



Compliance-Matters!

A Bi-Monthly Clinical Newsletter from Morehouse School of Medicine Office of Compliance
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Get Paid For WHAT YOU DO



The increasing number of forms submitted for providers to complete and patient “no-shows” have been practice issues raised by providers. Many physicians ask the question, “Is it OK to make money off non-clinical services?” They wonder if it’s unfair, ethical or illegal. Over the past five or 10 years, practices have experienced a growth in the amount of administrative overhead and time expected to provide non-clinical services. Patients often will return to have various forms completed such as camp, disability, pre-school, daycare, insurance, armed services, and sports. The increasing number of forms can become astronomical. Many providers will not charge if the forms are presented during the visit; however, if presented at a later date, this requires additional clinical and administrative time.

With the new HIPAA laws, the medical records arena has changed. You have to get special approvals – you have to ensure written consent, and records have to be handled per protocol. Providers and their support staff may spend hours of clinical time yet never get reimbursed. The current trend is for practices to establish a policy and fee for administrative services. Though these services may not be reimbursed by most payors, there are CPT codes for appropriate billing. The state board of medical examiners or state medical societies may offer guidelines on how much to charge patients for non-clinical services. Practices can check with their payors and review contracts regarding administrative costs and policies regarding “no-shows.” Practices should establish policies, give notices to patients at the front desk, and remind patients when they call to request these services. Before implementing new policies and changes, post notices 60 to 90 days to give patients advanced warning.

The Six-Month Rule: Primary Care Exception

Under the primary care exception, you may use the physician fee schedule payment for teaching physician claims billed under CPT codes 99201 – 99203 for new patients and 99211 – 99213 for established patients when such evaluation and management (E/M) services are furnished by residents without the presence of the teaching physician for the key portion of the E/M services. The encounter form should have the modifier – GE – noted to indicate that this service was rendered by a resident without the presence of the teaching physician.

One provision of the exception requires that any resident furnishing the service without the presence of a teaching physician must have completed more than six months of an approved residency program. In addition, under the exception, the teaching physician must fulfill certain responsibilities. Among these responsibilities, the physician

- Must direct the care from such proximity as to constitute immediate availability;
- Must not direct the care of more than four residents at any given time; and
- Must have no other responsibilities at the time.

**CONFIDENTIAL
DISCLOSURE LINE**

1-888-756-1364

MMA/MSM COMPLIANCE LINE

**Report suspected
noncompliance in the
workplace.**

**It's your responsibility
to maintain an ethical
environment!**



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QUIZ YOURSELF

BILLING FOR IMMUNIZATIONS

Q When a patient comes in just for an immunization or several immunizations, the patient is not seeing the doctor at all. A nurse will administer the shot. Can we charge a 99211 for the nurse giving an immunization or just the immunization code and administer 90471?

A You should not use the 99211 when delivering immunizations, even if you are taking routine vital signs. Verifying that a patient is OK for a shot and making sure the patient is OK before leaving the office are components of the administration code. You should bill for the vaccine and administration. If you are administering three vaccines; you should bill the appropriate vaccine codes and administration code 90471 for the first vaccine, then 90472 times two for the second and third vaccine. Note 90472 is an add-on code and must be used in conjunction with 90471.

DEFINING NEW PROBLEMS

Q Part of determining the level of medical decision making involved in an E&M visit is whether the presenting problem is a new one. Does that mean a new problem to the patient or new to this physician?

A A new problem is a problem new to the physician. It is the physician's work effort that is relevant for the level of coding in the medical decision making component. This factor may increase the billable level of service.

HOSPITAL VISITS AND DISCHARGES

Q May a physician report both a hospital visit and hospital discharge day management service on the same day?

A NO. The hospital visit descriptors include the phrase "per day" meaning they include all care for a day. Code 99238 (hospital discharge day management services) is used to report services on the final day of the hospital stay. To report both the hospital visit code and the hospital discharge day management services code would be duplicative.

Q May a physician report two hospital visits on the same day to the same patient for unrelated problems?

A NO. The inpatient hospital visit descriptors contain the phrase "per day" meaning code selected should reflect services provided for the day.

Reference: Your Best Practice / October 2007—A supplement to *Consultant for Pediatricians*



New Patient vs. Established Patient

Compliance Spotlight



The Compliance team commends **Drs. Osko (Peds) and Oduwole (Medicine)** for most improved audits during the second and third quarters. *Kudos!*

A new patient is defined as a patient who has not received any professional services within the last three years from the billing physician or by another physician in the same group practice of the same specialty. Therefore, in a multispecialty group practice, a patient referred to a different physician with a different specialty would be considered a new patient. When a physician is covering for another physician, the patient's encounter will be classified as if it were performed by the physician who is not available.

Please be sure to use this definition when selecting the appropriate evaluation and management code. Note that the LOCATION (Place of Service) HAS NOTHING to do with determining the patient status of New vs. Established.