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PHYSICIAN'S PAYMENT UPDATE™

INSIDE

DECEMBER 2001

VOL. 13, NO. 12 (pages 177-192)

American Health Consultants® is A Medical Economics Company

A business lesson from 9/11/01: Is your practice really disaster-proof?

Do your crisis-managing before it happens

Despite the evidence from Sept. 11 that we're now living in a different world from just a few months ago, relatively few medical practices have taken the time to think through and make contingency plans should their office be directly affected by a nearby disaster — natural or man-made.

About one of four small businesses forced to shut down due to a disaster never reopens, estimates **Diana McClure**, a consultant with the Tampa, FL-based Institute of Business and Home Safety, a nonprofit

Medicare payments to drop by 5.4% next year

Rule inflexibility cited

As the August issue of *Physician's Payment Update* predicted, the anemic economy and increased use of Medicare by senior citizens will cause Medicare's physician fee schedule to undergo a net cut in payments rather than the usual raise.

According to Center for Medicare and Medicaid Services (CMS) administrator **Tom Scully**, the conversion factor for the 2002 Medicare fee schedule is $36.19. This means that despite the fact that overall Medicare payments to physicians and nonphysician practitioners are predicted to increase by 1% next year, the conversion factor used to update payment rates for individual services will drop 5.4% below the 2001 level.

*(See **Medicare payments** on page 178)*

research group funded by the insurance industry.

Like these organizations, few physicians have developed disaster contingency plans, which should include such elements as keeping copies of key records at another site or knowing how to contact staff during an emergency to deal with disasters that temporarily disrupt or close their practice, notes **Patricia Thorp**, president of Thorp & Co., a crisis management firm in Coral Gables, FL.

Making a plan

Disasters can range from an explosion in your office building or having all your electronic files eliminated by a computer virus **(see related story, p. 179)** to something that happens miles away, like a flood or storm that shuts down the roads leading to your office. It could even happen to someone else entirely, such as your medical supply or prescription drug vendors, but a disaster that affects them would, in turn, affect your practice.

Rather than trying to think of every possible kind of disaster that could happen, the best approach to planning for an emergency is to answer the question, "How can I integrate any sort of business interruption into the way I do business?" advises McClure.

After his practice was disrupted by the 1989 San Francisco earthquake, **Eric Tabas**, MD, decided it was time to draw up a basic disaster plan for his office. His plan is as follows:

• Close the office.

• Have contact numbers available to inform employees to stay home.

• Put a message on voice mail informing patients that the office is closed.

• Go to a hospital to help care for injured people.

McClure recommends physicians consider the following questions when developing a disaster-response plan:

— What sort of disasters or hazards could shut down my practice?

— How long can my practice be shut down without completely depleting its financial reserves?

— How would I contact my employees and patients?

— How would I contact them if the phone lines were down?

— Is there an alternate site where I could temporarily run my practice?

— What are the most vital practice functions that must be attended to?

— What supplies and prescription drugs do I absolutely need?

— What vital records and data should I keep copies of off-site?

— What disasters does my business insurance cover?

— Do I need business interruption insurance?

"Designing a response plan doesn't have to be that complicated. It just takes a little bit of time and thought," stresses McClure. "Today, it is just good business to have a disaster plan on file."

(Editor's note: For more information on disaster planing, visit the following web sites:

• *The Association of Records Managers and Administrators — www.arma.org*

• *Institute for Business & Home Safety — www.ibhs.org/ibhs*

• *Small Business Administration — www.sba.gov/disaster*

• *American Medical Association — www.ama-assn.org/go/disasterpreparedness)* ■

Medicare payments

Continued from front page

In contrast, the Englewood, CO-based Medical Group Management Association's most recent cost survey reports that group operating costs are up by 6.2% over the past year.

"The law designing the physician update is incredibly prescriptive," said Scully. "The law gives us no flexibility in adjusting this . . . formula."

Physician organizations have complained for years that the formula used to calculate the conversion factor is flawed. Irked by this latest event, medical societies representing a wide range of specialties are joining forces in a campaign to lobby Congress to revise the conversion calculation.

Another change for next year is that nurse practitioners, clinical nurses, and physician assistants are covered to perform screening sigmoidoscopies, if allowed by state laws.

Also, Medicare will codify its existing policy that allows auxiliary personnel to provide services in a physician's office incident to the supervising physician, no matter what the worker's employment relationship with the physician is. That means qualified contract health workers can provide incident-to services, as can employees. ■

Terrorist attacks prompt FBI cyber-warning

Are your computer files vulnerable?

In the wake of the Sept.11 terrorist attacks, the Federal Bureau of Investigation's National Infrastructure Protection Center has issued an advisory notice that it "expects to see an upswing" in computer-related crime.

The two most likely forms of criminal computer activity the FBI expects to increase include patriotic "hacktivism," or computer hacking by both domestic and foreign fringe groups, and new viruses introduced into computer networks.

In addition, many pros predict more disgruntled present and former employees will be prompted by recent events to use computer virus bombs to get even with employers.

"A significant increase in cyber attacks is likely," agrees a separate study by the Gartner Group, a Stamford, CT-based consulting firm. "Enterprises must understand this threat and take action to limit their vulnerabilities."

Here is a list of things the Gartner Group says organizations can do to help protect their communications and information systems from cyber-terrorists:

• Form an internal cyber-incident response team, or contract with an outside vendor to monitor your Internet activity.

• Monitor any web sites your practice operates or is linked to for bugs.

• Contact third-party providers as needed. If internal security procedures are not adequate, contact a managed security service provider or consultant.

• Educate users. Tell them to expect an increase in unwanted "cyber activity."

• Establish phone numbers or e-mail addresses for reporting suspicious activities.

• Set up multiple communication methods. Make sure decision-makers and response team members have more than one method available to them, such as landline and wireless telephones and e-mail technology.

• Update and distribute contact information for all your staff, key vendors, and business contacts.

• Update virus protection on remote laptops and home computers of staff that interact with office systems.

• Review vendors' computer security policies.

• Evaluate and test physical security procedures, including access to facilities and interaction with electronic systems. Review procedures for background checks for individuals with access to key information or resources.

• Update virus detection signatures daily, if not more frequently. Scan for viruses at the firewall or server. If scanning network computers, remember that many users manually shut down their scans if they are executed during business hours.

• Initiate vulnerability assessments. These should be performed by trained security professionals, not internal administrators, Gartner advises.

• Disable all inactive accounts. Examine user account lists on all systems, removing all unnecessary or default accounts.

• Change passwords on root or administrator accounts.

• Review help desk and password reset procedures. ■

Specialist pay hikes beat primary care again

Weak productivity gains a cause of concern

Anesthesiologists, urologists, and cardiologists came out the big winners in compensation gains last year, reports the Medical Group Management Association's (MGMA) 2001 Physician Compensation and Production Survey.

This recent trend, where pay raises for selected specialists far outpace raises for primary care physicians, is a flip-flop from the pattern of the early and mid-1990s, notes **David Gans**, director of medical practice resources for the Englewood, CO-based MGMA.

On a cautionary note, recent increases in physician productivity have flattened out, which could drag down the annual payout for all doctors if the trend continues.

Anesthesiologists saw their average compensation increase 14.5% to $280,353, last year, compared to a 2.2% drop in that specialty's pay in 1999. Meanwhile, the average pay for urologists increased an average of 12.3% to $301,772, mirroring that specialty's 12% increase in the previous survey. Non-invasive cardiologists posted a 7.7% hike to $300,073 in average compensation, while

Compensation Gains

	Compensation (Production)			
	Primary Care		Specialist	
1990-91	3.70%	(7.42%)	7.80%	(8.87%)
1991-92	6.10%	(10.22%)	3.63%	(10.02%)
1992-93	7.47%	(2.92%)	-1.28%	(-0.75%)
1993-94	2.70%	(1.34%)	2.34%	(4.67%)
1994-95	4.46%	(0.57%)	1.79%	(5.59%)
1995-96	1.42%	(3.36%)	2.58%	(10.61%)
1996-97	0.42%	(2.56%)	-0.48%	(3.97%)
1997-98	2.54%	(4.67%)	5.22%	(6.51%)
1998-99	3.39%	(11.33%)	6.01%	(7.67%)
1999-00	2.27%	(0.40%)	4.30%	(4.83%)

Source: The Medical Group Management Association, Englewood, CO.

invasive cardiologists saw their average income rise 7.6% to $365,894.

On the downside, specialties that saw their income drop were diagnostic radiologists, down 5.1%, and neurologists, down 1.7%, according to the MGMA.

Primary care physicians, however, only had a small gain in average compensation compared to last year, inching up 2.2% to $147,232. This repeats the pattern of the past several years. Along the same lines, pay for family physicians increased 2.6% to $145,121. Internist pay increased 2.5% to $149,104.

Between 1996 and 1999, overall gains in physician productivity outpaced increases in compensation. However, last year average physician income rose an average 2.2% compared to a 0.4% overall gain in productivity, says MGMA.

Because increasing productivity, cutting costs, and developing new sources of revenue are the only ways specialties not in increasingly high demand can significantly increase their compensation, experts will be paying close attention to productivity numbers in coming years. ■

Outsourcing can move problems off-site

Fewer hassles possible, but get it in writing

In an effort to focus more of their time and energy on what they do best — namely, practicing medicine — a growing number of physicians are outsourcing their administrative and business functions to increase efficiency and collections while lowering costs.

"The benefits of outsourcing are cost containment, though not necessarily reduction, the ability to focus on the core business, and the ability to get resources like skilled labor in areas where there is a shortage of resources," says **Howard Lackow** of Reston, VA-based outsourcing consultants Transition Partners Co.

"Health care is trying to reduce costs, and one way to do that is to find more cost-effective and efficient ways of providing the services that are not core to health care," Lackow notes.

Hospitals have been outsourcing everything from janitorial and cafeteria services to building and grounds maintenance and emergency department staffing for some time, but individual medical practices have been slower to adopt the concept.

Besides billing and collections, other functions that can be easily outsourced include credentialing and managed care contract paperwork, payroll, accounting, and photocopying functions.

Observers say new technology will permit many more functions to be outsourced. The Internet, for instance, will increasingly be used as a way to send and receive all kinds of information, such as referrals, claims, and radiology results.

Many medical groups also use an application service provider (ASP), which can provide services like web hosting, physician practice management software, and billing software. Physicians can rent the technology from the ASP, which keeps costs down and ensures access to current technology.

"Even groups with as many as 50 physicians don't have the in-house resources and talent it takes to set up, fix, and tweak a state-of-the-art information system," says **Lawrence Benson**, president and CEO of Practice Partners, an ASP in Toledo, OH.

There are also companies organized to handle recruitment, development, discipline, and payroll for physician offices. "A physician can lease the entire office staff, setting up criteria for the [type of] people they want," says Benson.

"Indeed, you do it because it is cheaper to give that function away than pay the expenses of advertising job openings, training new employees, and being involved in other traditional human resources functions," he maintains.

For instance, San Jose, CA-based Electronic

Health Information (EHI) helps physicians with chart assembly and completion, coding, file room management, and retrieval and release of information. EHI can place full-time staff in a physician's office who also can manage files or the front desk. You also could have an EHI staffer visit your office once a week to perform these services.

If you are considering outsourcing, make sure you do your homework before signing a contract. Here are some tips from OutsourcingCenter.com on finding the right vendor and on writing a contract that works for you:

• **Talk with other practices.** Just like finding a good plumber, mechanic, or doctor, one of the best ways to locate an outsourcer who is right for you is to ask your colleagues in other practices about their experience and if they could recommend someone.

• **Check their regulatory history.** Given today's regulatory climate, it's especially important to ask vendors who will be dealing with billing and coding matters about the percentage of their claims for clients that have been rejected for things like upcoding. Also check whether they have ever been involved in a fraud audit and what the result was if they were. It's best that you have a written compliance plan the vendor can review and be expected to comply with; this provides an added layer of legal protection should any future questions arise.

• **Go over contract details.** Make sure your contract with the outsourcer specifies exactly what is expected — how fast bills will be collected, for example — and any penalties, including terminating the agreement, should it fail to deliver.

• **Ensure access to data.** Make sure the practice will always have direct access to its own data. A good way to do this is to keep data on your own internal system while permitting billing companies to dial into your office's computer network to do their work.

• **Hammer out payment terms.** There are different ways to pay for different outsourced functions. For billing services, many outsourcing experts recommend a flat fee plus a percentage of collections. Practices typically pay somewhere between 5% to 10% for billing, with an average of around 8%. However, your cost will vary depending on the type of claims common to your practice, the marketplace, and state regulations.

Coding costs range from $2 to $5 per transaction. While you can expect to pay between 75 cents and $2 per patient, some firms charge by the page for record scanning and transmissions services. ■

Don't miss out on revenue from expanded care

Here's a roundup of 2001 changes

Here's a checklist of items added to Medicare's list of covered services during 2001 that you can use to ensure your practice is getting properly paid:

• **Preventive services.** During 2001, Medicare expanded coverage for screening tests for breast, cervical, and colorectal cancers. Starting on Jan. 1, 2002, Medicare will also cover an annual glaucoma screening test and medical nutrition therapy by registered dietitians for people with diabetes and a renal disease.

The extended coverage comes from the Beneficiary Improvements and Protections Act (BIPA) enacted by Congress in December 2000. The legislation directs the Centers for Medicare and Medicaid Services (CMS) to phase in specific coverage for certain tests and therapies that can detect diseases early, when they are most easily treated or cured.

The newly covered services include a Pap test and a pelvic exam every two years (instead of every three years) for women not at high risk for uterine or vaginal cancers, effective July 1, 2001. Medicare will pay for screening Pap smears and pelvic exams, which include clinical breast exams, every two years for women who are postmenopausal and/or not at high risk for cervical or vaginal cancer.

Medicare still covers an annual screening Pap smear and pelvic exam for women of childbearing age who have had an abnormal Pap smear within three years or are considered at high risk for cervical or vaginal cancer. "Medicare considers a woman at high risk if she has a prior history of cancer or sexually transmitted disease; began having sexual intercourse before age 16; has had more than five sexual partners; has not had a Pap smear within seven years; or has a mother who used diethylstilbestrol during pregnancy," notes **Brett Baker**, a reimbursement specialist with the American College of Physicians - American Society of Internal Medicine (ACP-ASIM).

Coding tip: Use HCPCS G0101 to report a pelvic exam. Medicare will pay separately for a screening pelvic and clinical breast exam, G0101, and for obtaining a specimen for a Pap smear,

Q0091, when the two services are billed together for the same patient on the same date when billed with an evaluation and management service, as long as it is appended with modifier -25.

Also, Medicare will still pay separately for a pelvic and clinical breast exam performed during a medically necessary office visit, even if you do not obtain a specimen for a screening Pap smear. But make sure you append the evaluation and management service with modifier -25 and bill G0101 for the pelvic and clinical breast exam.

Colonoscopies covered every 10 years

Medicare will pay for screening colonoscopy every 10 years for people not at high risk for colorectal cancer effective, last July 1. Medicare defines high risk as individuals who have a family history of colorectal cancer; prior experience with cancer or precursor neoplastic polyps; a history of chronic digestive disease conditions (including inflammatory bowel disease, Crohn's disease, or ulcerative colitis); the presence of any appropriate recognized gene markers for colorectal cancer; or other predisposing factors. Medicare covers a screening colonoscopy for high-risk beneficiaries every two years.

Coding tip: To bill for a screening colonoscopy for a beneficiary who is not considered high risk for colorectal cancer, use HCPCS code G0121, Baker advises. The code applies to colorectal cancer screening on individuals who do not meet the criteria for high risk.

The Medicare 2001 payment for a screening colonoscopy performed in a hospital or other facility on a patient who is not high risk for colorectal cancer (G0121) is $239.51. This rate will vary slightly by geographic area. Medicare gives the same payment for a screening colonoscopy on a high-risk beneficiary, G0105, and a diagnostic colonoscopy, CPT 45378.

Other new Medicare-covered screening benefits include:

— annual glaucoma screening for people at high risk, a family history of the disease, or with diabetes, effective Jan. 1, 2002;

— medical nutrition therapy by registered dietitians or other qualified nutrition professionals for people with diabetes, chronic renal disease, and post-transplant patients, effective Jan. 1, 2002.

Other preventive services covered by Medicare include:

— four types of colorectal cancer screening tests, including a yearly take-home fecal-occult blood test;

— flexible sigmoidoscopy every four years;

— colonoscopy every two years for high-risk individuals, or a barium enema as an alternative to the colonoscopy or sigmoidoscopy;

— baseline mammogram for women with Medicare aged 35 to 39;

— an annual mammogram for women with Medicare aged 40 and older;

— bone mass measurements for people at risk for osteoporosis;

— prostate cancer screening exams for men with Medicare aged 50 and older (these exams include a digital rectal exam and a Prostate Specific Antigen test annually);

— flu shot each season and a pneumonia shot if needed;

— hepatitis B shot for people with medium to high risk for hepatitis. By law, most of these preventive services require about a 20% co-pay of a Medicare-approved amount. Some, like the annual flu shot (and pneumonia shot when necessary) are free when given by doctors who accept Medicare assignment.

• **Diabetes self-management training.** Diabetes self-management training is an interactive, collaborative process involving beneficiaries with diabetes and their physicians and instructors. Appropriate training should provide these beneficiaries with the knowledge and skills needed to care for themselves, manage diabetic crises, and make lifestyle changes to manage the disease successfully.

All providers and suppliers who currently bill Medicare for other services, including medical equipment suppliers and kidney dialysis facilities, are qualified to bill for self-management training if they meet all the other requirements. Registered nurses also may be used as part of a multidisciplinary education team instead of certified diabetic educators.

• **Diabetic foot care.** Beneficiaries with diabetic peripheral neuropathy with loss of protective sensation will be able to receive regular foot care. Medicare will cover two foot exams a year, provided beneficiaries have not seen a foot care professional for some other reason.

• **Glaucoma.** Medicare now covers annual glaucoma screenings for people with Medicare coverage who are at high risk for contracting the disease.

(Continued on page 187)

Physician's Coding Strategist™

National emergency leads to more depression coding

The combination of the holiday season and emotional reactions to the events on and after Sept. 11 mean practices are seeing a major jump in the number of patients with some form of depression.

When treating such patients, your code selection starts with the patient's medical record. For ICD-9-CM subcategories 296.0-296.6, make sure to use the correct fifth-digit subclassification code to identify the extent of the patient's condition. These are:

- 0 — unspecified;
- 1 — mild;
- 2 — moderate;
- 3 — severe, without mention of psychotic behavior;
- 4 — severe, specified as with psychotic behavior;
- 5 — in partial or unspecified remission;
- in full remission.

Reactive depression is the result of such stressful events as the death of a loved one, the loss of a job, or the end of a relationship. The patient experiences mild to moderate depression, but is able to continue his or her life, usually within a few months.

If the medical record says the patient's condition is "situational" or "adjustment reaction with depressed features, in a patient with no previous existing mental disorders," it is usually coded 309.0 (brief depressive reaction) or 309.1 (prolonged depressive reaction). **Caution:** Codes from the 309 category should not be assigned with any other code in the "Mental Disorders" chapter of the ICD-9-CM code book.

Use CPT code 90862 (pharmacological management) if:

- the physician is managing medication for a patient receiving psychotherapy from a limited-licensed colleague;
- the patient's condition is being effectively treated by medications only;
- the physician is managing medications for a patient with an organic disorder such as senile dementia;
- the patient is receiving no other services during the encounter;
- an evaluation and management psychotherapy service is provided during the same encounter.

Remember that only the appropriate evaluation and management or psychotherapy code should be assigned.

If a Medicare patient receives an uncomplicated drug monitoring, such as an adjustment in the dosage, assign HCPCS Level II code M0064. For comprehensive drug management services, assign CPT code 90862. ■

At times you can bill for E/M and prevention

While the Centers for Medicare and Medicaid Services (CMS) is expanding the range of medical services Medicare will pay for, many other types of routine related services remain uncovered. In cases such as a routine physical examination for a senior citizen, for instance, you will need to get Medicare patients to sign an Advance Beneficiary Notice that permits you to bill them, because Medicare does not cover this service.

However, in situations where a physician finds

a patient has significant medical problems that require further investigation during an otherwise routine health exam, most practices either use a preventive code or an evaluation and management (E/M) code when billing the claim.

However, in such circumstances it is often appropriate to bill both a preventive code and an E/M code, which can have a major impact on the ultimate reimbursement.

Specifically, American Medical Association guidelines say it is acceptable to use codes from both categories when "the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service."

Problem must be linked to E/M code

In this situation, use modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to append the code for the problem-oriented E/M service. In turn, Medicare should reimburse the problem-oriented code (99213).

Case study: A 72-year-old Medicare patient comes in for his routine annual physical. He has no complaints, and there is nothing on his chart since his last physical. During the examination, the doctor notes pallor and decides to perform a complete blood count, which reveals anemia. Additional clinical work is done to help find the cause of the anemia. Responding to questions from the doctor, the patient notes that he has been feeling a little off lately, but "has not really thought about it."

The documentation that has been gathered shows there are enough key components for physical exam and medical decision-making to justify a level 3 problem-oriented, established patient, E/M service.

In this case, the practice should bill for both a code 99397 (preventive medicine service, established patient, 65 years and older) and 99213-25 (level 3 office or other outpatient established patient visit, significant separately identifiable E/M service).

Tip: It is vital that the problem or condition be linked to the problem-oriented E/M under this coding combination. As such, two diagnoses should be placed on the claim. Code 99213 will not be considered significant or separately identifiable enough without a condition warranting use of the code. ■

CMS clarifies billing for teaching physicians

The Centers for Medicare and Medicaid Services (CMS) has modified the Medicare Carriers Manual to clarify billing for certain teaching physician services that are exempted from the requirement that the physician be physically present during the key portions of the service (Transmittal Letter 1723).

To qualify for the exemption under the new standard, claims for services must contain the "GE" modifier in Item 24d of form HCFA-1500. Claims for services that require the presence of a teaching physician during the key portions of the service must contain the "GC" in Item 24d of the HCFA-1500 form.

Since 1996, the rule has been used for certain low-level evaluation and management services. Residents who met certain requirements could provide key portions of the service in the absence of the supervising teaching physician. ■

CMS issues memo on use of physician query forms

The director of the Centers for Medicare and Medicaid Services (CMS) Quality Improvement Group has issued a Policy Clarification Memorandum stating that "the use of the physician query form is permissible to the extent it provides clarification and is consistent with other medical record documentation."

This clarification reverses a similar memo issued in January 2001 instructing peer review organizations (PROs) not to accept physician query forms as a substitute for documentation in the medical record.

According to the new procedures for PRO reviewers in the Oct. 11 Policy Clarification: "In conducting medical review for validating the DRG, the PRO reviewer shall use his or her professional judgment and discretion in considering the information contained on a physician query form along with the rest of the medical record for purposes of DRG validation. If the physician query form is leading in nature or if it introduces new information, the reviewer shall refer the case

to the physician for review. The PRO must perform physician review as described in the PRO Manual at 4130(D) and provide the opportunity for discussion if necessary."

When the Paperwork Reduction Act eliminated the need for physician attestation for Medicare inpatient cases in 1992, the physician query form lost popularity. However, its use has increased once again with the renewed emphasis on fraud and abuse issues.

Professional coding standards say coders should ask physicians for clarification and additional documentation before they code a case file containing conflicting or ambiguous data. The Office of Inspector General's Compliance Guidance for Third-Party Billing Companies also notes that coders should communicate with physicians when their documentation is unclear or conflicting. ■

Time must be devoted for critical care codes

CPT codes 99291 and 99292 are used to report critical care services. But what is sometimes overlooked is that physicians billing for critical care must have devoted their full attention to the patient. Consequently, they cannot bill for evaluating or managing any other patient during the same time period.

The physician must report the time period she or he spent working on the critical care patient's case. This time can be spent at the patient's bedside or on the hospital floor, as long as the doctor is immediately available to the patient. However, any time spent outside the patient's unit or floor, such as when taking telephone calls, cannot be billed as critical care.

To report services for a patient who is not critically ill but happens to be in critical care, intensive care, or another specialized care unit, use subsequent hospital codes (99231) or hospital consultation codes (99251-99263). Use code 99291 for the first hour of critical care provided on a given date.

Report the code only once per date, even if the physician has to break up the visit into separate parts. Critical care totaling less than 30 minutes on a given date should be reported using the appropriate evaluation and management code.

Use code 99292 to report each additional 30 minutes of care beyond the first hour, as well as the final 15-30 minutes of critical care on a given date.

Critical care services lasting less than 15 minutes over the first hour or less than 15 minutes beyond the final 30 minutes should not be reported separately.

Warning: Claim examiners see a red flag when two physicians divide the time and one bills using code 99291 while the other uses 99292 for the same patient on the same date. ■

Use modifier -60 for complicated surgeries

The CPT manual introduced modifier -60 in 2001 to allow providers to indicate when a procedure was more complex than normal due to an altered surgical field. Previously, coders had to use the usual services modifier (modifier -22) for a variety of conditions. The -60 modifier, however, is more specific.

Modifier -60 should be used when a procedure is significantly more surgical or requires more time as a result of:

- previous surgeries;
- significant scarring, adhesions, or inflammation;
- distortion of the anatomy;
- irradiation;
- infection;
- trauma;
- very low birth weight (i.e., neonates and small infants weighing less than 10 kg). ■

What the OIG wants on all proper bills

While it is the provider's responsibility to document each case, coders need to screen each claim carefully to ensure it is thoroughly and properly documented to speed the payment process and prevent queries from investigators. Here's a checklist of items that the Office of Inspector General says every properly documented claim

should be able to reference:

- reason for the patient encounter;
- appropriate history and evaluation;
- documentation of all services;
- documentation of the reason for all services;
- ongoing assessment of the patient's condition;
- information on the patient's progress and treatment outcome;
- documented treatment plan;
- plan of care, including treatment, medication (including dosage and frequency), referrals and consultations, patient and family education, and follow-up care;
- changes in the treatment plan;
- documentation of the medical rationale for the services;
- documentation that supports the standards of medical necessity, such as certificates of medical necessity for durable medical equipment, prosthetics, orthotics, supplies, and home health services;
- abnormal test results addressed in documentation;
- identification of relevant health risk factors;
- documentation that supports the evaluation and management codes that are billed;
- medical records that are dated and authenticated;
- prescriptions. ■

Outpatient Medicare pay to jump 2.3% next year

Hospitals will receive a 2.3% increase in Medicare payments for outpatient services effective Jan. 1, 2002, under a final rule announced today by the Centers for Medicare and Medicaid Services (CMS).

The new hospital Outpatient Prospective Payment System administers more than $17.5 billion in reimbursement for more than 6,000 hospital departments.

The rule includes a one-time policy change for next year to reimbursements for new high-cost and high-technology drugs and devices mandated by Congress in the Balanced Budget Refinement Act of 1999. The rule updates payments annually to hospitals for Medicare outpatient services in the prospective payment system that began Aug. 1, 2000.

"Given the restraints of the law, this rule adopts the best possible balance between protecting beneficiary services in outpatient settings and ensuring that those beneficiaries have access to all the new drug and device technologies that are critical to their improved health," said **Tom Scully**, CMS administrator.

The regulation "folds in" 75% of the costs of high-technology drugs and devices to the base payments for outpatient services, resulting in a significant enhancement of payments for these new technologies. Under the law, all of the costs are required to be included in the base payments for 2003, and the payment system for 2002 begins the transition of those new payments. ■

Medicare digs up ban on services to relatives

Adding to the fine print that goes with deciding when it is OK to waive copayments or provide physician courtesy services for free, Medicare has restated a relatively obscure ban on reimbursing doctors for any services they provide to immediate relatives of their partners and colleagues.

The rationale: Practices should not bill for such services because they would probably have been provided for free if Medicare was not there to pay for them.

Medicare's ban on billing for immediate family members was first introduced in the 1994 carrier manual. Now a 2001 Illinois-Michigan carrier bulletin declares: "Medicare will not cover charges by providers who are immediate relatives of the beneficiary or by providers who are members of a beneficiary's household. Medicare excludes payment for these providers because items and services furnished by them would ordinarily be furnished free of charge based on their relationship to the beneficiary. This exclusion applies to physician services, including services of a physician who belongs to a professional corporation and services incident to those services."

Not only does the ban include physician services provided in-office but also any physician extender services provided incident to the physicians' services in the office, ancillary tests provided in the office, and hospital consults physicians provide to relatives of colleagues, say experts. ■

(Continued from page 182)

• **Ambulatory blood pressure monitoring.** Beneficiaries with suspected "white coat" hypertension — the phenomenon of a person's blood pressure being higher during a medical exam, perhaps in response to the anxiety of being in the doctor's office — are now able to receive ambulatory blood pressure monitoring, in which the beneficiary wears a blood pressure cuff over a 24-hour period. The readings are stored in the device and later interpreted in the physician's office.

• **Macular eye degeneration.** Medicare has extended coverage of ocular photodynamic therapy with verteporfin to those with "occult lesions." Coverage of the therapy for those with other lesions has already been put in place. However, occult lesions are less well-defined and more difficult to detect. The therapy involves the infusion of a light-activated drug called verteporfin, followed by a laser that activates the drug and treats the adjacent lesions.

• **Home testing for blood thinness.** Medicare now covers home testing that enables patients with mechanical heart valves to measure how well their blood is thinned. Previously, there had been no national coverage policy for self-testing the prothrombin level in the home (also called INR testing) for patients with mechanical heart valves, and the insurance companies that process and pay Medicare claims had been denying claims for home prothrombin self-testing.

Under local carrier coverage policies, patients receiving home health care could have their prothrombin level measured by home health personnel, and phlebotomists could come to patients' homes to draw samples to be processed in laboratories. The new national coverage policy allows beneficiaries to perform the test themselves and could permit more frequent monitoring of a patient's response to blood-thinning medication.

• **Liver transplants.** Medicare liver transplant coverage now includes certain patients with primary hepatocellular carcinoma (HCC), which is Medicare's first movement toward transplant coverage for a liver malignancy. CMS is considering the possibility of expanding coverage to other types of malignancies.

A Decision Memorandum dated May 18, 2001, says a patient with primary HCC is eligible for Medicare coverage if the patient is not a liver resection candidate, the patient's tumor(s) is less than or equal to 5 cm in diameter, there is no macrovascular involvement, and there is no identifiable extrahepatic spread of tumor to surrounding lymph nodes, lungs, abdominal organs, or bone.

• **Intestinal transplants.** Medicare covers intestinal transplants for beneficiaries with irreversible intestinal failure performed at approved transplant centers, these being the University of Pittsburgh Medical Center, Jackson Memorial Hospital Transplant Center in Miami, and The Mt. Sinai Hospital in New York City.

• **Sun-induced skin lesions.** CMS expanded Medicare coverage nationally for the treatment of common sun-induced skin lesions, known as actinic keratoses, that can develop into skin cancer. The decision established a national Medicare coverage policy for removing the lesions without restrictions based on lesion or patient characteristics. Previously, some Medicare carriers had local policies that restricted coverage to specific lesion types (such as those located on specific parts of the body) or in certain patients (such as those with a prior history of skin cancer). ■

Fraud police announce targets for next year

ABNs, E/M, procedure codes in for close scrutiny

One of the best indicators of where federal fraud cops are focusing is the Office of the Inspector General's (OIG) so-called work plan, which outlines its investigative and regulatory priorities for the coming year.

Items high on the OIG's recently released 2002 work plan include:

• **Use of advance beneficiary notices (ABNs) and their financial impact on beneficiaries and physicians.** Physicians must provide advance notices before they provide services that they know or believe Medicare does not consider medically necessary or that Medicare will not reimburse. Beneficiaries who are not notified before they receive such services are not responsible for payment. "Indications are that practices vary widely regarding when advance beneficiary notices are provided, especially with respect to noncovered laboratory services," notes the OIG.

Reacting to physician frustration with the language and administrative burden presented by the ABN form, the Centers for Medicare and

Rx-physician relationships will be scrutinized

Gifts to doctors will be examined

Federal investigators and Department of Justice prosecutors will be taking a close look at the financial relationships and business practices — especially concerning gifts, speaker fees, and "educational" trips — between drug companies and physicians, states the Office of Inspector General's (OIG) 2002 work plan.

"The sheer number of government activities focused on the pharmaceutical industry is unprecedented," says **John Bentivoglio**, a partner in Arnold & Porter's Washington, DC, office.

The OIG, for instance, will investigate the amount and nature of drug companies' gifts and payments to physicians in light of the $12 billion drug companies reportedly spend each year developing relationships with practices as part of their marketing efforts.

"Some of these gifts may present an inherent conflict of interest between the legitimate business goals of manufacturers and the ethical obligation of providers to prescribe drugs in the most rational way," the OIG's work plan says. It notes that the gifts could also violate federal anti-kickback laws if they are aimed at inducing referrals.

In addition, the work plan said pharmaceutical fraud would be a "special focus area" for the OIG, which plans to issue a formal program guidance on the topic in the near future, say government sources. ■

Medicaid Services (CMS) has proposed a revised one-page ABN that would eliminate the term "not medically necessary," which has caused consternation among physicians and confused beneficiaries. **(See related story, p. 190.)**

• **Consultations.** Last year, Medicare paid some $2 billion for physician consultation services. Regulators want to know if these consultations are being properly billed. **(See related story, *Physician's Payment Update,* October 2001, p. 154.)**

• **Coding of evaluation and management (E/M) services provided in physician offices and use of documentation guidelines.** OIG will work with Medicare carriers to identify potential patterns of incorrect E/M coding and corrective actions taken.

This seems to be the next step in the long-running saga over how best to revise the E/M coding system. Separate sets of 1995 and 1997 guidelines — which CMS admits are cumbersome for physicians to use — already exist. Meanwhile, Medicare has halted work on its latest attempt to create a consensus set of E/M codes and is rethinking its strategy.

• **Review of the procedure codes billed by both a hospital and physician for the same outpatient service.** Preliminary studies by the OIG have found that nearly 25% of outpatient claims billed by hospitals and the corresponding physician procedure code don't match.

• **Services and supplies "incident to" physicians' services.** OIG investigators are turning up the heat again on "incident to" billing, this time looking at when physicians bill incident-to services and supplies. Physicians may bill for the services provided by allied health professionals, such as nurses, technicians, and therapists, as incident to their professional services. Incident-to services, which are paid at 100% of the Medicare physician fee schedule, must be provided by an employee of the physician and under the physician's direct supervision.

• **Medical necessity of durable medical equipment.** The OIG wants to study the appropriateness of Medicare payments for certain items of durable medical equipment, including wheelchairs, support surfaces, and therapeutic footwear. The OIG is especially interested in whether the suppliers' documentation supports the claim, whether the item was medically necessary, and whether the beneficiary actually received the item.

• **Laboratory services.** Whether laboratories conduct tests and bill Medicare within the scope of their certifications under the Clinical Laboratory Improvement Amendments (CLIA) of 1988 will be a focus of the OIG next year. Laboratories with certifications of waiver or physician-performed microscopy procedures may perform only a limited menu of test procedures. Moderate- and high-complexity laboratories are also restricted to testing within certain preapproved specialty groups and must meet CLIA standards.

• **Bone density screening.** As the number of

claims for bone density screening increases, there are questions about the appropriateness and quality of some services, which the OIG plans to investigate.

• **Medicare billings for cholesterol testing.** The OIG wants to know if cholesterol tests billed to Medicare are medically necessary and accurately coded, especially relating to the frequency of testing and the medical necessity of lipid panels.

While total cholesterol testing can be used to monitor many patients, Medicare claims reflect a preponderance of claims for lipid panels, which include HDL cholesterol and triglycerides also. Systems capable of doing all three tests plus glucose are advertised on the Internet as CLIA-waived.

• **Clinical laboratory proficiency testing.** The agency will also look at the policies and procedures used for proficiency testing under CLIA and examine the quality of the testing results. CLIA requires all moderate- and high-complexity laboratories to enroll with an approved proficiency testing agency for certain tests. These agencies are responsible for grading the accuracy of a laboratory's results. Repeated failures can cause the laboratory to lose approval to perform those and similar tests.

• **End-stage renal disease.** Questions have been raised about Medicare payments for a wide range of services for end stage renal disease beneficiaries, along with medical necessity and accuracy of related coding.

• **Physicians at teaching hospitals.** A longtime favorite topic of the OIG, this effort will include verification of compliance with Medicare rules governing payment for physician services provided in the teaching hospital setting and will seek to ensure that claims accurately reflect the level of service provided to patients.

• **Billing for residents' services.** The OIG wants to find out if hospitals have been improperly using residents' physician identification numbers to bill Medicare. Medicare regulations allow residents, who are licensed physicians, to be issued physician identification numbers for purposes of billing Medicare for their services. Residents can bill Medicare only when they are "moonlighting," which is defined as providing medical treatment, other than in their field of study, in an outpatient clinic or an emergency room.

• **Inpatient dialysis services.** This review will determine whether Medicare payments for inpatient dialysis services met the billing requirements of Medicare Part B. The Medicare Carrier Manual requires that the physician be physically present with the patient at some time during the dialysis and that the medical records document this in order for the physician to be paid on the basis of dialysis procedure codes. If the physician visits the dialysis inpatient on a dialysis day, but not during the dialysis treatment, physician services are billable under the appropriate hospital visit codes. Fee schedule amounts for inpatient dialysis codes are higher than those for hospital visit codes.

• **Medicare payments for EPOGEN.** There is concern that Medicare is overpaying claims submitted by dialysis facilities for the drug EPOGEN.

• **Medicare coverage of prescription drugs.** The OIG will examine whether prescription drugs paid for by Medicare met coverage requirements and determine the extent to which drug coverage decisions varied among Medicare carriers. Medicare does not pay for over-the-counter drugs or most outpatient prescription drugs. However, under specific circumstances, Medicare Part B covers drugs used with durable medical equipment or infusion devices. Medicare also covers certain drugs used in association with organ transplantation, dialysis, chemotherapy, and pain management for cancer treatment.

Additionally, the program covers certain vaccines, such as those for influenza and hepatitis B.

• **Drug prices paid by Medicare vs. other sources.** A study will compare Medicare reimbursement for prescription drugs with costs incurred by the Department of Veterans Affairs, the physician/supplier community, and Medicaid. Previous OIG reports showed that Medicare reimbursed for prescription drugs at significantly higher levels than did these other sources. ■

The Top Fraud Trio

According to the Health Information Association of America in Washington, DC, the most common forms of fraud in which health care providers knowingly file claims containing deceptive or false information are:

- fraudulent diagnosis — 43% of bad claims;
- billing for services not rendered — 34%;
- waiver of patient deductibles and copayments — 21%.

Beneficiary notices get closer attention from feds

Here's a primer to keep out of trouble

A longtime point of contention between physicians and Medicare — the advance beneficiary notice (ABN) that practices must ask patients to sign — has moved to a front regulatory burner.

Last April, Medicare issued a proposed revised standard ABN form that should receive final approval soon. Additionally, the Office of the Inspector General's (OIG) work plan for 2002 includes an investigation into whether doctors are properly notifying Medicare patients about coverage and use of the ABN.

The following series of common ABN-related questions and answers developed with the help of the Center for Medicare and Medicaid Services (CMS) will help you sort out what's what when it comes to ABNs.

Q: What is an ABN?

A: The purpose of the ABN is to give the patient an opportunity to refuse to receive the service or item in question. The ABN itself is a written notice (government form CMS-R-131) that physicians, providers, or suppliers must give to patients to sign before they furnish a service or item. The documents tells patients:

— that Medicare will probably deny payment for the specific service or item in this particular instance;

— the reason the physician, provider, or supplier expects Medicare to deny payment;

— that the patient will be personally and fully responsible for payment if Medicare denies payment.

Q: Are there one or two standard ABN forms?

A: The CMS-R-131 came into use in June 2001 and is expected to be the only ABN in use by September 2002. In the meantime, you may use ABNs containing the old approved model language, which reads:

"Physician/Supplier notice: Medicare will only pay for services that it determines to be 'reasonable and necessary' under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is 'not reasonable and necessary' under Medicare program standards, Medicare will deny payment for that service. I believe that, in your case, Medicare is likely to deny payment for (particular services) for the following reasons: (reasons for predicting denial).

"**Beneficiary agreement:** I have been notified by my physician/supplier that he or she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

"Signed, (Beneficiary Signature)."

Under the rules for using the older ABNs, some physicians modified the above notice language for their own use. The new ABN, however, is a standard form. If a patient receives one of the older ABNs, signing it is the same as choosing "Option 1. YES" on the new ABN. If a patient refuses to sign, it is the same as choosing "Option 2. NO" on the new ABN.

Q: How does an ABN protect the patient?

A: The ABN protects senior citizens from unexpected financial liability in cases where Medicare will probably deny payment. That allows consumers to decide whether to obtain the service or item and be prepared to pay for it (that is, either out of their own pocket or by their other insurance coverage) or to choose not to receive it.

Q: What information must be included in an ABN for a Part B service or item?

A: The ABN must identify the service or item for which denial is expected, and it must clearly state the reason a Medicare denial is expected.It may include an estimate of the cost for the service or item.

Q: What options are patients given?

A: Patients may choose to receive the service or item and to be responsible for payment if Medicare does not pay ("Option 1. YES") or elect not to receive the service or item ("Option 2. NO"). After checking one, the patient should then sign and date the ABN.

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Q: What about payment?

A: Patients who choose "Option 1. YES" receive the service or item, and a claim is sent to Medicare. Meanwhile, the physician may also bill the patient while waiting for Medicare to make its payment decision. Medicare will not decide whether to pay unless it is sure the patient has received the service or item and received the claim. If Medicare does pay, the patient is refunded any payments he or she made. If Medicare denies payment, the patient is personally and fully responsible for payment. The patient also has the right to appeal Medicare's decision.

Q: What if a patient chooses "Option 2. NO" to not receive the service or item?

A: No claim is sent to Medicare.

Q: What if the patient refuses to sign the ABN but still wants to receive the service or item?

A: If the patient refuses to sign, the physician who takes assignment of their Medicare claim can elect not to provide the service or item, or the physician can have a second person witness the patient's refusal to sign the agreement and then furnish the service or item anyway.

Once an ABN is witnessed, the patient may be held liable, because he or she has been notified of the likelihood of a Medicare denial.

Q: Are there any exceptions?

A: Patients cannot be held liable if they do not sign an ABN when items and services are furnished and assignment of the claim is not accepted by the physician or supplier. Senior citizens cannot be held liable if they do not sign an ABN when certain medical equipment and supplies are furnished (even on an assignment basis) as a result of unsolicited telephone contacts; when there is failure to obtain advance determination of coverage; and when the supplier does not have a Medicare supplier number.

Q: Are there any limits to how much a patient who signs the ABN can be charged?

A: Once the patient signs the ABN and becomes liable for payment, there are no Medicare limits on how much a physician can charge for that service, as Medicare fee schedule amounts and balance-billing limits do not apply.

Q: What if the patient does not receive an ABN, or something is wrong with the ABN he or she signed?

A: If a physician, provider, or supplier fails to give the patient an ABN or gives the patient a defective form, he or she probably won't have to pay for the service or item he or she received.

However, in cases where the physician takes assignment of the Medicare claim, if there is any proof that the patient knew or should have known that Medicare would not pay, for the services or items before they were furnished, then they may still be held liable for payment.

The most likely case in which this could happen is if a patient received the same (or closely similar) services or items before, and Medicare denied payment for them. In such a case, the earlier denial from Medicare could be considered a "notice" to the patient that Medicare will not pay. However, this does not apply to claims that are not assigned. In that situation, the patient must receive an ABN and sign it to be protected from financial liability. ■

Physician's Payment Update™ (ISSN# 1050-8791), including **Physician's Coding Strategist**™, is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Physician's Payment Update**™, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m.-6:00 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday EST. Web: www.ahcpub.com. E-mail: customerservice@ahcpub.com.

Subscription rates: U.S.A., one year (12 issues), $457. Outside U.S., add $30 per year, total prepaid in U.S. funds. Two to nine additional copies, $366 per year; 10-20 additional copies, $274 per year. For more than 20, call for more details. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $76 each. (GST registration number R128870672.)

Editor: **Larry Reynolds**, (202) 347-2147.
Vice President/Group Publisher: **Donald R. Johnston**, (404) 262-5439, (don.johnston@ahcpub.com).
Editorial Group Head: **Glen Harris**, (404) 262-5461, (glen.harris@ahcpub.com).
Managing Editor: **Robin Mason**, (404) 262-5517, (robin.mason@ahcpub.com).
Production Editor: **Brent Winter**.

Editorial Questions

For questions or comments, call **Glen Harris** at (404) 262-5461.

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Make sure patients understand ABNs

Can you determine if a notice is valid?

Medicare requires physicians to give beneficiaries an Advance Beneficiary Notice (ABN) to read and sign when physicians believe that Medicare will not cover a service they are about to provide or that Medicare will consider the service to be "medically unnecessary." If you do not provide the patient with a "timely" ABN and the carrier denies the claim, you may have to give the patient a refund. "Timely" is defined as far enough in advance of receiving the medical service that the patient has enough time to make a rational, informed decision.

Don't wait until they're strapped to the table

The ABN should ideally be handed to the patient, preferably while he or she is in the office. Telephone calls informing a patient that a service may not be covered are not considered adequate notice because they cannot be verified. Other examples of situations that are not considered adequate notice include when the patient is connected to a testing device or on the table for an MRI, because this kind of last-minute notice is considered to be coercive, regardless of your intentions.

If you do not use the standard government-issued ABN form, you must be sure to explain why you expect that Medicare may deny payment so the patient can make an informed decision about whether to go ahead with the service and pay for it out of pocket. A routine statement to the effect that you can never be sure when Medicare might deny a claim is considered insufficient. Also, Medicare frowns on routinely giving out ABNs for all claims and services.

A patient must be able to comprehend the ABN for it to be legal. A patient is considered unable to understand the ABN if he or she is:

- comatose;
- confused, i.e., experiencing confusion due to senility, dementia, Alzheimer's disease, etc.;
- declared legally incompetent, under great duress, or in a medical emergency;
- unable to read the language in which the notice is written;
- blind or visually impaired and cannot see the words on the printed page;
- deaf and cannot hear an oral notice;
- unable to speak to ask questions about the printed form without help of a translator.

In such situations, a relative or other legally authorized person may sign the form on the patient's behalf. If that is not possible, you could have forms printed in another language; have someone read the form to the patient in his or her native language; have the form printed in extra-large letters or Braille; or get a sign-language interpreter to translate the form.

If the patient or the person acting on the patient's behalf decides not to sign the ABN, you should make a note on the form indicating the circumstances and persons involved in the decision. In such cases, you may decide not to furnish these services to the patient because the patient has not agreed to be personally liable should Medicare deny the claim.

Even when a patient signs the ABN, you should still submit the claim to Medicare. But first, ask the carrier if they want you to submit the ABN with the form or simply indicate on the claim form that an ABN exists.

Once Medicare denies the claim, you can bill and collect from the patient. ■

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