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Contact Us:

GR Medical Management

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http://www.grmed.com

info@grmed.com

877.799.3300 x139

Billing for a PA

Do you have a PA in your practice? The addition of a physician's assistant can be a great asset to a busy practice. But, depending on how the organization is billing the PA services, there may be limitations that supersede the PA scope of practice that must be observed.

Scope of Practice
The guidelines for PA Scope of Practice vary from state to state. The following is an excerpt from the California Code of Regulations. For the complete text, refer to the following website: **http://www.pac.ca.gov/supervising_physicians/faqs.shtml.** There are also limitations for ocular services that covered under the Business and Professional Code.

"The scope of a given PA's practice is limited by his/her supervising physician. Whatever medical specialty a physician practices (e.g., general practice, cardio-thoracic surgery, dermatology, etc.) limits the PA's scope of practice. The Delegation of Services Agreement between the PA and the supervising physician then further defines exactly what tasks and procedures a physician is delegating to the PA. These tasks and procedures must be consistent with the supervising physician's specialty or usual and customary practice and with the patient's health and condition.

Before authorizing a PA to perform any medical procedure, the physician is responsible for evaluating the PA's education, experience, knowledge, and ability to perform the procedure safely and competently. In addition, the physician should verify that a PA has a current California license issued by the Physician Assistant Committee (PAC)."

Any MD or DO may supervise a PA so long as they have no disciplinary or probationary limitation precluding this activity. Under California guidelines, a physician may supervise up to 4 PA's at a time. A PA must be supervised – the PA cannot practice independently.

Supervision – Based on Scope of Practice
Per the guidelines, supervision may take one or more of the following formats:
1. The physician sees the patients the same day that they are treated by the PA.
2. The physician reviews, signs and dates the medical record of every patient treated by the physician assistant within thirty days of the treatment.
3. The physician adopts written protocols which specifically guide the actions of the PA. The physician must select, review, sign and date at least 10% of the medical records of patients treated by the physician assistant according to those protocols within 30 days.
4. Or, in special circumstances, the physician provides supervision through another mechanism approved in advance by the PAC.

Also, per the California scope of practice guidelines, the billing provider is not required to be onsite when the services are performed.

Billing Guidelines
Since the PA cannot practice independently, carriers are not allowed to make payment directly to the PA. All services billed by the PA are paid in the name of the practice employing the PA. There are two ways the PA's services may be submitted to the carrier:

1. Services performed by the PA are billed in the PA's name (carriers may require credentialing the PA)
2. The services may be billed in the name of the supervising physician

If the PA is billing under option #1, then only the scope of practice guidelines apply.

But, if the PA is billing under option #2, then, under Medicare guidelines, the PA is working "incident to", and in this case, the "incident to" billing guidelines supersede scope of practice.

"Incident to" Guidelines: Primary Differences from Scope of Practice

- An incident to provider cannot see new patients or new problems – he/she can only carry out a treatment plan that is already established by a physician.
- The incident to service must be provided under direct supervision – meaning that the billing physician must be onsite in the office suite when the services occur.

Both these requirements are significantly different from scope of practice guidelines. However, if the services are reported "incident to", these are guidelines that must be followed according to Medicare.

Shared/Split Services

The shared/split services guidelines become applicable if both the physician and the PA see the patient. (An example of this type of service is the PA doing the patient's initial intake and then the physician participates in the encounter confirming salient facts and doing the decision making.)

In the office setting, if both the PA and the physician see the patient for an E/M encounter, and the incident to guidelines are not met (i.e., the patient is new or the problem is new), then the encounter must be reported under the PA's UPIN number.

According to Medicare guidelines, inpatient services cannot be provided on an "incident to" basis. Billing in this case depends on who saw the patient. If the PA is the only provider from the practice to see the inpatient that day, then the bill must be submitted in the PA's name.

However, if both the physician and the PA see the patient on the same day in the hospital inpatient/outpatient/ED setting, then under the inpatient shared/split services rule, the services may be reported under either the physician or the PA's name. (Note this is entirely different than the shared/split service rule in the office setting.)

Modifiers: 25 versus 57

Both modifier 25 and modifier 57 are reported exclusively with E/M services: neither would ever be appended to a procedure code.

The modifier 25 is used to identify an E/M service as a significant separately identifiable service from other services performed on the same day. This includes minor procedures and certain diagnostic procedures.

If the patient presents specifically for a procedure, then the procedure is all that is billed and no E/M service (and consequently no modifier) is reported. But if there is sufficient service performed and documented to support the requirements of an E/M service, then the E/M service can be reported, and the 25 modifier should be appended.

The 57 modifier is used to indicate that during the E/M service, a decision has been made to perform major procedures. "Major procedures" are procedures with a 90 day global.

Per CPT, the encounter where the decision for major surgery is made is always excluded from the global period. The global period for major procedures begins the day prior to the procedure. The 57 modifier is usually applied when the decision is made for same day or next day major surgery, in order to separate the service from the global period.

Countdown to ICD-10:

How Does Your Documentation Measure Up?

One of the biggest concerns about ICD-10 is whether or not physician documentation is going to be sufficiently supportive of the specificity requirements.

Many organizations are concerned that the documentation currently being produced is not specific enough to be able to be assigned a code under ICD-10 and that this will require additional documentation training for physicians at the same time as they are trying to master the new coding.

For example, in ICD-10, the current code for "sprain and strain, unspecified site, elbow and forearm" (841.9), has 30 potential crosswalk codes in ICD-10. Choosing the correct code will depend on the site (elbow versus forearm), whether or not digits are involved (digits are individually identified in addition to the forearm), laterality (right versus left), and whether it is the initial encounter for the problem, or a subsequent encounter.

Orthopedic codes are especially problematic for specificity because of laterality issues. Many of the orthopedic codes are also dependent on whether or not the encounter is the initial encounter for the problem or the subsequent encounter.

By now, you should be familiar with the ICD-10 code sets most likely to be used in your practice. Evaluate the specificity requirements of these codes against the specificity of documentation currently being produced to see if additional documentation specificity is going to be required.

Worker's Comp Corner

California Legislative Decision on Compound Medications

It appears as if the insurance industry is about to prevail in the ongoing fight over the prescribing of compound medications. The business community has been attempting to limit the use of these medications for some time, and now the State Legislature has unanimously approved a bill designed to cut down on the practice of physicians dispensing compound drugs for profit by capping the reimbursement for the medications until they are covered by a fee schedule. The bill, would limit reimbursements to 120% of the documented costs of the compounding pharmacy rates in the Medi-Cal database, or 83% of the average acquisition costs of the drug. Although the Assembly already approved a similar measure, they will have to vote on it again as amendments have been inserted. The bill is expected to pass the Assembly.

Coding Case Study: What's the Level of Service?

PRIMARY TREATING PHYSICIAN PROGRESS REPORT

Patient Name:
DATE OF INJURY:
CLAIM NO:

BRIEF HISTORY:

The patient is seen in follow up today after my last visit on [x]. He has been on a regular work duty status since [x]. He has noted that with certain types of activities he still experiences some pain about the metacarpophalangeal joint of the right thumb. As you are aware, he had a strain or a partial tear of the right thumb ulnar collateral ligament that we treated with 6 weeks of cast immobilization. With using of the shears and other activities that require forceful use of the thumb, he begins to develop some soreness throughout his workday over the dorsoulnar aspect of the metacarpophalangeal joint of the right thumb. Throughout his workday he also begins to experience some pain over the dorsal central aspect of the right wrist. Both of these areas of pain are alleviated when they are resting for any prolonged period of time. Working, particularly forceful, but also with repetition, causes the pain to develop.

The patient has been wearing a thumb spica neoprene wrist wrap while at work. This provides some additional support yet is not rigid and does not result in significant stiffness.

REVIEW OF SYSTEMS:
GENERAL: Negative history for weight changes, fever/chills, night sweats, and dizziness.
NEUROLOGICAL SYSTEM: Negative history for headaches, seizures, episodic neurological symptoms, pain or sensory perceptions, weakness, head trauma, stroke, and sleep disorders.
ENDOCRINE SYSTEM: Negative history for heat or cold intolerance, thyroid problems, neck surgery/irradiation, or diabetes.
ENT SYSTEM: Negative history for difficulty hearing, ear discharge, tinnitus, epistaxis, hoarseness, sinusitis, vertigo, or speech difficulty.
CARDIOVASCULAR SYSTEM: Negative history for difficulty breathing, chest discomfort, palpitations, syncope, edema, phlebitis, or calf pain.
PULMONARY SYSTEM: Negative history for shortness of breath, coughing, sputum production, or wheezing.
GASTROINTESTINAL SYSTEM: Negative history for nausea, vomiting, retching, difficulty swallowing, indigestion, heartburn, abdominal pain, abdominal swelling, jaundice, blood in stool, diarrhea, or constipation.
GENITOURINARY SYSTEM: Negative history for frequent urination, difficulty passing urine, hard to start urination, dribbling, burning sensation, bladder infection, urethral discharge, or genital lesions.
MUSCULOSKELETAL SYSTEM: Negative history for joint stiffness, joint pain, or joint swelling.
PSYCHIATRIC SYSTEM: Negative history for interpersonal relationship difficulties, anxiety, depression, or substance abuse.

PHYSICAL EXAMINATION:
GENERAL: He is an alert and attentive male who speaks fluent Spanish. The examination was done with the assistance of a professional translator.

VITAL SIGNS: BP 137/79, pulse 72, respiratory rate 16.

NEUROLOGICAL: He is alert and oriented x 3.

UPPER EXTREMITIES: Grip strengths on the right today, which is his dominant injured hand, measures 65, 65 and 62 pounds, while the left measures 68, 65 and 65 pounds.
Two-point pinch on the right measures 9, 9, 8, pounds, while the left measures 15, 15 and 14 pounds.
Three-point pinch on the right measures 12, 12, 10 pounds, while the left measures 11, 10 and 10 pounds.
Key-pinch on the right measures 15, 15, 15 pounds, while the left measures 15, 15 and 15 pounds.

He has some continued thickening of the soft tissue over the dorsoulnar aspect of the right thumb at the metacarpophalangeal joint, dorsoulnar aspect. It is tender to palpation. He has a very subtle fullness over the dorsal central aspect of the right wrist directly overlying the area of the scapholunate articulation. He has a negative right scaphoid shift test, however.

ASSESSMENT:
1. Acute tear ulnar collateral ligament, level of metacarpophalangeal joint, right thumb, occurring on [x], treated with 6 weeks of cast immobilization, stable yet intermittently symptomatic over the dorsoulnar aspect of the junction of the ulnar collateral ligament and the dorsal capsule.
2. Status post immobilization development of small soft tissue fullness, dorsum of the right thumb, without clear evidence of any ganglion at this time, symptomatic.

DISCUSSION:
The patient will have a steroid injection placed over the dorsal central aspect of the right wrist in the most painful area and in the painful area over the dorsoulnar aspect of the metacarpophalangeal joint of the right thumb. The patient will be given a new thumb spica neoprene wrist wrap.

I will schedule the follow up for the patient for [x]. As of this evening, he will be on total temporary disability given the 2 injections. That doesn’t really affect his work for today, but it will have him off work tomorrow unless there is light duty available which does not require use of the right hand. The following day, will result in reverting back to usual and customary duties. I will assess his progress at his next visit.

The face-to-face evaluation required more than 25 minutes. More of half that time was spent in counseling the patient with the assistance of a professional translator regarding the nature of the injuries, the progress he is making, why we are treating it the way we are, and what to expect over the next several weeks.

Coder's Audit:
This is reported as a follow-up encounter by an orthopedic surgeon

Chief complaint
There is no specific chief complaint statement
[Coder's Note: All E/M encounters require a chief complaint. If the encounter is a follow-up, the chief complaint should indicate the condition necessitating following – i.e., "follow-up for thumb injury"]

4 HPI elements are present:
- Location (thumb)
- Modifying factors (activities that cause increased pain)
- Associated signs/symptoms (Symptoms patient currently experiencing)
- Timing (soreness throughout the work day)

10 System Review present
General, neurological, endocrine, ENT, cardiovascular,, pulmonary, gastrointestinal, GU, musculoskeletal, psychiatric
[There are several concerns about the system review as repreented.
First, for coding purposes, only review of those systems considered relevant to the presenting problem are counted as medically necessary. A carrier auditor may remark on the relevance of some of these systems to the presenting problem
Second, each system statement begins with the statement "negative history for…". A system review is general intended to cover symptoms the patient may be experiencing. When documentation speaks to a "history of", this is generally considered past history, not system review.
However, if the provider considers this information as system review relative to current findings, then the provider has indicated in the system review that the patient is negative for "joint stiffness, joint pain, or joint swelling". This statement contradicts the HPI Per Medicare, this would negate the medical necessity for the encounter, and the contradiction makes the service non-billable.]

PFSH:
Social History – patient's work status
[Coder's note: the overall history is detailed]

Exam:
1995:
4 organ systems covered: constitutional, psych, MS, skin
[Coder's Note: Based on 1995 guidelines, the exam would be considered expanded problem focused.]

1997:
7 bullet points:
Vital signs, general appearance, psych for alert and oriented, MS x2 for bilateral grip strength, skin x2 for inspection and palpation
[Coder's Note: The exam would be considered expanded problem focused]

Medical Decision Making
1. Follow-up problem with exacerbation
2. Second problem identified, no treatment indicated

Overall
History: Expanded problem focused
Exam: (1995) Detailed; (1997) Expanded problem focused
Medical Decision Making: Low Complexity

Based on the problems identified in the ROS discussion above, the service may not be billable because of the contradiction between the HPI and the ROS.

However, for the purposes of assigning a code, then based on Key Components, using 1995 or 1997 guidelines, the encounter would support 99213. The provider also included a time coding statement indicating that greater than half of the 25 minute encounter was spent counseling the patient and included the nature of the counseling in that statement. Based on this, the encounter supports 99214.

According to the plan, 2 steroid injections are actually planned for the same day, but there is no actual documentation of the injection procedure to confirm the occurrence. It would not be appropriate to report the steroid injections without that additional documentation.

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