minor, urgent problem and I did not really establish a relationship with them.

Further complicating matters is that one of our other two providers might see the patient for the first time, but I may have previously seen the patient at the urgent-care facility.

Can we characterize these patients as new? The urgent-care facility was privately owned by a local physician; the new office is owned by a hospital system (they are two completely different entities). A: It’s good that you pointed out the two facets of the issue as they have different answers. The CPT book is quite clear that a new patient is one that has not received services from a (particular) physician, or another physician in the same group (with the same Tax ID) and with the same specialty or subspecialty within the last three years.

So, if you are providing services to a patient that you saw at your previous practice within the last three years, you must bill the visit as an established patient, regardless of the whether you previously saw the patient for a minor, major, or urgent problem.

When other providers at your new practice treat a patient that you saw at the old practice, they do not have to bill the patient as established as this patient does not meet the conditions set out above.

Emergency Psych Consults

Q: I am a psychiatrist who works in a hospital setting principally doing consults and admits through the emergency department for patients that are being "Baker-Acted" or assessed for potential psychiatric crisis. I regularly bill hospital-admit codes at the middle and high levels to reflect the acuity or potential acuity of these patients.

Many of these patients are screened by emergency medicine or internal medicine providers and I am really providing the psych aspect of the consultation. I am told that my review of systems (ROS) is not up to par for these codes as it is limited to the relevant system. Am I cut off from the use of
these codes?
A: CPT codes 99222 and 99223 do require a comprehensive ROS. That is 10 systems, not all within your specialty. So from that perspective the answer is yes, you are somewhat ineligible for these codes.
I'm assuming that your consultation includes the full-psychiatric exam; and past, family, and social histories. And based on your question, it sounds as if the decision making is easily in that range. Those are all of the components that you would need for a 99222 or 99223.
The scenario you describe has someone else really clearing the patient medically for a potential psych admit — and the broader ROS may be more properly their area of concern. But that said, the codes themselves require the components noted above, think of them as performance standards. The federal guidelines allow you to give the pertinent positives and negatives, and then state "ROS otherwise negative." You could list the relevant psych and constitutional concerns, plus or minus, and base the "otherwise" portion on your review of the rest of the note, including the other provider’s ROS. No one wants you to do work that is not medically necessary, but there are thresholds and requirements that you must meet.
Find a way to shape your note to the guidelines; you are likely closer than you think.

**Notes in List Form**

**Q:** I have some history of present illness (HPI)-related questions. For HPI, can a note be in list form with answers rather than in narrative form? For instance: A. location, B. quality, C. severity, etc.? Is it acceptable to have a list indicating the status of three chronic/inactive conditions? Also what if an HPI is about a follow-up of Barrett's esophagus, new diagnosis, but there are no symptoms? Not everything falls into the categories of location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms. Some patients are here for follow-up or consults that do not fall into those categories. What should we do in these cases?

**A:** Per your question about a note in list form. Yes, you can use a list, but you'll need a fourth list item to meet the new patient 99203 requirements, established patient 99214, or beyond. The list item that is most frequently missed is duration (how long something has been going on). Include this even on assessments of preexisting or new problems.
Per your question on follow-up visits, you don't need to have all three components of history, physical exam, and medical decision making. If you can't really get the history, then the physical exam becomes more important. The decision making component should always be included. Also, for a 99213 you only need one HPI and review of systems element. So if the problem is stable, then you should be able to describe duration, modifying factors, or severity. If the problem is worsening, the HPI should be easier to meet and move the visit closer to the 99214. I hope that helps.

**Infusions Oversight**

**Q:** I perform oversight of IVIG infusions in a hospital outpatient department. I know I can't bill for things that hospital nurses do, but what if a nurse is supported by a grant? Can I bill the professional services codes 96365-96366 for the upwards of three or four hours I spend in the suite?

**A:** These infusion codes specifically state that those codes are not to be used by physicians in the facility setting. Although the nurse that is performing the service may be grant-supported and approved for other "incident-to" type services, the fact that services are done in the hospital using hospital equipment and hospital-purchased drugs, would lend these services a predominantly facility-based character.

As a result, these codes do not appear available to you. However, the context of these encounters in which you are spending up to four hours in the suite could raise other billing opportunities. I assume you are available to patients while receiving updates on their vitals and reactions to the IVIG, and I'm sure you aren't just watching the bag. If these encounters begin with an E&M visit of any significant complexity, you may have an E&M as long as it is "separate and significant" from the infusion monitoring to follow. If there is an E&M, then you may be able to use the prolonged services codes 99354-99355 appropriately in conjunction with a 99213, 99214, or 99215 to represent the time you spent directly involved with the monitoring of the patient.
Any time spent in other activities would need to be subtracted from the total prolonged services time. In other words, even if the infusion lasted four hours, it might only have involved one hour or one hour and 30 minutes of your direct supervision. Document this time component clearly. This is not a case where a one-size-fits-all macro will suffice.
If there is no distinct E&M, and the overall session is scheduled solely for the infusion, then I don't see a good billing option for you in that site of service.

**Documenting Results**
Q: I do several types of procedures in the office and I incorporate the results in my office note. I have been told I need to have a procedure section for these. Is that true?

A: Not exactly. There is no requirement on the professional side, at least not from AMA or the Federal Documentation Guidelines, that says information needs to be in a certain place in a chart. More than likely, you are being asked to make the procedures more distinct, or visible. I would advise you to write "Procedure Note:" followed by the name of the procedure, then a description of the work or the results. The problem with the way you are documenting now could be that an auditor may not be able to match your findings with a given test. We see this often, a collection of acronyms or values that is meaningful in context and may be recognizable to you, but not recognizable to those unfamiliar with your specific work. At the very least, I'd advise labeling the results: EKG Results, PFT's, or VFE. If you don't, you run the risk of an auditor, or even another clinician, missing the results completely.

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