Practice Expense–Only Codes: No Physician Work, No Sweat

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PRACTICE **POINTS**

- Billing same-day procedures and evaluation and management services is under close scrutiny by insurers, and accurate and complete documentation is a must.
- For practice expense–only codes, only the provision of the service by staff is included in the code reimbursement; there is no physician time or work built into these codes.
- Practice expense–only codes require the presence of a qualified health care provider on premises to bill.

I have written previously about *Current Procedural Terminology* (*CPT*) procedure codes submitted on the same date of service as evaluation and management (E/M) services in the context of modifier -25.[1] Billing same-day procedures and E/M services is under close scrutiny by insurers, and accurate and complete documentation is a must.[2] An understanding of what aspects of evaluation are included in the global surgical package is critical in deciding whether a separate and distinct same-day evaluation was performed. In general, the decision to perform a procedure is included in the payment for the procedure itself, as is the examination of the body site in question, diagnosis of the medical condition, discussion of treatment options, and postoperative services related to the procedure. This is true for *CPT* codes that contain physician work, which constitute the majority of *CPT* codes reported by dermatologists.[3]

However, there is one set of codes where these principles do not apply: the practice expense (PE)–only codes, or no physician work codes. These codes are defined by *CPT* and the Relative Value Scale Update Committee (RUC) of the American Medical Association as containing no physician work. Their valuations are based only on staff/nursing time and the other aspects of direct and indirect practice costs included in providing the service, such as gauze, sutures, equipment, office rent, and utilities.[4] Examples of PE-only codes include the nonphysician-performed photodynamic therapy code 96567; phototherapy codes 96900, 96910, and 96912; and patch testing and photopatch testing codes 95044, 95052, and 95056.

For PE-only codes, only the provision of the service by staff is included in the code reimbursement; there is no physician time or work built into these codes. Thus, neither the initial evaluation of the patient by the physician, the decision to perform the procedure, nor the evaluation of therapy effectiveness or side effects or interpretation of the results is included. Understanding that there is no physician involvement in PE-only codes is critical in deciding whether an E/M service should be billed on the same day as a PE-only code. To that end, although a physician does not actually have to personally evaluate the patient on the day of service to bill PE-only codes, the Centers for Medicare & Medicaid Services has indicated that a physician or qualified medical provider must be on premises.[5] Billing for PE-only services when no provider is present will be interpreted as a false claim or fraudulent billing practice.

Because PE-only codes do not include physician work, an E/M service will be billed in addition to the treatment almost any time a same-day physician evaluation is performed. For example, if a patient presents with a changing mole that is evaluated on the same date of service as phototherapy for the treatment of psoriasis, that service is clearly reportable with an E/M code because the mole check is separate and distinct from the phototherapy treatment. A more common scenario is for the physician to see a patient with a rash consistent with an allergic contact dermatitis and the decision to perform same-day patch testing is made. In this circumstance, the E/M service is still reportable because the evaluation of the rash and the decision to perform patch testing are not included in this PE-only code.

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Phototherapy typically is provided as a prolonged course of multiple treatments, and reporting of same-day E/M services during the course of therapy is common. Phototherapy must be monitored by the physician for clinical effectiveness, dose changes, and side effects, as well as to determine whether to continue therapy. A standard operating procedure should be created to document that the physician typically evaluates the patient's progress at set intervals or as dictated by patient or staff concerns. Reporting an E/M service with every phototherapy session is not considered medically necessary. Moreover, a nurse evaluation of the patient prior to each phototherapy treatment, including questions on disease severity, how the patient did with the last treatment, and whether medications have changed, is included in the payment for the phototherapy codes. Only formal and medically necessary physician E/M services should be billed, not drive-by visits in which the physician pops in just to see how the patient is doing.

Final Thoughts

Practice expense–only codes include no payment for physician time or work but require the presence of a qualified health care provider on premises to bill. Medically necessary physician evaluations on the same day as PE-only services will typically result in both an E/M service and the procedure being reported. Understanding performance and documentation requirements of PE-only codes is critical for proper reimbursement for a dermatology practice.

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