Navigating the Maze of Physician Billing Documentation and Coding (P16)

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Objectives
- Discuss the importance of “medical necessity” for physician billing.
- Identify the appropriate circumstances for using time to choose an Evaluation & Management (E & M) Services code.
- Define the “key components” for choosing an Evaluation & Management Services code based on complexity.

With changing and shrinking reimbursement, the ability of hospice and palliative care organizations to bill appropriately for all billable services is more important than ever. Optimizing physician billing requires an understanding of the regulatory requirement of the levels of care under the Medicare hospice benefit. Hospices and palliative care physicians and nonphysician practitioners struggle with the counterintuitive documentation requirements of billing for physician services. Physicians and nonphysician practitioners coming from private practice may be familiar with office visit codes, but now find themselves trying to code for “something called GIP,” home, ALF, and nursing facility services. One set of E & M codes may have five levels of service, another four, and still another three; no wonder there is confusion. And there are two sets of documentation guidelines: 1995 and 1997. Yet the threat of audits and recoupment makes understanding the requirements a must. This session will discuss how to properly document a patient’s visit using the three key components, or time, to help ensure third-party payers are not successful in retrospective recoupments. The session will begin with the documentation requirements and end by applying this knowledge with an interactive, hands-on auditing of some “typical” hospice and palliative physician notes.