Professional Billing Compliance Frequently Asked Questions

Billing

1. Why is it necessary to record the payer denial code/reason on the patient's account in the billing system?

It is an appropriate audit trail. It ensures appropriate follow-up action is taken. It tracks and establishes trends of potential billing and/or coding problems.

2. Can a physician bill for sutures removed during an office visit that were originally placed by a different physician? How should the suture removal be reported?

If the physician/group who is removing the sutures did not place the sutures, then the suture removal would be considered part of the E/M (Evaluation & Management). The ICD-10 for suture removal would be used. If the physician originally placed the sutures it is not separately reportable. There is not a separate code that describes removal of sutures when the removal is not performed under anesthesia.

3. The resident admits a patient to the hospital and the attending is called to ok the admission and give orders for the patient's care. The attending sees the patient the next morning and takes the history and performs an examination. Can the attending bill for a hospital admit, if so what date would be used?

Yes, the attending can bill for the admission. It should be charged on the day the attending actually saw the patient. The CPT description of the hospital admission (99221-99223) requires that the physician is to complete a history and an examination. Even if the resident

is the one to admit the patient, the attending cannot code the admission until he/she has had a face-to-face encounter with the patient. In this case, it would be the next day. CMS Medicare Claims Processing Manual

4. **Why can't I just make it simple and charge the same level for all my patients?**

   Not every patient is the same, nor is the amount of time and service provided the same. Become familiar with components requirements of the evaluation and management services and it will become second nature to assign the appropriate level code and be reimbursed for the work effort.

5. **Can someone other than the attending physician sign the superbill/encounter form for the physician?**

   No. The attending physician's personal signature confirms two essential facts to initiate Billing: (1) The attending was directly involved in the patient care services. (2) The selected level of CPT codes and ICD-10 codes are supported by the attending's documentation in the medical record.

6. **How long after identifying an overpayment from a federal payor should a refund be issued?**

   Medicare states overpayments should be refunded within 60 days of discovery. A provider can be assessed interest of 12.625% verify if not refunded within that time period.

7. **Can I bill for consultation with the patient's family?**

   In certain types of medical conditions, including when a patient is withdrawn and uncommunicative due to a mental disorder or comatose, the physician may contact relatives and close associates to secure back ground information to assist in diagnosis and treatment planning. When a physician contacts the relatives and associates for this purpose, expenses of such interviews are properly chargeable as physician's services to the patient on whose behalf the information was secured. If the beneficiary is not an inpatient of a hospital, Part B reimbursement for such an interview is subject to the special limitation on payments for physicians' services in connection with mental, psychoneurotic, and personality disorders.

   A physician may also have contacts with a patient's family and associates for purposes other than securing background information. In some cases, the physician will provide counseling to members of the household. Family counseling services are covered only where the primary purpose of such counseling is the treatment of the patient's condition. For example, two situations where family counseling services would be appropriate are as follow: 1) where there is a need to observe the patient's interaction with family members;

and/or 2) where there is a need to assess the capability of and assist the family members in aiding in the management of the patient. Counseling principally concerned with the effects of the patient's condition on the individual being interviewed would not be reimbursable as part of the physician's personal services to the patient.

8. Must I have different diagnosis codes when billing an E/M and a procedures (using the 25 modifier) on the same visit?

In many instances the diagnosis code referenced for the E/M service is different from the diagnosis code referenced for the procedure (that is, two different medical conditions), Example: A patient is seen for a scheduled follow-up visit for hypertension and complains of a sore shoulder. After evaluation of the blood pressure and the shoulder, a diagnosis of bicipital tendonitis is made, and the shoulder is injected. In this case, the appropriate E/M code for the level of service provided, as well as the procedure for injection, should be submitted.

In some instances, however, the diagnosis code referenced for the E/M service and the procedure are for the same condition or illness, Example: A patient complains of a sore shoulder. After evaluation of the shoulder, a diagnosis of bicipital tendonitis is made, and the shoulder is injected. In this case, the appropriate E/M code for the level of service provided, as well as the procedure for injection, should be submitted.

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