



# MPECS PRODUCTIVE PROVIDER Newsletter

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## Productive Provider Newsletter

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All material contained in this publication is the original work of Jim Meeks, P.A.-C. unless otherwise noted. Quotations from and references to this material are encouraged and authorized as long as credit is given to the author, this newsletter by name and reference to the MPECS web site is included.

## Please Share

I receive many messages of thanks for the information published in this newsletter. Most of these newsletter articles end up being published in ADVANCE for PAs and some on-line web sites which is wonderful.

However, I still need your help in getting this information out to the many people like you that practice medicine every day and get confusing information on how to document, code and bill for the services you provide.

Can you please forward this and any other issues of the Productive Provider Newsletter to your associates? I'd be very appreciative.

As always, your comments and questions are appreciated.

## Cancer Battle Update:

Please visit my personal health blog for updated and current information on the treatment of my cancer. You can find the blog at:  
[jimmeekshealth.blogspot.com](http://jimmeekshealth.blogspot.com)

## Answering Questions . . .

***“Do I have to be personally recognized as a PA by each individual private insurance company to bill for first assist under the PA ID number?”***

To bill for surgical first assisting, you do need to use your unique NPI number. In order for any entity to recognize your number, you do have to be credentialed with that company.

This is a double edged sword. To get paid for the service you provide, you need to bill. To bill, you need to be credentialed. Credentialing leads to identification of you by the insurance company and therefore, gives them the opportunity to discount (penalize) the amount they pay for your services in all settings, not just first assisting.

As more and more PAs and NPs credential with the various insurance companies across the country, we will see more and more attempts to penalize us for our service to their client base. This will complicate our lives and worse yet, the lives of the patients we care for.

***“If the supervising physician is in the clinic but I see his patient without the doctor having any involvement with the patient, can we bill it legally under the doctor's ID number or do we have to use the PA ID number?”***

With the exception of Medicare, the supervising physician does NOT need to be involved with the patient at the time of the clinic visit as long as that visit falls within the Practice Act of the State where you work. All such visits can and should be billed under the supervising physician's NPI number.

Medicare is the only entity (so far - see “double edged sword” above) that requires that the physician see the patient on the first visit or for any “new problems.” Any follow-up care provided by a PA or NP thereafter is considered “incident to” when the encounter is a follow-up of that physician's first visit and treatment plan and the physician is present in the clinic. I am not aware of any private insurance company imposing the same “incident to” rule to their patient population. However, with that said, every medical practice needs to be sure that there are no clauses in their provider contract with any insurance company that requires physician presence or involvement. Know your contracts and negotiate accordingly. (Contracts are negotiated between the physician/practice and the insurance carrier.)

Additionally, be aware that there is nothing to prevent you from seeing a Medicare patient on the first visit, implementing a treatment plan and taking care of that patient. That is OK to do. You just have to be sure to bill that type of encounter with your NPI number which will then lead to a discount (penalty) for your services to that patient. There is a HUGE misconception by many office managers and providers that somehow it is taboo to see Medicare patients on the first visit or for new problems. It is NOT. You just have to understand how to bill for that service.

The question you have to ask yourself is where is the greater service to the patient? Will the needs of any patient be served if they have to wait for an appointment to see the physician and thus allowing that visit to be paid at 100% of the allowable Medicare fee schedule? Or, will the patient's needs be better met if a PA/NP sees the patient in a more timely manner, gets a treatment program started or surgery scheduled and the practice accepts the discounted (penalized) fee of 85% of the Medicare allowable. In my practice setting, it is much more acceptable to see ALL patients as they need to be seen, new patient, new problem or whatever, regardless of how Medicare will pay for their services. Everyone is much happier.

Personally, I believe it is up to the PA/NP seeing the patient to make the determination of whether or not to bill a specific visit as “incident to” or not. You might consider simply writing “IT”



## Questions . . .

(for "incident to") on the superbill somewhere to give the billing staff the heads up that this visit qualifies for "incident to" billing. Otherwise, any Medicare patient superbill without "IT" on it is billed under your NPI number. A simple solution to a daily problem.

Remember that if you work in a hospital based clinic, you are not eligible to bill "incident to" in any circumstance. "Incident to" applies only to clinics not operated by the hospital. For example, If I work in a hospital based clinic where the supplies, utilities, nursing staff, etc. are all provided by the hospital - that is a hospital based clinic. I cannot bill incident to for any patient encounters. If however, I work in a clinic attached to a hospital (office building), but the practice is owned and operated by a physician or group of physicians, "incident to" billing is appropriate as long as I meet the "incident to" criteria. It boils down to who is paying the bills.

Please review the in-depth article on "incident to" billing in the previous MPECS Newsletter from July 2004 entitled "So Many Questions, So Much Confusion."

***"If I see a doctor's patient on a day where he is not in the office and I am being supervised by another physician, can I still bill under the original doctor's ID number for his patient? Is it the same for private insurance versus Medicaid/Medicare?"***

Yes, that is an appropriate concept. If your primary supervising physician is out of the office (in surgery, on vacation, etc.) and a substitute supervising physician is present, your billings should continue the same as they always have. Nothing requires any change to the billing process and it is the same for private insurance and Medicare/Medicaid.

For Medicare, the "incident to" rule continues to apply as it always has. If the supervising physician is not present or on site, then you cannot bill Medicare encounters as "incident to."

With regard to patients with private insurance, you can continue to bill all encounters as you would normally. Generally speaking, physician presence is not required and "incident to" doesn't apply because it is a Medicare rule. Bill these patients under the physician's numbers as you would normally do.

You need to be sure that your billing practices are not contrary to any state laws or practice acts. You need to be sure that you follow the procedures of your insurance carrier contracts.

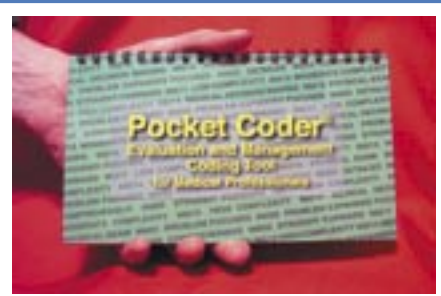
***"I spent 30 minutes with the parents of a child to discuss labs and they did not bring the patient in. I hear a variety of info re: coding this visit. I believe I could code it as a 90211 since there is no physical exam required but that only pays a fraction of the cost of the visit. Can I code time based? Is there another code out there to use?"***

Coding this as a 99211 would be a gross under-valuation of your time and skills as a skilled provider. Assuming that the patient is a minor and the parents are the guardians, you are providing medical care for that child in your office setting. The fact that the patient isn't present is unfortunate, but you can bill for the service and expect to get paid.

Your documentation of the encounter will be the key to billing this correctly. First and foremost, document the time of the visit. Stating that you spent "30 minutes" with the patient is a good start, but I advise all my clients that they should document a start time and a stop time in the chart to provide absolute times in case any of it comes into question.

Secondly, you can bill the parents for the time discussing the child's care as long as you document it specifically as such. For an established patient 30 minute encounter, you should bill a 99214 for the service you provide - especially if you are providing medical advice. You need to document the elements of the discussion, i.e., the parents concerns, your advise and recommendations, lab tests, treatments, follow-up, and the reason the parents didn't bring the patient to the visit.

When billing an established patient encounter based on time, no physical examination is required. If this were a new patient, I would think that the patient needs to be present. Yet, if billing is based on the length of the encounter, again, no physical exam would be required, but that would be a very rare encounter indeed.



If you are unsure of what constitutes history, exam and medical decision making (you are not alone), you should consider getting the **POCKET CODER** which outlines the specific elements of a patient encounter in an easy to understand matrix format.

Every **SOSE exam** is available now, and you can download them in PDF format for your perpetual use.

See information on the **PRODUCTS** page of this web site.

**Please Join Us**

At the "World's Largest Family Practice PA Conference" in San Diego, California, October 29 through November 1, 2008 at the San Diego Marriott Mission Valley. This is the Association of Family Practice Physician Assistants Fall conference. The MPECS Billing and Coding Essentials Workshop will be presented there. Details at [www.afppa.org](http://www.afppa.org).