CME

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NEW VS. ESTABLISHED PATIENTS WHEN COVERING FOR OTHER PHYSICIANS

Q A family physician from another group practice and I often provide coverage for each other. When I see the other physician's patients for the first time, should I report them as new patient visits?

A No. CPT instructs that when a patient receives services from an on-call physician or one who is covering for another physician, the services are classified as if they were provided by the physician who is not available. If the patient would be established to the primary physician, then the patient is considered established to the covering physician as well.

CODING FOR WEEKEND CLINIC SERVICES

Q Is it appropriate to code 99051 for claims to non-Medicare health plans for services provided during our normal Saturday morning clinic?

A Yes. CPT code 99051, "Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours," is reported in addition to codes for the services provided (e.g., office visit or laceration repair). While some payers, including Medicare, will not provide separate payment for code 99051, others do. Separate payment for this code recognizes that extended primary care office hours allow patients to avoid pricier visits to urgent care or emergency departments. Payers may also pay separately for code 99050, "Service(s) provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed."

INCIDENT-TO RULES FOR MEDICARE ADVANTAGE PLANS

Q Do Medicare Advantage plans allow the reporting of services by advanced practice providers under the Medicare incident-to provisions?

A Generally, yes. However, at least one Medicare Advantage plan (Anthem of Virginia) has a policy to not pay for incident-to services for any provider who can credential and bill directly to the plan. Others may have similar policies, so it's worth checking with Medicare Advantage plans in your area. Payment policies are often available on each plan's website and should be reviewed for changes periodically. Be aware of any requirement to use modifiers such as SA (nurse practitioner rendering service in collaboration with a physician).

CORRECTING SCRIBE DOCUMENTATION

Q Our practice plans to begin using scribes to document office visits. What is the appropriate way to correct documentation that scribes enter into the EHR?

A This may depend somewhat on the EHR. However, each system should allow a physician to edit the scribe's entries before signing the record. If the EHR does not allow this, or the scribe has composed a paper record, the physician should include a signed and dated addendum with the scribe's note.

REMOVING EARWAX USING INSTRUMENTATION

Q When removing bilateral impacted cerumen using instrumentation, do I report one or two units of service?

A Generally, it is correct to report one unit of 69210, "Removal impacted cerumen requiring instrumentation, unilateral," and add modifier 50 (bilateral procedure) when billing most payers. Medicare, however, pays only one unit of 69210 whether the service is unilateral or bilateral. In fact, some Medicare Part B contractors will reject claims when modifier 50 is appended to 69210. Medicare's "Medically Unlikely Edits" policy limits payment for code 69210 to one unit of service per day.

Some payers, including some Medicaid plans, may require you to report the services on two claim lines with modifiers indicating laterality (i.e., "69210 LT x 1 unit, 69210 RT x 1 unit"). Billing staff should verify the individual payer's policies on cerumen removal and reporting bilateral services. If you're reporting a significant, separately identifiable E/M service on the same date, append modifier 25 to the E/M code. FPM

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EDITOR'S NOTE

Reviewed by the *FPM* Coding & Documentation Review Panel. Some payers may not agree with the advice given. Refer to current coding manuals and payer policies.

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