

The Teaching and Supervising Physician: Why Do We Need (Have) Rules?

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In today's world, it is the physician's responsibility to decide on the correct code for services rendered. We as neonatologists embrace taking care of newborns, but the business of neonatology remains a tedious chore. Since the daily rounding requirements of the physicians and associated ancillary groups continue to increase, most neonatal groups employ a business office with coding specialists to assist in assigning both CPT (Current Procedural Terminology) and ICD (International Classification of Diseases) codes. I have often pleaded "not to kill the messenger."

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The teaching and supervising physician includes residents, fellows, neonatal nurse practitioners, and other healthcare providers. The global concepts deal with improper coding (coding for services and procedures that the documentation in the medical record cannot substantiate); coding for the level of service which cannot be substantiated; sloppy reporting, or finally, intentional improper coding now considered "fraud and abuse."

The teaching supervising physician should document their presence, especially their care involvement. When quoted, participation times are called "typical times," and the "typical time" is derived from CPT or RUC surveys. The involved individuals also must match ICD-10-CM diagnoses to the level of service.

The business office must understand the contractual relationships which establish the documentation of services. General evaluation and management principles (E&M) must be followed. The physician must provide timely information, and if there is an addendum added to the note, it needs to be dated and timed.

The PATH Guidelines (Physicians at Teaching Hospitals) are an initiative by the Inspector General (OIG) of the Justice Department to investigate coding and documentation practices. These include presumed abuses, including upcoding and especially the "non-presence" of the teaching physician.

Unfortunately, investigations at all levels are increasing, and they utilize the same audit tools that Federal Medicare employs. Is the term "whistleblower" all too familiar? The justification of the costs of audits is justified by the large amounts of payoffs that are offered. The awards include \$3,000 - \$10,000 per claim in addition to treble the damages. The whistleblower can receive 10-15 percent of this amount.

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Some definitions guide the use of the term "direct services." By definition, this describes a service to a patient furnished by a physician or by a resident supervised by a physician in the teaching hospital. The service furnished and the teaching physician's participation are required to place a code. If the neonatologist is just "on the floor" and not in the area dealing with the patient directly, the code cannot be placed. Remuneration by Medicare will be provided if the teaching attending was present for the critical/key portions of the service. Documentation should include information regarding the performance of the service by the physician and participation in the management decision.

The level of E/M service based upon CPT can be a combination of the resident, fellow, and teaching physician notes which can determine the level of documentation. If audited, the reviewer will consider these notes and decide upon the correct level of code or service.

Several scenarios should be presented. First, the admission and follow-up note must be capable of "standing alone." Second, the resident or fellow performs the key elements in the presence of the attending physician. In that case, as an attestation, the attending physician would state, "I was present with the resident/fellow during the admission or follow-up examination. I discussed and agreed with the findings and plan."

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In addition to all of the above, I recommend that one member of the neonatal team provides input to the billing office. Oftentimes when a code is denied, there needs to be appropriate claims filings, timely follow-through, and an aggressive appeal process that is ongoing. Neonatologists want to care for babies and families and often find these coding guidelines onerous. We often incorrectly believe that reduced payment can be offset by increasing volume. Does this sound familiar?

Certain comments never should be professed to an auditor or claims representative when you are asked to substantiate a CPT or ICD code. These include:

1. You underpaid us, and we want that money right away
2. You people did it again
3. You're completely useless. Let me talk to your supervisor
4. Do you know who I am?

Someone on the neonatal team and in the billing office needs to be aware of the appeal process, the designation of a "clean claim," and the ability to evaluate the explanation of benefits (EOB) where processing errors or inappropriate codes are provided. The teaching physician (us) is ultimately responsible for CPT codes selected and billed. Fraud and abuse will not look good on your curriculum vitae.

The "proactive teaching physician" should have input in the negotiation process on contracts, frequently meets with billing staff to assess denials, claims for additional information, and non-payment. Like the "clotting mechanism," a billing and reimbursement cascade is often repetitive but not always consistent. When we pay our monthly bills, there is often an "interest charge" for delayed payments if late. Why is it that neonatologists and billing offices do not consider this approach? If we don't pay the plumber, the water will be turned off. If we don't pay the electric bill, we sit in darkness. If we don't pay our mortgage, we will be snoring under the stars. Where is the justice?

A Coding Limerick for Today

We disdain the term whistleblower,

In dealing with a feeder or grower.

Our language must not be terse,

When we consider the term "reimburse,."

We don't want our payments to be lower.

Thank you to Dr. Stephen Pearlman, who provided the verbiage for the title of this "MISSIVE".

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