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Billing

How to choose from 3 patient-monitoring codes to bill properly, avoid edits

Recent shifts in Medicare payment policy have created multiple codes for primary care providers to get paid for monitoring services or other activities that occur outside of a face-to-face encounter.

But don't expect to get paid for all of those codes at once. A combination of CCI edits and CPT policies will limit you to choosing one of the three codes you'd likely bill for patient monitoring:

- **Chronic care management (CCM):** Providers can bill the newly covered CCM code **99490** for spending at least 20 minutes a month monitoring a patient with at least two chronic conditions (*PBN 11/10/14*).

*(see **Patient monitoring**, p. 6)*

Meaningful use

Weigh benefits, drawbacks of EHRs if you're still deciding whether to jump in

If you haven't yet attested for meaningful use, you'll face a 1% payment adjustment in 2015 — yet the penalty might be less costly than investing in an electronic health record (EHR) system.

To figure out what makes sense for your practice, assess the impact on your bottom line and work efficiency to determine whether you should take the plunge with an EHR.

While approximately three in five physician practices have

*(see **EHRs**, p. 7)*

Holiday break

Part B News will take its scheduled break next week. Our next issue will be dated Jan. 5, 2015. In the meantime, stay tuned to www.partbnews.com for news updates. Best wishes for a safe and happy holiday and happy new year from Brandon, Karen, Roy, Richard and Tonya.

Billing

Solve SNF billing challenges with patient assessment, correct claim submission

Seeing skilled nursing facility (SNF) patients adds a wrinkle to your billing procedures, but you can avoid denials by identifying patient status and "unbundling" your professional services and billing them directly to Medicare.

Much of the confusion about billing for services furnished to SNF patients surrounds the distinction between professional and technical services, explains Maxine Lewis, consultant with Medical Coding and Reimbursement in Cincinnati.

SNFs operate with a consolidated billing (CB) requirement, originally enacted as part of the Balanced Budget Act of 1997, which dictates that a SNF "must submit all Medicare claims for the services that its residents receive." This requirement carries over to physician practices, at which point the service distinction becomes relevant:

• **Bill professional services directly to Medicare Part B.** Professional services, such as office visits that take E/M codes, "are excluded from billing the SNF unit itself," says Lewis. Medicare also lists other services "categorically excluded" from consolidated billing. In other words, bill services delivered by these providers directly to Medicare because they are considered unbundled:

- Physician assistants under physician supervision.
- Nurse practitioners and clinical nurse specialists working collaboratively with the physician.
- Nurse midwives.
- Psychologists.
- Nurse anesthetists.

These services also are excluded and should be billed to Medicare:

- Dialysis supplies and support, both institutional and home-based, including Epoetin Alfa and Darbepoetin Alfa.
- Hospice care.
- Ambulance services for initial SNF admission and final discharge.

Although claims for those services go to Medicare, claims "must include" the SNF's Medicare provider number, says CMS.

Note: Bill all physical therapy, occupational therapy or speech-language services to the SNF; they are always subject to CB, no matter whether they're provided by a physician or under the supervision of a physician.

• **Send the claim for technical services to the SNF.** For the majority of other services — think of an X-ray or EKG, for example — the claim goes to the SNF. However, heed the exceptions to this rule as well. Excluded services that would be billed directly to Medicare instead of to a SNF include:

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- Cardiac catheterization.
- Computerized axial tomography (CT) scans.
- Magnetic resonance imaging (MRIs).
- Ambulatory surgery that involves the use of an operating room.
- Emergency services.
- Radiation therapy services.
- Angiography.
- Certain lymphatic and venous procedures.

• **Use the correct place of service when billing SNF claims.** For claims directed to the SNF, "send the claim through and use place of service 31 (SNF)," advises Ann Silvia, CPC, regional director of revenue cycle for Reid Physician Associates in Richmond, Ind. For professional services, use office place of service 11.

• **Bill incident-to services to the SNF.** Although some services are excluded from CB, physician incident-to services are not among them. "Incident-to services furnished by others to SNF residents are subject to CB and, accordingly, must be billed to Medicare by the SNF itself," advises Medicare. In other words, physicians and associated providers can furnish services to patients and bill Medicare directly; however, incident-to services, which are ancillary services to a primary injury or illness, are billed to the SNF.

Section 60 of the Medicare Carriers Manual describes incident-to services as follows: "Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness." Incident-to services "represent an expense" to a practice, according to Medicare. For example, supplies that fall under the umbrella of incident to include gauze, ointment, bandages and oxygen.

Billing

Questionnaire to determine patient status during an office visit

Use the questionnaire below to gather valid information from the patient at the time of check-in. The checklist will help determine special billing requirements for patients currently in a skilled nursing facility (SNF) or hospice.

SO THAT WE MAY CORRECTLY BILL TODAY'S CHARGES

ARE YOU CURRENTLY IN A SKILLED NURSING FACILITY? (100-DAY STAY FOR THERAPY OR REHAB) ☐ YES ☐ NO

ARE YOU CURRENTLY IN A HOSPICE EPISODE OF CARE? ☐ YES ☐ NO

If the answer is yes to either question, complete the following.

Name of nursing home/hospice: ____________________

Phone number: ____________________ MFP # (SNF only) ____________________

Spoke with: ____________________

THEN:

If SNF, ask billing office/administrator:

- Is (patient) in a skilled nursing facility Part A or Part B episode of care?____________________
- When did the episode of care begin?____________________

OR

If hospice, ask:

- Who is the patient's attending physician? ____________________
- What is the patient's admitting diagnosis? ____________________
- Is (patient) "inpatient" hospice or "at home" hospice? __________
- When was (patient) admitted to hospice? ____________________

Adapted from Allied Physicians of Michiana, South Bend, Ind.

Identify patients early to gauge status

Ward off claim denials in the future by assessing whether your patients are SNF inpatients when they visit the office. "If they don't know that the patient is admitted somewhere, [the claim] will get denied," warns Silvia. Use a checklist (*see p. 3*) to assess patient status and triage accordingly. — *Richard Scott (rscott@decisionhealth.com)*

Resource:

- Skilled Nursing Facility PPS, Consolidated Billing: *www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/ConsolidatedBilling.html*

Compliance

5 steps to take signs of overpayment seriously and avoid prosecution

Tighten up your audit procedures and take employee complaints seriously because the feds are growing more attentive to Medicare overpayments and may look to escalate more of them into fraud prosecutions.

Medicare administrative contractors (MACs) have dropped hints that they're concerned with overpayments. CGS reminded providers Nov. 10 that "payments made by Medicare in excess of amounts due and payable under statute and regulations must be reported to the Medicare contractor."

Providers have good reason to worry about takebacks stemming from overpayments by contractors. Recovery auditors (RACs) retrieved $3.65 billion in overpayments in fiscal year 2013, according to a recent CMS report. Part B claims made up 30% of the claims reviewed (*PBN 11/3/14*).

"Know that MACs and other government entities are under a lot of pressure to show recoveries," says Mark Pastin, president of the non-profit Health Ethics Trust in Alexandria, Va. "So repayments are going to be a fact of life."

Provider obligations under False Claims Act

Adding to the urgency: The Affordable Care Act widens the prosecutorial mandate on overpayments, classifying some failures by providers to investigate overpayments as violations of the False Claims Act — a "reverse false claim." Last summer, the U.S. government joined its first whistleblower case based on the ACA's logic.

"The ACA makes an overpayment an obligation — a special word in the context of the FCA — that effectively means if you know that you owe money and you avoid paying it, that's fraud and an actionable false claim," reports Dave Parker, managing partner at the law firm Liles Parker in Washington, D.C.

Now providers have to be concerned not only about takebacks, but also about prosecution. That's a concern exacerbated by a judge's 2013 denial of a motion to dismiss in *Keltner v. Lakeshore Medical Center*, a whistleblower case in which the center stands accused of fraud because, after finding and even paying back some overpayments caused by upcoding, management failed to continue auditing for overpayments. The case, one not joined by the government, has yet to go to trial.

Listen to the whistle

Keltner may sound like a disgruntled-employee situation, but "the media coverage of multimillion dollar settlements might encourage disgruntled employees to try a whistleblower claim," says Brenda Tso, an associate with the Khouri Law Firm in Dallas.

Every whistleblower case Parker has seen could have been headed off in the human resources department by addressing the employee's concerns. But many don't because "it's hard to listen [to whistleblowers] with an open mind because they're perceived as disloyal to the company," he says. He suggests you warn your managers and your human resources professionals to treat these situations with appropriate seriousness.

5 ways to avoid overpayment trouble

- **Refocus your current auditing for compliance.** For many practices, auditing charts is mainly about "not leaving money on the table" — that is, maximizing physician revenue, says Harry Nelson, senior health care attorney at Nelson Hardiman in Los Angeles. "What's taking longer to be absorbed by these practices is, they have to be concerned, not just with getting more money, but also with identifying the problems, preventing them going forward and identifying moneys to be returned."

- **Get a second opinion on whether a claim is an overpayment.** "The relator's main beef [in *Keltner*] was that the practice did not act on her suggestions," says Tso. "Not that she was necessarily right, but taking

immediate action like getting a second biller/auditor opinion or hiring an attorney to evaluate legally whether there is an overpayment, or having some sort of policy on how such billing error allegations are looked into, may have helped the employee feel her allegation was being looked into instead of ignored."

So if you're nervous about it, "one possible remedy is hiring an outside biller/auditor to make sure the contract puts billing liability on them for correct billing — based on records provided by the practice, of course," says Tso. "Many billing companies will claim their software correctly codes everything, but make sure this is backed up by them taking liability for any discovered overpayment." In fact, "if you know you're in a perilous situation, don't hire your own auditor," says Parker. "Have your lawyer hire him so you're protected by attorney-client privilege. Courts are deferential to that."

- **Beware the 60-day window.** "The Affordable Care Act's 60-day compulsory reporting requirement for overpayments requires a provider to report the overpayment and pay it back within 60 days after the overpayment has been identified," says Kristen L. Gentry, a partner in the Health Law Practice Group of Quarles & Brady, Indianapolis. Thus, in the eyes of auditors and

Benchmark of the week

Leading high-price denials span cardio, gastro, E/M services

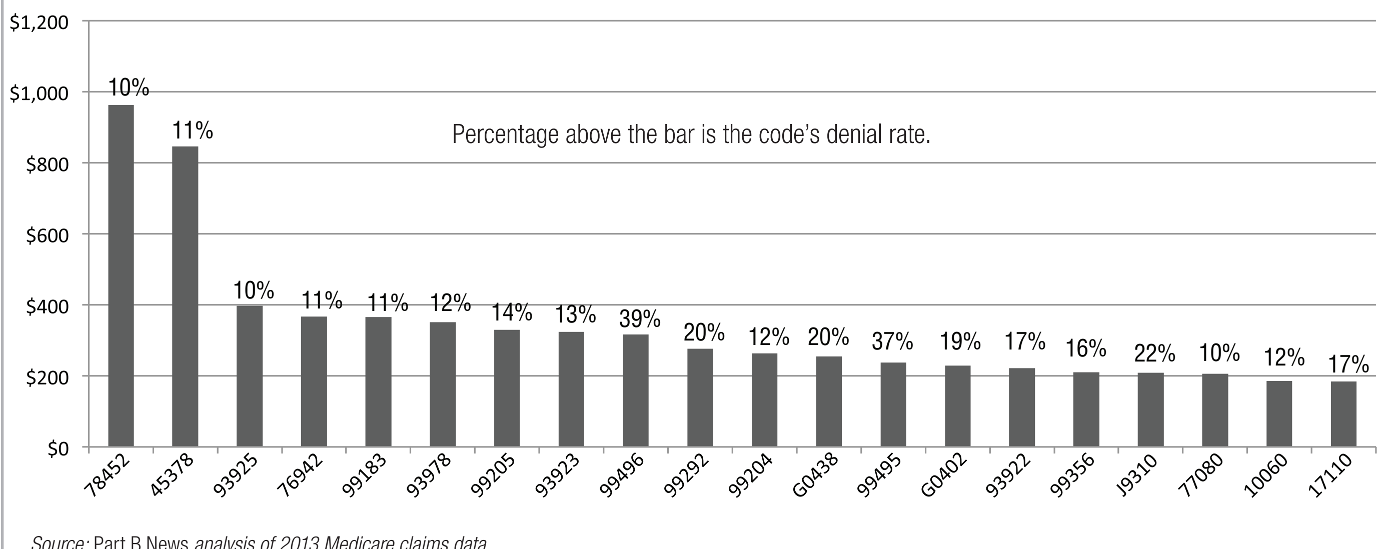
The biggest dollar figure attached to a commonly denied service belongs to **78452** (Nuclear medicine study of vessels of heart using drugs or exercise multiple studies) at $962.29 per denial.

The chart below includes the 20 highest-priced denials per claim for physician services that met the following two requirements: services billed more than 50,000 times nationally and services that had a denial rate of 10% or higher. In other words, the data, which are based on an analysis of 2013 Medicare claims data, the latest available, highlight the most common and expensive areas where practices are losing reimbursement dollars.

After 78452 comes gastro code **45378** (Diagnostic examination of large bowel using an endoscope), which is denied 11% of the time at a cost of $845.13 per claim. From there comes a steep drop to several vascular and radiology codes, beginning with **93925** (Ultrasound study of arteries and arterial grafts of both legs) — at a price of $397.18 per denial.

Six E/M codes help round out the top 20, including both transitional care management codes (**99495**–**99496**), which saw the highest denial rates, and office/outpatient visits (**99204**–**99205**), which led the way in frequency with nearly 2 million claims between the two of them.

Average loss per claim denied by code and denial rates



Source: Part B News *analysis of 2013 Medicare claims data*

prosecutors, "if an overpayment is retained after the 60-day deadline, it becomes an obligation under the False Claims Act." Gentry says some of her own clients have been reporting and paying "even minimal overpayments" to make extra sure they don't get stung.

- **Look for patterns of denied claims.** "While pre-bill auditing is a best practice, it's also a cumbersome and potentially expensive practice, especially for individuals and small groups," says Pastin. "A less-consuming approach is to work your claims denials. If you are having a problem, it will usually show up as a pattern in denied claims."
- **Follow through with action on your audit results.** If it comes to discovery, the fact that you saw something will suggest to a judge that you should have done something, Parker says.

"If you're going have chart audits, my main advice is to follow where they take you," says Parker. "If they take you where they did in *Keltner* and they show an overpayment of 50%, you have to follow the logic, give it back and keep looking for overpayments. If you open the box, you can't close it up and ignore it." — *Roy Edroso (redroso@decisionhealth.com)*

Correction

The Dec. 15 issue of *Part B News* incorrectly stated Paul Keckley's title: He is managing director for the healthcare practice of Navigant in Chicago.

Patient montoring

(continued from p. 1)

- **Transitional care management (TCM):** Billed with code **99495** for moderate complexity and **99496** for high complexity, TCM debuted in 2013 to help manage the transition of patients who require moderate- and high-complexity medical decision-making as they transition from an inpatient, observation or nursing facility setting to a community setting, such as the patient's home or a rest home. While much of the work behind this service involves coordination of care for the patient, a face-to-face visit is required.
- **Home health supervision:** Medicare makes a monthly payment with HCPCS code **G0181** for 30 minutes of physician supervision of a patient receiving monthly home health services, including monitoring and revising the patient's plan of care, review of labs and phone calls to coordinate the patient's care, among other things. This service is paid on a calendar month basis.

How the services differ

Though each of those services is done for different reasons, the nature of the work overlaps. Just don't expect to get paid for more than one, says Maxine Lewis, president, Medical Coding and Reimbursement Solutions, Cincinnati.

TCM code 99495 is bundled into the CCM code payment, 99490, in a new CCI edit that takes effect Jan. 1,

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according to a *Part B News* analysis of the latest revisions to the CCI edits. The edit cannot be overridden with a modifier.

An edit already in place prevents you from billing the home health monitoring code G0181 at the same time as TCM code 99495. Payment for the home health monitoring code is bundled into the TCM code, and it may not be overridden with a modifier.

Note: While payment for the TCM codes and the CCM code is limited to primary care physicians, the home health monthly management code can be billed by any specialty and is intended for the physician who actually certified the patient for home health and created the plan of care.

When it comes to billing CCM code 99490 with the home health monthly management code G0181, CPT policy stands in the way, Lewis says. The CPT descriptor does not permit the reporting of CCM in the same month as domiciliary or rest home codes, Lewis points out.

Factors to choose the right service

Given that you can report only one service of the three monthly monitoring or management services, the next step is to determine which one is appropriate.

- **Factor in whether a face-to-face visit occurred.** The TCM codes require one face-to-face visit, which is not required for home health monthly management or the CCM service, Lewis notes. So if you don't see the patient, TCM is not an option.
- **Look at the payments.** TCM code 99495 pays about $165.30, while G0181 pays about $110 and the CCM code pays roughly $42.
- **Watch the timing of services.** When you bill the TCM service with a face-to-face visit as part of a patient transition home, including the patient receiving home health care, you can bill TCM and then transition to the monthly home health monitoring code G0181 for the next calendar month, assuming you can track the 30 minutes of monthly engagement in the patient's care required by the HCPCS code.
- **Pay attention to documentation requirements.** CCM, which pays the least, becomes the likely third choice in the above scenario. Note CCM has the easiest documentation requirements, as it allows the practice to use outside contracted services to help with the patient's management. — *Scott Kraft (pbnfeedback@decisionhealth.com)*

EHRs

(continued from p. 1)

adopted meaningful-use-eligible EHRs, according to a December 2014 data brief from The Office of the National Coordinator for Health Information and Technology, many others are still going the paper route, which could have big financial ramifications on their practices in the coming year — and beyond.

Negative payment adjustments, which will ding each eligible provider 1% of total allowable charges in 2015, are set to rise to 3% in 2017 and 5% by 2019, and ultimately will "go on in perpetuity," says David Zetter, president of Zetter Healthcare Management Consultants, Mechanicsburg, Pa.

"None of these regulations are going away," says Todd Searls, executive director, Wide River LLC, Lincoln, Neb. "Even if they're modified or tweaked, there will always be, as we move to pay-for-performance, electronic reporting requirements."

To put the 2015 payment adjustment in perspective, consider a practice with three eligible providers, each of whom accounts for $100,000 in allowable Medicare charges. Without an EHR system and meaningful use attestation, the practice would lose $1,000 per provider for a total of $3,000 in revenue. As the penalty rises in 2016 and beyond, so too does your potential loss. Come 2019, the three-physician practice described above would forfeit $15,000 in revenue because of payment adjustments.

'Do the ROI calculation'

Compare the cost of investing in EHR with what you'll lose by not attesting to meaningful use to determine your return on investment (ROI). Here's how:

- **Look at your books and figure out how much you stand to lose in Medicare revenue.** To gain a clear picture of your potential losses, tally the number of Medicare patients you see and calculate their total charges, Zetter says. Do this for the past two or three calendar years to get a better understanding of average annual charges to Medicare. Then multiply the total charge by 1% to see your estimated losses in 2015, 2% to see your losses in 2016, 3% for 2017 and so on.
- **Compare potential lost revenue with the cost of the EHR purchase.** Implementation costs vary depending on the suite of services, the technology pro-

vider and other factors. One study from the Agency for Healthcare Research & Quality (AHRQ) pegs first-year implementation costs at $46,000 per provider. However, that price point may be at the high end, adds Searls. "It all depends on the type of system being implemented and how many bells and whistles the provider wants to bring live and get trained on." The cost may be as little as $1,500 per provider, he says.

Be sure to factor in the add-ons too. "Don't underestimate the cost of implementation and training," warns Searls. "Don't underestimate the long-term support costs."

- **Weigh annual vendor costs.** If your specialty is not health IT, you'll need to enter a service contract with your vendor — which costs money. Typically, recurring costs are a percentage of the entire contract, so look to your base price to get an estimate of yearly costs down the road. For the budget conscious, free options exist, adds Searls. But beware: Free software comes with its own price tag, namely ethical questions about the vendor's collection and sharing of patient information.

- **Factor in side benefits of EHR technology.** The ability to meet meaningful use requirements can be substantial, but many benefits hinge on improved practice management (*PBN 11/24/14*). "There are definite efficiencies in EHR [use] if it's done properly," says Zetter. Having all the patient data in one, accessible location ameliorates the burden of tracking and locating multiple paper records, and much correspondence can take place through the EHR's patient portal, saving both time and money.

Moving to EHRs will save you space, too, by eliminating the need for record storage. One gastro practice, for instance, was able to construct a pathology lab in the practice's basement in what had previously been its 1,800-square-foot record-filing area, Zetter says.

- **Come to a conclusion based on your calculation.** Give your numbers a hard look to ascertain whether it makes fiscal sense to continue operating without an EHR while penalties increase substantially in the years ahead, say experts. *(If you decide to buy, see sidebar, right, for tips.)* If your calculation shows that the upfront costs and ongoing expenses of an EHR system far exceed the hit you'll take in penalties — and if you don't have any other reason to implement an EHR system — then "don't bother," says Zetter. — *Richard Scott (rscott@decisionhealth.com)*

5 tips to buy an EHR system now

A calculation showing how meaningful use penalties will hurt your practice may persuade your providers to buy an electronic health record (EHR) system *(see story, p. 1)*. Here are five tips to start that process:

- **"Examine your scope of practice" when hunting for the right EHR**, advises Todd Searls, executive director, Wide River LLC, Lincoln, Neb. If you're in family practice, you will have different requirements than someone in a specialty practice. "If I'm a cardiologist, I want to get reports from marrow registries and blood banks," offers Searls. Pinpoint your specific needs, and make sure your system meets all of your requirements.
- **Make sure your tech systems are in sync, and start with practice management software.** Often, practices implement one electronic system for their front-office needs and a second compatible system for the medical needs. "My recommendation is to install the practice management system first," advises David Zetter, president of Zetter Healthcare Management Consultants, Mechanicsburg, Pa. "You can start doing the billing piece if you're still on paper charts."
- **Work with your vendor to build your templates** and avoid a technical headache down the line. "That is probably the single biggest issue that every practice has — they don't spend time to build the templates," says Zetter. Building templates before implementation will increase your efficiency by ensuring the EHR suite is custom built for your specific needs and workflow.
- **Take into account other requirements besides meaningful use.** Now is also the time to take a wide-lens view of the health care landscape. "Have that heart-to-heart conversation about every single major issue that's coming down the pike," urges Searls. Will your system be equipped for ICD-10, meaningful use and physician quality reporting system (PQRS) measures? The 2016 payment adjustment for providers who fail to meet PQRS is a 2% reduction, so factor other pertinent reporting requirements into the equation as well.
- **Use someone who's familiar with EHR contract laws**, advises Searls. "Find a specialist or go to your law group," urges Searls. Using an expert who's familiar with this specialization will help ensure you receive favorable terms with your vendor in the event of a missed deadline or other delay. If not, the investment may turn into a boondoggle.

— Richard Scott (rscott@decisionhealth.com)

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