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The Most Common Billing Mistakes for PA Services

MOST COMMON MISTAKES IN CODING AND BILLING FOR PHYSICIAN ASSISTANTS.

Coding and Billing properly for a Physician Assistant is often challenging. How to avoid the most common mistakes and the best way to achieve the appropriate reimbursement for a physician assistant. You are listening to ReachMD XM-157, the Channel for Medical Professionals. Welcome to The Clinician's Round Table.

I am Lisa D'Andrea, your host, and with me today is Emily Hill, a Physician Assistant, and the President of Hill & Associates, a medical billing and coding consulting firm in Wilmington, North Carolina. Emily currently serves on the AMA's Correct Coding Committee and is here to help us avoid some of the most common mistakes in coding and billing for physician assistants.

LISA D'ANDREA:

Hi Emily, welcome to ReachMD.

EMILY HILL:

Hi Lisa, thanks for having me.

LISA D'ANDREA:

Emily I would like to go through some of the top billing and coding mistakes that are made by practices that employ PAs. What's your favorite?

EMILY HILL:

Well my favorite really is that there is a lack of communication between the billing and coding staff and physician assistants, in part because this is a problem that we have in medical practices all across of the providers and the billers talking together, but it is even more critical for PA Services, because there is a lot of misunderstanding about billing guidelines, Medicare's Incident-To provisions, how to report services on the claim form and folks just need to talk and be sure everybody is on the same page.

LISA D'ANDREA:

Who is responsible for learning these and teaching the rest of the staff?

EMILY HILL:

Well I think that the PA really needs to take the initiative to understand billing and reimbursement guidelines and that is the frequent problem when we go to practices with PAs is that they've left that all to the billing staff and the billing staff may or may not completely understand the services of a PA. Sometimes they are the first PA they've had in that practice and there are a lot of resources out there for PAs. The American Academy of Physician Assistance has wonderful guidance on their website at www.aapa.org and it is accessible to the physicians who employ the PAs as well. They will actually even get on the phone and chat with you and answer questions as you need to, but a PA really needs to understand the basic guidelines for billing and reimbursement, particularly when it comes to Medicare, which is very we see the most confusion.

LISA D'ANDREA:

There is a learning curve here though, it takes years for a PA to learn these things, especially when it comes to reimbursements and guidelines and they are constantly changing, so is it best for the PA to work as a team with the billing staff.

EMILY HILL:

Absolutely! Team work is always best. Whether we are talking about PAs and billing staff or physicians and billing staff. Some of the guidelines do change. Medicare guidelines are relatively stable. We have some exceptions to that over the last several years. We've had, in fact, in many of those instances; it is made it easier for PAs and MDs to work together. In some instances, it has hindered the PA a bit or decreased the services they might be able to provide. For example, Medicare came up with a concept of a shared visit, which really applies to the hospital setting, but basically states that if the physician and the PA see a hospital patient on the same day, they can combine that work, report it under physician's name, get a 100% of the reimbursement and the requirement is that the physician provide face-to-face service to the patient and personally document their encounter. Now this only applies, however, to evaluation and management services and specifically excludes consultations. So while it opened up the avenue for increased reimbursement for hospital services, it sort of shut the door on being able to bill a shared visit for consultations. So you are right, there are constantly changes, but understanding the general principles of Incident-To, the fact that you can bill under your own number or not is important. I hear lots of rumors from both PAs and their office staff. For example, it says PA can't see new patients. Well that is not true at all. PAs can see new patients or new Medicare patients as long as they are billing under their own provider number, so the PA needs to understand some of the basics. The billing and coding staff also have some responsibility to understand those things as well and to understand their other third-party payers, their managed-care organizations and how they are going to treat PA services.

LISA D'ANDREA:

So when you consult for an office-based practice, do you suggest that the PA meets with the billing staff daily to go over any billing issues or weekly, monthly? Do you have any kind of guidelines for them to follow?

EMILY HILL:

I think Lisa a lot depends on how new in the practice that PA is, both in general clinical practice and with that particular group, probably

daily is not necessary, except perhaps in a very few instances, but early on in the relationship maybe once a week is a good idea. Certainly no less than once a month and I will tell you that this is a problem not only with PAs and billing staff, but as I had mentioned before physicians and billing staff. The provider and the billing and coding staff need to get together periodically to look at what is happening, what things are not being pain, what things are being changed, where their problems are with the third-party payers and that way receiving information from that billing staff, coding staff back to the provider can alter perhaps in some instances behaviors that are leading for example to denials, inappropriate denials.

If you are just joining us, you are listening to The Clinician's Round Table on ReachMD XM-157, The Channel for Medical Professionals. I am Lisa D'Andrea and I am speaking with Emily Hill, a physician assistant and the president of Hill and Associates, a medical billing and coding consulting firm in Wilmington, North Caroline. We are discussing how to avoid some of the most common mistakes in coding and billing for physician assistants.

LISA D'ANDREA:

So Emily the PA gives the biller a super bill. What should the biller be checking before they submit the claim?

EMILY HILL:

Well the same types of things they would be checking for physicians and that there is a CPT code or codes reported and there are ICD-9 codes or diagnosis codes that have been associated with those procedures. There could be instances when the practice chooses to bill the PA services to Medicare either under Incident-To guidelines or under the PA's number depending on the particular clinical situation. So if the practice alternates between those 2 billing processes, the PA is going to need to indicate on that super bill whether the claims should be billed under her name or whether the claims should be billed as Incident-To.

LISA D'ANDREA:

Let's talk about reimbursement denial for a PA. What do you do if you get denied payment for a PA service?

EMILY HILL:

Well the first thing you need to do, is to determine the reason for the denial and the payers send out, what we call EOBs or explanation of benefits, that say by line item, how they pay that line item claim and that line item being a CPT, particular CPT code, or if they denied it and give us what we call a non-covered reason code and that reason code very often will reflect perhaps a reason other than the fact that it was a PA service as the reason for the denial. What I see happened in practices, is that they will see a claim or line item denied by the payer, assume it is denied because the PA provided the service when in essence the denial was really for some other payer rule, either bundling rules or some other situation. So it is really important to look and make certain that it is a PA-related problem as opposed to some other denial. If it is a PA-related problem, you need to make certain if you didn't do this at the outset. What that particular payer's guidelines are for reimbursing physician assistants? So if that payer for example doesn't recognize services furnished by a physician assistant, then you are going to have a reason for that denial that is PA related. When practices actually check with a third-party payer to determine do they cover services provided by PAs, what billing mechanism do they need to provide, either the PAs name and number, the physician's number, is there a specific modifier they like to see, etc. When you do that, you begin to understand how those services should be reported to that payer. If you have not done that, you may be finding out on the back end that particular payer's reimbursement guidelines and we would like to avoid that.

LISA D'ANDREA:

A common reason for denial of payment is the failure to provide linkage between the CPT and the ICD-9 codes. Can you explain the importance of that?

EMILY HILL:

Sure, Actually what ICD-9 codes do in terms of reimbursement is to provide the medical necessity or stated another way, the clinical justification for the CPT code that's being billed. So there needs to be a reasonable relationship between the CPT code and the ICD-9 code. For example, I was in a practice where a PA had seen a child for an otitis media and on the way out the door, the parents said, Oh by the way, he started wetting the bed at night. So they did a urinalysis to rule that out, but the PA didn't provide an ICD-9 code that would justify the urinalysis. So when the claim goes in, it looks like a visit for otitis media and a urinalysis performed for otitis media, and so that makes obviously no sense clinically and it makes no sense to the clinical edit that a payer may have put into their billing software. So 2 things need to happen in that instance. #1 the PA needed to mark both the diagnosis for the otitis media as well as signs or symptoms for the bedwetting or anuresis or whatever the appropriate ICD-9 was and more importantly or just as important perhaps is to somehow link to that office visit all the diagnosis or diagnoses that should go with that and to link to that urinalysis, the diagnoses that justify that and simply what people do when their super bill allows them to write in diagnosis 1, 2, 3, 4, is they take a #1 and place it next to all the CPT codes to which that diagnosis applies and diagnosis #2 and put that next to all the procedure codes to which that diagnosis applies, and then the billing staff, when they see that, they can make the proper association on that claim.

LISA D'ANDREA:

Is there a maximum number of ICD-9 codes?

EMILY HILL:

There used to be max number of 4 ICD-9 codes. Now HIPAA guidelines will allow up to, I think, it's 8 ICD-9 codes per claim. Most folks never get into needing 8 diagnoses and in fact, you really only need the diagnoses that actually support that CPT code you are billing. So it hardly ever happens that we really max out the number of diagnoses that we need.

LISA D'ANDREA:

Let's talk about undercoding for E&M services.

EMILY HILL:

That's common problem I see with PAs. They typically write terrific notes. They do great workups. They are usually very thorough and then they pick a low-level visit and I have tried to understand for years exactly why that is and it is not that PAs are the only folks that undercode. Certainly physicians can do that as well, but it seems to be fairly common for PAs to do a lot of work and then be afraid to pick the proper level, so they just love that code in the middle, the 99213 for established patients for example. Some of them like the 99212, but we see a lot of level-3 visits when, in fact, the work they did may have supported a higher level of service.

LISA D'ANDREA:

Thank you Emily for coming on the show.

EMILY HILL:

Thanks for having me Lisa.

I am Lisa D'Andrea and you have been listening to The Clinician's Round Table on ReachMD XM-157, The Channel for Medical Professionals. Please visit our web site at ReachMD.com which features our entire library through on-demand pod casts or call us toll free with your comments and suggestions at 888 MD-XM157 and thanks for listening.

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