Professional Receivables Control, Inc.
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HELP DESK HINT

Looking up patients in the Appointment log with the sort option*:* In the Appointment Log's Patient Account Lookup screen: Left click once on the **? Bubble** to the right of the Find field. A Query by Example Settings box will appear.

Type in the field, next to the sort option, the information to look up. Then click the box to the right of that field to specify equal to, greater than, less than, not equal to, or blank for not applicable. Once all necessary fields are completed, press the OK button. Example: Last name equal to Smith, First Name equal to Thomas.

Only those accounts associated with the sort options you entered will appear in the Patient Account Lookup Screen.

BILLING FOR A HOSPITALIST

The hospitalists are seeing more and more patients all the time. With the increase in billings, you have to be careful not to bill improperly.

One area of concern is the consultation. Remember that a consult requires specific criteria to qualify. Let's say you, the hospitalist, are requested to follow a never before seen patient after a surgery.

Your first alarm should go off knowing that there is a post-op period for which any and all care related to the surgery is included in the payment made to the surgeon and you can not bill. However, if you are seeing the patient for an unrelated problem, example might be the orthopedic surgeon requests that you follow the patient for diabetes, this is billable. Now, the question is, it's a new patient to you, how do you bill? In this example you would bill and initial new patient visit plus any follow-up days. A Consultation would not be appropriate because you are taking over the care of the patient. Consultation is defined as seeing a patient upon request to evaluate and report back to the referring physician with no management of care. Once you take over care management, this is not a consultation.

Usually if a patient has multiple medical problems, good medical care dictates that they be followed for complications after surgery. This would not be billable unless there is good reason, a medical necessity to follow the patient, then you may bill.

Part B News offers this advice: “Use modifiers 54 (surgical care), 55 (postop management) and 56 (preop care) to split care when money is deducted from payment for the surgery to pay the hospitalist.”

Part B News reports that Ken Simone, D.O., president of the Hospitalist and Practice Solutions of Veazie, Maine states, “you can’t bill for a hospitalist if:

- there is a duplication of services;
- the service is not medically necessary; or
- the hospitalist is “consulted out of convenience by the surgeons”.

DUPLEX SCAN, SPECTRAL AND COLOR

Recently a question to MedLearn Matters was asked with regard to the radiologist not dictating that the spectral portion of the duplex was done and if so, must the service be down-coded?

In response; “According to the language that is now in the CPT code book (which is now consistent with what the American College of Radiology previously stated), evaluation of vascular structures using both color and spectral Doppler is separately reportable. However, color Doppler alone, when performed for anatomic structure identification in conjunction with a real-time ultrasound examination, is not reported separately. In our opinion, if both components are not defined, the non-invasive code should not be assigned.”

BILLING HOSPITAL CARE SERVICES, OBSERVATION, ADMISSION/DISCHARGE

Physicians and NPPs who admit a patient for less than 8 hours on a given date should report the Initial Hospital Care with the CPT codes 99221, 99222, or 99223. Do not use Discharge Management CPT Code 99238 or 99239.

If the patient is admitted and discharged on different dates you are permitted to bill the Initial Hospital Care 99221, 99222, or 99223 and the Discharge Management 99238 or 99239.

If the patient is admitted for a minimum of 8 hours but less than 24 and discharged on the same calendar date, billing should be for Observation or Inpatient Hospital Care (including Admission and Discharge Services Same Day) with codes 99234, 99235, or 99236 and no additional discharge service.

Documentation must meet the E/M requirements for history, exam and medical decision making. CPT codes 99234, 99235, and 99236 require documentation stating the stay in the hospital involved 8 hours but less than 24 hours. You must also identify the billing physician was present and personally performed the services and identify the admission and discharge notes were written by the billing physician.

M A PLANS, HOW DOES YOUR OFFICE HANDLE THEM?

Medicare Advantage Plans (MA Plans) are here to stay so you might as well make sure you, and your staff, handle them properly.

Before a Medicare patient even comes to your office, the staff should ask the correct questions and verify the patient’s insurance before their appointment time. When they are talking to the beneficiary on the phone, ask generic questions like, “Do you have any other insurance?”, or

"Have you recently added another insurance?" The Medicare patient sometimes is confused and thinks he has only taken an additional insurance to cover his drugs when in fact, he has taken a whole new carrier for his Part B coverage.

Find out the names and ID numbers off the cards along with the insurance name as printed and get the patient's date of birth and address, as you may need that information to confirm coverage. Get the insurance 800 phone number printed on the card in case you can't determine coverage through the insurance company's website.

Educate your staff on the MA plans in your area. Make copies of the cards so your staff becomes familiar with them. You can find local plans here www.medicare.gov/MPDPF/Public/Include/DataSection/Questions/SelectState.asp Choose your State, then County and click on "Show Plans".

Take the time to verify the coverage and find out the required copay. ALWAYS collect the copay up front, upon arrival, before the services are rendered.

Your office will run smoother and you will avoid long delays in seeing the patient's promptly, if the insurance information is clear and confirmed before the patient's arrival.

BILLING CARDIAC STRESS TESTS

There is the global CPT code 93015 which covers the physician supervision, tracing and performing, and interpretation and report. However, there are individual codes for each of these: 93016 covers physician supervision only, 93017 covers tracing only, which includes performing the test and 93018 covering the interpretation and report.

It is perfectly acceptable to bill any of the individual codes if the services are split between providers. If your physician orders the stress test to be done at a local facility and supervises the testing, then the facility will bill the 93017 and you will bill the 93016. If your doctor then has a cardiologist interpret the testing and send him a report, the cardiologist will bill the 93018.

Linda Gates-Striby, compliance manager for The Care Group in Indianapolis tells *Part B News* that if the test is done in your office, the physician only has to be present in the office not necessarily in the room where the testing is being done. However, if the test is done in an outpatient setting, the physician must be in the presence of the patient during the testing to bill supervision.

CMS EXTENDS COVERAGE TO INCLUDE PRO-TIME HOME MONITORING

CMS has directed the carriers to cover prothrombin time home monitoring for anticoagulation management. The directive implements the coverage change by August 25, 2008 but the effective date goes back to March 19, 2008 so if you have denials they will be paid if you request it. Contact your local carrier to find out if they want these resubmitted or done through re-opening.

You should use G0248 through G0250 on the claims a diagnosis codes V43.3, 289.81, 451.0-451.9, 453.0-453.3, 415.11-415.19 and 427.31. Note that this will be covered under certain criteria.

You can find more information by review the online transmittals:

Transmittal 90: http://www.cms.hhs.gov/transmittals/downloads/R90NCD.pdf

Transmittal 1562: http://www.cms.hhs.gov/transmittals/downloads/R1562CP.pdf

CO-MANAGING SURGERY BILLING AND DOCUMENTATION

A recent article in *Part B News,* warns that the Office of Inspector General (OIG) is watching for illegal kickback relationships in co-management of surgeries. However, there are legitimate reasons to co-manage and you can bill and be paid with little worry as long as you document properly

Specifically, back in 2003 the OIG found that optometrists were referring patients to ophthalmologists for cataract surgery only if they were promised that they could handle the post-op care.

In a *Part B News* interview with the president of operations for a large vision group in Michigan, she stated, "In general terms, for any surgeon, there can be co-management".

Example: A patient in a small town sees his local orthopedic surgeon, who determines hand surgery is needed that he can not provide. The nearest hand surgeon is in a major city a good distance away. So the patient is referred to the hand surgeon who does the surgery and bills with modifier **54** to show that he only taking care of the surgery. The surgeon then receives 80% of the fee.

The patient returns home after surgery to be followed by his local orthopedic physician and he bills with modifier **55** to show that he is providing post-op care only. He will then be paid 20% of the fee. This is acceptable to provide care to the patient without him having to travel long distances for follow-up care.

The use of the two modifiers 54 and 55 is absolutely necessary when co-management is being done. In the case where the performing surgeon does a single day of post-op or maybe a week of post-op before handing the patient to the local doctor (as in our example above); most carriers required that the surgeon document the number of days he did post-op. Check with your local carrier to see how they want that handled on the claim.

Highmark the carrier for Delaware, DC and Maryland has a good LCD on what justifies co-management. You should also check with your local carrier but here is a link to what Highmark has set in their LCD http://www.highmarkmedicareservices.com/policy/mac-ab/12781.html

COLLECTING COPAYS BEFORE PROVIDING SERVICE

It is good business practice to collect the patient's co-payment up front, before you provide the service. In order to handle this efficiently you have to educate your patients and train your staff, consistently.

The best way to educate your patients is to include a collection policy statement in the new patient information packet and have the patient sign it. If there are any problems at a later date, you have the signature to show that you did inform the patient of what is expected in your office.

The next step is to uniformly train your staff on how to handle each step of the patient calls, scheduling and arrival at your office. *Part B News* offers this template:

> "Here's a basic template for a script your front desk staff can follow when scheduling patients and checking in:

Scheduling patients:

Once insurance and co-pay amounts have been determined…
Front Desk: OK, Mrs. Smith, we have you scheduled for Friday, January 14. Your insurance calls for a $20 co-payment which will be required to be paid prior to seeing the doctor that day. We accept cash and check (remember, only credit cards as a last resort, if you have to). Please remember to bring your copay, otherwise we will need to reschedule.

Appointment reminder call:

Front Desk: This is Doctor Jackson's office reminding you of your appointment on Friday, January 14. Please remember you have a $20 copay obligation in order to see the doctor.

Patient checks in:

Front Desk: Hello Mrs. Smith. How will you be paying your $20 copay today?
Patient: I'm sorry, I don't have any cash and I forgot my checkbook.
Front Desk: That's alright. We accept debit and credit cards.
Patient: I didn't bring my wallet
Front Desk: Mrs. Smith, I'm sorry, but our contract with your insurance carrier and the agreement you or your employer have with your health plan require that we collect the copay at the time of service.
Otherwise we can be found in breach of our agreement with them and possibly removed from their network. We certainly wouldn't want this to happen, so we will need to collect your copay prior to seeing the doctor.
If you like, there is an ATM around the corner at the bank. Again, we accept cash, check, debit and credit card.
How would you like to handle this? We can always reschedule your appointment for another time when you have your wallet with you.

NOTE: You can use judgment for specific situations, such as a patient with an urgent medical problem (sprained ankle, for example) or a patient who becomes irate and persistent when told to reschedule due to refusal to pay. In these situations, you can treat the patient without pay, then make sure he or she leaves with a statement indicating immediate payment is required. Your front desk staff can make a note in the patient's record and follow up accordingly.
Source: David J. Zetter, consultant, Health Care Professional Management Services, Mechanicsburg, PA"

CMS CLARIFIES BILLING PROLONGED SERVICES

Transmittal 1490: www.cms.hhs.gov/transmittals/ downloads/R1490CP.pdf The link will take you to the CMS detailed directive on billing prolonged time.

CMS is clearly stating that prolonged billing must be based on face-to-face time spent with the patient. Also the prolonged codes, 99354 and 99355 are add-on codes based on the total face-to-face time spent with the patient. CMS has designated "times" to the E/M codes, *Part B News* gives us examples in their April 21, 2008 Issue:

“**Example**: A physician had a 75-minute, face-to-face office visit with an established patient that was predominantly counseling. The physician should report E/M code 99215 and one unit of code 99354, CMS says. The average physician time for the frequently used E/M code is about 40 minutes.

In contrast, CMS states that if the physician documented a medically necessary 99213 ($59.80) that was 65 minutes long, the physician could also bill the 99354 based on an average 99213 duration of 15 minutes and the extra time hitting the 40-minute threshold to add 99354. CMS also gives you an example of a non-billable situation.

Example: During a subsequent office visit a doctor counsels a patient for 60 minutes. “The physician cannot code 99214, which has a typical time of 25 minutes, and one unit of code 99354,”

CMS says. “The physician must bill the highest level code in the code family (99215 which has 40 minutes typical/average time units associated with it). The additional time spent beyond this code is 20 minutes and does not meet the threshold time for billing prolonged services.”

Example: A patient is on an exam table during an E/M visit for 2.5 hours as a doctor evaluates an acute asthmatic condition. The doctor spends 125 minutes of face-to-face time with the patient, so you bill 99215, 99354 for an extra 60 minutes and one unit of 99355 for the additional 25 minutes.”

HIPAA UPDATE

It has been 5 years since the HIPAA Privacy Regulations when into effect, and with the passing of time, you may need to review your practice safeguards of your patient’s medical information. During the last 5 years there have been a considerable amount of complaints to the HHS Office of Civil Rights (OCR) with regard to the dissemination of patient’s personal health information (PHI).

Per *Medical Office Billing & Collection Alert; “*Keep in mind: The Department of Justice isn’t going after people who leave their computer screen turned on with the patient schedule showing, says Kirk J. Nahra, Esq., with Wiley Rein, LLP in Washington, D.C. “Most of HIPAA is just a question of good practices,” he says. “People aren’t going to jail for the minimum requirements under the privacy regulations. They’re getting into trouble for things like stealing patient information.”

A FEW TIPS:

- Be sure you are not e-mailing patient PHI to carriers for claim status information.
- Make sure that your practice obtains a business associate agreement from the patient, which allows you to legally share PHI with any outside collectors you use.
- If you have an in-house collections policy of sending letters and making calls before forwarding past-due accounts to an outside collector, you should outline this policy in your Notice of Privacy Practices.
- Avoid leaving detailed messages on a patient’s phone that contains patient information.

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