

Billing Audit Deeper Dive: Coding and Documentation

March 14, 2018

You Asked the Questions. We've Got the Answers!

The Q&A session that followed the March 14, 2018 Webinar, "Billing Audit Deeper Dive: Coding and Documentation," hosted by Conventus was quite strong. Due to time constraints, we were not able to address all the questions that were submitted by webinar attendees. Please find answers to the questions submitted

1. Does a Physician Assistant have to be credentialed if the claims are billed under the supervising physician that is cosigning the visit notes?

Each practice must ascertain payment policy and claims submission instruction from each payer with whom they contract. When plans do not credential or issue provider numbers to PAs, they typically instruct the practice to bill the service under the name of the supervising physician, occasionally with a modifier code attached. It is critically important that one not assume a policy for billing for PAs. It is essential to check with the individual payer as to how PA-provided services should be billed, preferably in writing.

2. Can a credentialed physician sign off and submit an encounter under a non-credentialed Physician Assistant?

See answer above.

3. How long can you bill for a Locum Tenens under a supervising providers NPI is it 60days or 90 days and do you have to credential those providers if they are only staying with the practice for 60-90 days?

For both commercial carriers and Medicare, a 60-day consecutive limit applies for each locum physician—beginning from the first patient seen (even if patients aren't seen certain days when physician is on vacation, has days off, etc.) After the 60-day limit expires, a practice may no longer bill for that locum physician. If services still are needed after this time, the practice must employ a different locum physician. If the absent physician returns to the practice for a short period of time (within the 60-days) this resets the 60-day clock. The Q6 modifier (Service provided by a locum physician) is added to each CPT code on a claim. You should check with your individual carriers to ensure they do not require locum tenens to be credentialed.

Under Medicare and most commercial carriers, Locum Tenens physicians do not have to be enrolled in the Medicare program or be credentialed since they are contracted physicians who are substituting for a physician who is temporarily unavailable. A locum tenens physician must have a National Provider Identifier (NPI) and possess an unrestricted license in the state in which he/she is practicing. In addition, the locum tenens physician would be paid on a per diem or similar fee-for-time basis.

4. Does a Locum Tenens physician need to be credentialed?

Locum Tenens physicians do not have to be enrolled in the Medicare program or be credentialed by commercial carriers since they are contracted physicians who are substituting for a physician who is temporarily unavailable. A locum tenens physician must have a National Provider Identifier (NPI) and possess an unrestricted license in the state in which he/she is practicing. In addition, the locum tenens physician would be paid on a per diem or similar fee-for-time basis. You should check with your individual carriers to ensure they do not require locum tenens to be credentialed.

5. With a commercial payer (NOT AWP MEDICARE) would you consider addressing the patient's hypertension or diabetes as an additional code for E&M while doing a PE, as well with commercial insurance? (I thought it would be for a separate acute problem such as sinusitis or UTI but not a chronic problem)?

There is no provision in the guidelines which indicate chronic problems are not be subject to the modifier 25 rules. In fact, there is guidance in CPT Assistant, which is published by the AMA, quite to the contrary. Per vignette posted in the August 1997 edition, "Family Practice and Internal Medicine - A 55-year-old established male patient presents to the physician's office for periodic preventive medicine reevaluation and management. The patient has established diagnoses of hypertension, on beta blocker therapy, Type II diabetes controlled with sulfonylurea, and chronic stable angina controlled with sublingual nitroglycerin as needed.

A comprehensive history and examination are performed as part of the preventive medicine service. The physician counsels the patient regarding diet, exercise, and injury prevention. Risk factors are identified, and interventions discussed. Medically appropriate laboratory tests and diagnostic procedures are ordered. Anticipatory guidance counseling/risk factor reduction interventions are covered to the extent that they have not been in previous preventive medicine examinations.

Furthermore, specific history is taken, and further examination is performed regarding the established diagnoses as listed above. The physician performs a problem-oriented expanded problem focused history and examination including medication compliance, diet, stress issues. Expanded problem focused examination including vital signs, chest and heart examination, check for edema. Medical decision making of low to moderate complexity including counseling about medication and alternatives, a plan for appropriate laboratory work, review of possible medication side effects, and plan for ongoing management.

To report this, CPT code 99396 would be used for the preventive medicine services visit. In addition, the appropriate problem-oriented level of E/M service would be selected based on the key components associated with providing the problem oriented E/M service."

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