

UTMB COMPLIANCE STANDARD

UTMB OFFICE OF INSTITUTIONAL COMPLIANCE	mm/dd/yy	-Effective
Documentation, Billing, and Coding Policy	mm/dd/yy	-Revised

Billing for Multi-Disciplinary Clinics

Purpose	To define how coding and billing will be determined for clinic visits when more than one billing provider provides patient care.
Audience	Physicians, Non-Physician Providers, Department Administrators, Billing Managers, Billing and Coding Staff
Policy	Billing and coding rules vary depending on how many health care providers see the patient on the same day, and where the patient is seen. When more than one billing provider sees a patient in the same visit, specific billing rules apply. UTMB will follow the procedures outlined below to ensure correct billing.
Procedure	<p><u>Three or more billing providers (at least one of which is a physician) in the SAME clinic:</u> This is considered a multidisciplinary team visit. Each physician/non-physician provider bills a separate professional service – using the appropriate CPT visit and/or procedure codes for that provider. However, since the patient remains in the same clinic, only one facility charge is billed. The facility fee should be billed with the multidisciplinary visit code G0175 (team conference with a minimum of three providers, not including the nursing staff).</p> <ol style="list-style-type: none">1. If Charge Automation is used for multidisciplinary visits, each visit should be arrived and dispositioned, but coders must very carefully determine which service is to have the facility technical charge attached to it. Any additional professional charges should be processed <i>without</i> a facility charge.2. Someone in the clinic (an OSA or coder) must be responsible for ensuring that the hospital visit code is scratched off on all but the <u>primary</u> physician’s charge document so that the hospital code is erased and not used for billing a facility fee. On the primary physician’s charge document the OSA/Coder should note “professional and tech”. On all additional charge documents the OSA/Coder should write “professional only.”

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	<p>3. The coder for the primary physician is responsible for entering the facility multidisciplinary visit code, as well as any technical (facility) charges for procedures done <i>by any physician/non-physician provider</i> during the service. If there are procedure charges, the coder must add the appropriate modifier (-25) to the multidisciplinary facility visit code.</p> <p>4. All other physicians/providers seeing the patient should bill a professional CPT code on their Charge Automation visit without a facility charge. If procedures are performed during the visit, by ANY provider, the facility/technical charge will be billed by the primary physician’s coder, as described in #3 above, and the professional charge will be billed by the coder of the provider who performed the service.</p> <p><u>Two Billing Providers in the SAME clinic:</u> The coder should determine the E/M level for each billing provider and the professional services for each provider should be billed. To calculate the appropriate facility fee level, the coder should determine the higher of the two E/M levels and add one level to account for the additional resources used for the facility. Remember that the <i>total</i> time/resources used determine the level of facility fee billed. CMS has indicated that they do not expect the facility fee E/M level and the physician’s professional E/M level to always match. This facility fee level would be coded and processed by the primary physician’s coder as in steps 2 through 4 above. So, while there may be two professional charges, there should be only one (combined) facility fee level billed.</p> <p><u>More than one physician in DIFFERENT Clinics:</u> Separate charges are allowed for each visit - both professional (physician) and facility (hospital). Each visit is arrived and billed appropriately. The rules for concurrent care apply, so each service should have a different primary diagnosis to support the medical necessity. No modifiers are required at charge entry. The hospital billing requires a G0 condition code on the claim to indicate that multiple clinic visits occurred on the same day in separate areas. If the same case number is used for the visits in each clinic, then the Invision system will add the GO condition automatically. If different cases are used, then hospital finance must manually work a report to identify the multiple clinic visits on the same day, and enter the GO code; therefore, it is important to use the existing case number when appropriate. Registration can ask the patient if they have been in another clinic or</p>
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	seen another UTMB provider that day.
References	HCPCS Level II 2005, Ingenix Federal Register, April 7, 2000, vol.65, no. 68 (APC Final Rule)

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