| | Tenet Physician Resources Policy Job Aid | No.: TPR.RCC.100.04.JA |
|---|---|---|
| | **Title:** | **Page:** 1 of 6 |
| | **CODING COMPLIANCE – PHYSICIAN SERVICES: CHARGE TICKET STANDARDS AND GUIDELINES** | **Effective Date:** 09-30-19 |
| | | **Previous Versions Dated:** 10-01-15; 07-08-15 |
| | | **Corporate Review Dated:** 09-19-19 |

## I. PURPOSE:

The purpose of this job aid is to support accurate coding and billing of physician services.

## II. DEFINITIONS:

A. "**Official Guidelines**" mean applicable portions of the following publications: International Classification of Diseases, 10th revision, Clinical Modification, as applicable, including addenda, conventions and instructions (to be referenced throughout this policy and job aids as ICD-10); Current Procedural Terminology (CPT) and HCPCS, including addenda, conventions and instructions; the Centers for Medicare and Medicaid Services manual system, including the National Correct Coding Initiative (NCCI), and other applicable payer-mandated guidelines; 1995 and 1997 American Medical Association/CMS Documentation Guidelines for Evaluation & Management Services (EM). *CPT Assistant*, while not an official CMS reference, provides additional nationally recognized guidance regarding CPT codes and shall be included as an "official guideline" in areas not addressed in CMS or other payer-specific official references.

B. "**Professional coding**" or "**physician coding***"* means reviewing and assigning the correct coding for physician services, procedures and diagnoses for the purposes of medical claims submission on behalf of, or by, a Tenet Physician Practice provider (physician or non-physician provider) or related to some other Tenet professional coding and billing arrangement. This includes assignment of ICD-10 diagnosis codes, assignment of CPT codes, HCPCS Level II codes, modifiers, or reporting of services otherwise per payer-specific coding protocol. Coding also includes the review and validation of code assignment. The terms "professional coding" and "physician coding" are not limited to the activity of a certified professional coder, but are inclusive of all of the activity of the individuals involved in the code assignment, review or monitoring processes at a physician practice.

C. "**Professional Coder**" or "**physician coder**" means a Tenet Physician Practice, hospital, regional or corporate employee, contractor, subcontractor, agent, or other person who is certified with a nationally recognized certification organization (*e.g.,* American Academy of Professional Coders or "AAPC") and who performs professional coding and related clinical documentation improvement work with Tenet Physician Practice providers or as a part of some Tenet professional coding and billing arrangement.

D. "Charge Ticket" or "charge documents" means any and all paper documents used by the physician, non-physician provider, or ancillary staff member, to record and code professional services to be billed to patients and third party payers.

## III. PROCEDURE:

A. The Practice will keep charge documents up-to-date to allow for accurate coding for the current year for CPT and ICD-10 coding. The Practice will design its charge documents for correct communication of services performed to the patient, billing department and to the payers.

B. The Practice will maintain separate charge document for each specialty in the practice when different specialty-specific codes are needed.

C. Use separate charge documents to capture hospital, skilled nursing facility or nursing home, domiciliary or patient home services as CPT code categories are specific to the place of service.

D. Clearly indicate place of service and site of service. Hospital services report patient status (outpatient on or off campus, or inpatient) for correct selection of CPT and place of service codes.

E. List services grouped by CPT category (*e.g.*, evaluation and management code office visits, consultations, preventive medicine, surgical procedures, laboratory, injections/immunizations).

F. Use a standardized charge document lay-out that includes: CPT code, CPT descriptor and a write-in area for each fee, if fee is recorded at time of service. The charge document also shall include an area for the Provider of Services to write in procedure descriptions as necessary. The charge document also shall include space or enable the physician to link diagnosis codes to each CPT/HCPCs co to support medical necessity for billing.

G. Reflect current codes and code descriptors on all charge documents.

H. Reflect the date of last revision on all charge documents.

I. List evaluation and management codes in ascending order, lowest level of service to highest level of service. List all levels for codes where level indicates complexity of service.

J. List most commonly performed services (CPT/HCPCS codes) by the physician/group. Do not list services that are not performed at the Practice. The charge ticket will not be used as an order form for outside lab or imaging services.

K. When using a single charge ticket for hospital-based providers, list services to be billed through Part A separately from professional services.

L. Clearly communicate professional and technical components charges. When only the professional or technical component of any service is performed at the practice, do not list the global code alone on the charge ticket. Print the code on the charge form with the appropriate modifier or appropriate component code. For example, when the only x-ray service offered at the Practice is the reading of x-rays, all x-ray codes will be printed with modifier -26 attached. If only the professional component of EKGs is done, only CPT code 93010 will be printed on the fee slip.

M. List modifiers relevant to the Practice's services and payers with accurate descriptions or provide a designated modifier write-in area. Ensure the design allows for clear communication as to which code a selected modifier is to be attached. As applicable for surgical cases with multiple procedures, modifier 51 is to be posted in the EPM system for the lesser valued codes (excluding add-on codes) for all payers; where there are payers that do not allow/accept modifier 51, the modifier will be suppressed from the claim. Modifier 59, 25 and other NCCI-associated modifiers must not be used to bypass an NCCI edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used. (See Job Aid: Surgical Coding Process.)

N. The charge document shall allow for specificity, sequencing and linking of diagnoses codes to services, when necessary to support medical necessity. Commonly used diagnoses may be printed on the form; however, there also include a diagnosis write-in area to allow for reporting of diagnoses not on the list and for designating order (e.g., first through fourth, etc).

O. A clinician who codes his/her own services is responsible to select procedure and diagnosis codes or to describe services in adequate detail for qualified staff to code. Coding and billing staff are encouraged to offer input into charge form design and content. The Practice physicians will approve the charge form drafts annually, prior to the forms going to print. Final approval will be given by the Practice Manager or other designated personnel working with the Market Coding Manager or TPR Regional Director – Physician Coding.

P. The charge form will clearly communicate the Provider of Service (rendering provider) and, when applicable, the supervising/billing physician (for non-physician, or mid-level providers in practices with more than one physician).

Q. Paper office charger forms shall include a provider signature line on when a physician signature is required. Practice operations management shall determine when the physician signature is required.

1. Medicare incident to services: For non-physician or mid-level providers billing incident to professional services of a physician or for mid-level providers billing under the physician's name and provider number per specific payer requirements, there may be signature lines for both the mid-level and for the supervising/billing physician when physician and mid-level provider signature is a practice/state requirement. A signature may be required when the mid-level provider is supervised and bills under more than one physician at the practice or as determined by either management or the physician.

   Non-Medicare payers that require billing under the physician for non-physicians or mid-level providers: there may be signature lines for both the mid-level and for the supervising/billing physician when physician and mid-level provider signature is a practice/state requirement. A signature may be required when the mid-level provider is supervised and bills under more than one physician at the practice or as determined by either management or the physician. It is Market Operations/Management's responsibility to determine payer rules.

2. Teaching physicians will identify billings for services that include medical residents. The charge form will include a statement under the teaching physician signature line to identify the services, to attest to meeting the requirements for billing and to direct the billing department to add the appropriate modifiers required for Medicare services.

   For services that include medical residents, the statement to be printed under the signature line is:

   Statement for Primary Care Exception, E/M:

   *My code selection accurately represents my review and direction of services during the patient's visit. (Add modifier GE to E/M code for Medicare.)*

Statement for all other teaching services:

*My code selection accurately represents my personal presence and participation in the patient's care. (Add modifier GC for Medicare*.)

(See Reference: TPR.QMC.111.00 Teaching Physician Documentation and Coding.)

3. Clearly report billings for services performed by locum tenens or through a reciprocal billing arrangement on the charge form. Identify both the performing and billing physicians with clear direction to the billing department to add the appropriate modifiers required for Medicare services.

R. Print the standard coding policy statement on all charge forms:

*It is the physician's responsibility to select the proper code even if it does not appear on the charge ticket. It is the policy of this practice to choose accurate and complete CPT, ICD-10 and HCPCS codes not limited to any subset here.*

When signature is applicable, the statement appears with the signature line.

When paper office charge documents are used in a practice, they will reflect the coding policy statement. The policy statement may be added to electronic statements as well. The statement may not be required on hospital charge documents due to space limitations or the exclusive use of hospital face sheets.

S. Use computer compatible forms that allow for printing of specific patient information on the form prior to the visit, including demographic information necessary for claim submission and the current account status (*e.g.*, past due amounts).

T. As needed, designate an area on the charge form to identify scheduling for the next appointment.

U. Include a signature line for the patient to provide for assignment of benefits on the charge form, as needed.

V. Sequentially number charge forms to provide an audit trail for daily reconciliation.

W. Annual update charge forms to these criteria. (See Attachment A for an update checklist.)

1. The Practice Manager or designee will review and update the charge documents on an annual basis for timely capture of changes to ICD-10, CPT and HCPCS Level II codes.

2. The annual review and update to the charge documents will be accomplished by January 30 of each year.

3. The Practice Manager or Site Coordinator is responsible for including the physician(s) and other clinical and coding personnel in the update process to ensure new services, medications, or supplies are included and for improvements in accurate capture of services.

4. The Practice Manager is responsible for the final review and approval of all charge forms.

X. Distribute this guideline and references during new hire orientation at physician practices where charge documents are used.

## IV. REFERENCES:

TPR.RCC.111.00 Teaching Physician Documentation and Coding
TPR.RCC.100.02.JA Coding Compliance – Physician Services: Surgical Coding Process

## V. ATTACHMENTS:

TPR.RCC.100.04.JA.ATT.A Charge Ticket Guidelines and Standards: Charge Ticket Update Checklist