Here a Form, There a Form

by Cindy Parman, CPC, CPC-H, RCC

Claims, appeals, requests for additional documentation, insurance enrollment and credentialing forms—all require physician or staff time to complete. Charging the patient may appear to be the way to recoup for this lost time, but a number of laws, regulations, contract requirements, and other issues affect billing for this service.

Who Pays?

Do not assume that the patient can always be charged for form completion. The American Medical Association (AMA) provides a formal opinion on this issue as part of its Code of Medical Ethics:[1]

> ***Opinion 6.07 – Insurance Forms Completion Charges:*** *The attending physician should complete without charge the appropriate "simplified" insurance claim form as part of the service to the patient to enable the patient to receive his or her benefits. A charge for more complex or multiple forms may be made in conformity with local custom.*

With respect to "local custom," you may need to have healthcare regulatory counsel review applicable state laws. If a form or document must be completed by a physician, practice, facility, or cancer program as a state requirement, it may not be possible to charge the patient for this mandatory service. However, if the form is required by the state, there may be separate reimbursement. For example, the California Division of Workers' Compensation reimburses for the completion of certain forms:[2]

> ***Final Treating Physician's Report of Disability Status (DWC Form RU-90)*** *where the physician renders an opinion concluding that the employee is released to return to the pre-injury occupation or concluding that the employee's injury is likely to permanently preclude the employee from returning to the pre-injury occupation. Use code 99080.*

In contrast, the Indiana State Medical Association states:[3]

> ***Indiana law is silent on this specific issue. Indiana's general law on fees, 844 IAC 5-2-9, states:*** *"Fees charged by a practitioner for his/her professional services shall be reasonable and shall reasonably compensate the practitioner only for services actually rendered." The rule also includes a series of factors to consider when determining reasonableness. Physicians should check their contracts with commercial insurance companies to see if the terms of the contract prohibit such administrative fees. Medicaid does not allow such fees.*

You also need to check your participation agreements and payer contracts to ensure that this charge can be billed to the patient. Each contract or agreement will define "patient liability," or the dollar amount an insured individual is legally obligated to pay for services rendered by a provider. For example, when the code for special reports (99080) was billed to Regence Blue Shield, the resulting EOB statement indicated that the code was a provider "write off" that could not be charged to the patient.[4]

Patient Notification

After you review all relevant state and insurance payer regulations and requirements for form completion charges, and you determine that you may charge the patient directly for this service, your next step is to draft a policy and patient notification statement.

Establishing a billing policy ensures that charges are uniformly applied to the entire practice or facility patient population. The Tennessee Medical Association states that the practice or facility should: "Apply the policy equally to all eligible patients unless financial hardship will be considered on a case-by-case basis."[5] Ideally during the initial patient visit—and before you charge the patient for the completion of forms—you must provide the patient with a written schedule of the charges for form completion. You can do this by directing patients to a notice on your website, by posting the information in the waiting room, and/or by providing a written document to the patient and family.

Again, it is best to draft any language for this notice with the assistance of regulatory counsel, but considerations include:

Introduction. This statement informs the patient that payment is required for the completion of certain forms; that this service requires extra work, time, and financial resources in excess of what is required to complete and maintain the medical record; and provides information on how long completion of the form will take. This policy section may also include a statement that payment is required prior to form completion.

Forms completed with no charge. While not required, this section notifies the patient that some items do not require separate payment, such as:

- Application for public assistance forms
- Family Medical Leave Act (FMLA) forms
- Workers' Compensation forms
- Department of Social Services (DSS) forms
- Social Security Administration (SSA) forms.

Specific forms to be completed at no charge will be determined by each facility, practice, or cancer program.

Forms that will be completed at a stated charge. This section should include the fees for form completion (per page, per form, per hour, etc.) and a list of forms that will be completed by the provider. Remember that the amount charged for form completion

may also by impacted by state law. For example:

- Loan payment forms
- Credit insurance forms
- Unemployment insurance forms
- Life insurance applications
- Passport applications
- Adoption forms
- Sports physicals
- Disability, Workers' Compensation and FMLA forms.

Instructions. This section provides patients with guidelines on how to complete their portion of the form; to provide a stamped, addressed envelope; and a timeline for form completion and submission. In a survey performed by the Medical Group Management Association, some practice administrators indicated that their physicians completed the first form without charge and then required a nominal fee for each subsequent form.[6]

There's a Code for That...

Although providers tend to think of form completion as a service that is not reimbursed by insurance payers, there is a specific procedure code to report this service:

- ***99080:*** Special reports, such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form.

According to *CPT Assistant*, Winter 1994, this code is not to be reported for brief standard reports, but is intended to be charged for detailed forms that are not part of the basic healthcare service, such as those related to accidents, injuries, and other special reports. For insurers that reimburse for this service, a copy of the "special report" may be required prior to reimbursement. Of note, code 99080 is *not* reported in addition to the evaluation and management service codes for work-related or medical disability evaluations performed by the treating physician (refer to codes 99455 and 99456).

Regardless of whether the special report will be reimbursed by the insurer or the patient, code 99080 allows providers to track these costs and charges.

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