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# The MOMI Monitor

Monitoring the pulse of Healthcare for YOU!

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## TERMINATING PATIENT RELATIONSHIPS

The physician-patient relationship is the result of a contract, express or implied, between a physician and patient that is voluntary and arises when a patient requests and is supplied medical information/treatment. While both the physician and patient have the right to terminate the relationship, the requirements for ending the relationship are more complicated for physicians. Physicians need to follow a process of proper documentation and adequate notice to avoid allegations of patient abandonment. According to *Texas Medical jurisprudence*, a patient may have a cause of action for abandonment when “without reasonable notice to the patient, a physician unilaterally discontinues treatment at a time when continued medical treatment is necessary.” A physician’s obligation of continuing medical attention can be terminated only by a) cessation of the medical necessity which gave rise to the physician-patient relationship; b) discharge of the physician by the patient, or when a patient voluntarily chooses not to return to his physician; or c)

withdrawal from the case by the physician after giving the patient reasonable notice, so as to enable the patient to secure other medical attention. The process recommended is first a counseling process with the patient that is well documented. The next step would be a certified letter to the patient. The letter should include a statement that the physician-patient relationship will terminate in a specified time period and a recommendation that the patient find another physician. Describe in general terms how the patient can find another physician. Include an authorization for the release of the medical record. Risk managers advise against including a reason unless it can be stated in a brief, clear, and objective way. Keep a copy of the dismissal letter and the return receipt in the patient’s medical record. Once the time period specified in the letter has passed, the physician is no longer required to treat the patient. A similar process should be followed if the patient dismisses the physician. The physician should send a letter to the patient to confirm that the patient has terminated the relationship.

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## **NPP BILLING**

One of the biggest decisions is whether to bill incident-to the supervising physician. Incident-to means the service and/or procedure provided by the NPP is billed under the physician's NPI number and not the NPP's NPI. There are pros and cons for each billing option and very often, the payer makes the decision for the NPP. Since incident-to was developed by the Centers for Medicare and Medicaid Services (CMS), you should verify with commercial payers to check specific billing guidelines for these services to compare their definitions. Commercial payers may, for example, allow NPP's to see new or existing patients with new problems whereas Medicare does not. The pro to billing incident-to is that no special distinction is necessary for supervising physician billing. When billing incident-to, staff must assure that all CMS guideline criteria are met. The criteria includes that 1) services must be performed under a physician's supervision and 2) the services must be an integral, although incidental part of the physician's personal professional service. Other limitations of using CMS incident-to guidelines include the following:

- 1) The NPP cannot bill incident-to if the supervising physician is not present in the office suite when the service is provided.
- 2) Services provided by NPPs who do not have their own NPI recognized by the patient's payer, and are working without on-site supervision, cannot be billed under any circumstances
- 3) The NPP cannot provide incident-to services to any patients new to the practice
- 4) The NPP cannot treat an established patient for a new problem.

One of the perceived cons of incident-to is that NPP's billing with their NPI directly will be paid at a lower rate than if billed incident-to the supervising physician. Incident-to services are paid at 100 percent of the physician fee schedule. The reduction for direct NPP billing is generally 15-20 percent by most payers and CMS uses 15 percent for Medicare.

*AAPC Coding Edge*

*Sept 2008*

### **Modifier 52-Reduced Service**

Use modifier 52 when a radiology or surgery service is partially reduced or eliminated. The physician may discontinue a procedure not entirely completed due to a number of circumstances, such as adverse patient reaction or medical judgment that a complete study is unnecessary. To report modifier 52, the patient must be prepped and taken to the room where the procedure is performed. This modifier is used to indicate a service that does not require anesthesia.

### **Modifier 53-Discontinued Procedure**

Modifier 53 can be used under some circumstances where a surgical or diagnostic procedure is terminated after the induction of anesthesia (i.e., local, regional block, or general) or after the procedure was started (incision made, intubation started, or scope inserted). Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate a surgical or diagnostic procedure was started, but discontinued. This modifier is not used to report the elective procedure cancellation prior to a patient's anesthesia induction and/or surgical preparation in the operating suite.

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*Sept 2008*