INTRODUCTION
By Gary S. Moak, M.D., Editor-in-Chief

While nursing home psychiatry is the quintessential activity of geriatric psychiatry, it ironically also is the area in which practitioners are buffeted by the greatest number of forces threatening the financial success of their practices. Greater clinical complexity, federal and state regulatory requirements, facility staff limitations, Medicare documentation guidelines, and billing hassles all make nursing home care more complicated, demanding, and less efficient. At the same time, Medicare, Medicaid, and commercial insurance payments do not reflect the greater intensity of service provided, and Medicare even imposes a fee reduction for facility-based services. To make matters worse, psychiatrists who provide high volumes of nursing home services may find themselves subject to scrutiny for fraud and abuse by their Medicare carriers. Geriatric psychiatrists who remain undaunted by such difficulties face the challenge of providing high quality, medically necessary services in a financially viable fashion. How do they do it? Can you make a living practicing long-term care psychiatry?

Practice patterns that succeed in one region may fail in other areas. The table of commonly used procedure codes for billing in LTC facilities may be helpful to readers attempting to figure this out for the first time. (page 12)

Variability also affects reimbursement in geriatric psychiatry. Mastering the complexities of third-party billing and collection is critical. Geriatrics practice requires not only familiarity with Medicare, which most often is the primary payer, but also proficiency collecting from secondary insurance plans and possibly a patient’s copayment. Some discouraged practitioners settle for the Medicare payment for their long-term care practice, cynically concluding that the cost of collecting the copayment will not be worth the effort. Unfortunately, this belief is reinforced by Medicaid payment policies that, in...
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Intended Audience
This activity is intended for psychiatrists.

Learning Objectives
Upon completion of this activity, participants should be able to:

• Describe the positive aspects of psychiatric consultation in long-term care facilities.
• Adopt strategies that will help ensure a fiscally viable nursing home practice.
• Identify opportunities for geriatric psychiatry practice in Assisted Living Facilities (ALFs).
• Discuss mental health care practice challenges in serving assisted living residents.
• Provide practical information for consumers evaluating ALFs.
• Establish effective procedures to garner appropriate reimbursement from coinsurers.
• Review methods that could improve collection rates for long-term care services.

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GERIATRIC PSYCHIATRISTS WHO REMAIN UNDAUNTED BY SUCH DIFFICULTIES FACE THE CHALLENGE OF PROVIDING HIGH QUALITY, MEDICALLY NECESSARY SERVICES IN A FINANCIALLY VIABLE FASHION. HOW DO THEY DO IT? CAN ONE MAKE A LIVING PRACTICING LONG-TERM CARE PSYCHIATRY?

many states, leave the nursing home psychiatrist writing off most of the copayment for Medicare/Medicaid patients. A significant number of nursing home patients and many, if not most, assisted living patients have other forms of coinsurance that will pay some or all of the Medicare copayment. Because of the 50 percent psychiatric limitation, meticulous attention to collecting these payments may make or break a long-term care practice. The article by Dr. Stein provides an overview of this area and many useful and practical tips for improving your collection rate for long-term care services. Readers may wish to refer to the Medicare Primer (see box, this page) to review some basic concepts and terms either before or after reading the articles by Drs. Stein and Anderson.

If the nursing home is the sine qua non of geriatric practice, then assisted living facilities are rapidly emerging as long-term care settings of equal importance. The article by Dr. Swantek rounds out this issue of The Clinical View with a helpful orientation to assisted living facilities and many of the issues faced by psychiatrists who elect to practice in these residential programs. A question frequently asked by attendees of AAGP’s practice management workshops regards billing codes to use for assisted living visits. Psychiatrists already experienced in assisted living facilities may appreciate that the home visit codes are absent from the table of commonly used procedure codes for long-term care. Many practitioners use the home visit codes (99344-99350) for services provided to patients in their private apartments in assisted living facilities, as they might for similar services they provide in retirement communities, senior housing, or patients’ private residences. Some carriers actually have advised their providers to use these codes, even though national Medicare policy states that home visit codes are not to be used in any type of “facility” setting where residents receive personal care and assistance. Suffice it to say that this represents one (of many) controversial aspects of long-term care billing for which the correct answer is not entirely clear. At the time of this publication, AAGP is working actively in collaboration with other LTC physician provider groups to bring about improvements in the payment rates for domiciliary/custodial care in assisted living facilities.

Long-term care psychiatry, done properly, is challenging, stimulating, gratifying, and time consuming. Passionate practitioners should apply commensurate zeal to billing for their services so they can continue to offer them. We hope this issue of The Clinical View provides insight into how to think about long-term care practice. In the next issue, we will look at the manifestations of personality disorders in long-term care settings and the roles of psychotherapy and behavioral interventions. This will end Volume II on a more positive note, focusing less on the frustrations of long-term care practice and more on its professional richness.

LONG-TERM CARE REIMBURSEMENT PRIMER

MEDICARE
Medicare is a federal government benefit for retirees or disabled people of all ages. It currently covers more than 49 million beneficiaries, making it the largest health insurance plan in the world. It covers physician services, hospital care, short-term, rehabilitation care in a nursing home, and now offers a limited prescription drug benefit. It is the most common primary payer of nursing home psychiatric services.

MEDICAID
Medicaid is a shared federal/state health insurance plan available to those of limited financial means. It covers nursing home costs, including prescription drugs, for the majority of nursing home residents, and is the largest secondary payer of physician services for nursing home residents who have Medicare. Medicaid is administered by the states.

MEDICARE CARRIER
Medicare is administered by a group of regional or national insurance companies that contract with the U.S. Department of Health and Human Services to process (and, it is hoped, pay) claims from providers for covered services.

THE PSYCHIATRIC LIMITATION
Medicare imposes a fee reduction on outpatient psychiatric services except for diagnostic services and medical management of Alzheimer’s Disease (ICD-9 codes 290xx or 331.0). This reduction is set at 62.5 percent of the allowed payment. The 62.5 percent reduction results in an effective 50 percent mental health copayment: Medicare’s 80 percent of 62.5 comes out to 50 percent of the original fee. A Medigap plan is required by federal regulations to pay the other 50 percent of the original fee. Other coinsurance plans are not bound by these regulations. Many will interpret their responsibility for the copayment to be limited to 20 percent of the Medicare amount. Thus, they may pay 20 percent of 62.5 percent of the full fee, or 12.5 percent. This leaves a remainder of 37.5 percent that you are entitled to collect from the patient.

SECONDARY INSURANCE, COINSURANCE, MEDICARE SUPPLEMENT INSURANCE
These terms often are loosely used in an interchangeable manner. They refer to plans that supplement Medicare by covering some or all of the Medicare copayment. These plans include commercial plans that patients purchase, plans offered by employers to retirees, and Medicaid. Medigap is a highly specific form of Medicare supplement insurance (see below). Non-Medigap plans can establish their own policies regarding coverage of the psychiatric copayment (see “The Psychiatric Limitation”, above).

MEDI-GAP
This is a form of Medicare supplement insurance which must meet standards pursuant to Title VIII of the Social Security Act (the Medicare enabling federal legislation). State insurance commissioners are required to establish procedures for certifying that these plans marketed to Medicare beneficiaries meet these standards. Medigap policies are required to pay the copayment for all Part B physician services covered by Medicare, including the 50% copayment for “biologically based mental disorders”. One exception is Medigap group plans offered by employers to retirees. These Medigap plans are not bound by the same standards, and may have restrictions regarding what they do or do not cover of the psychiatric copayment.
MANY GERIATRIC AS WELL AS GENERAL PSYCHIATRISTS HAVE FOUND PRACTICING IN LONG-TERM CARE FACILITIES TO BE A REWARDING PROFESSIONAL EXPERIENCE. There is a substantial need for psychiatric evaluation and treatment of the elderly residing in these locations. A number of financial barriers, however, may lead the clinician to avoid this practice arena. First, travel time to and from facilities adds to the cost of delivering the services. Second, Medicare reimbursement often is inadequate. The fees do not reflect the complexity of the services rendered. There also is a lower facility fee for services provided in the nursing home (i.e., the fee for any service is somewhat lower in a long-term care setting than the fee for the same service in your private office). Finally, in most nursing homes, most of the residents have Medicare and Medicaid. Currently, most state Medicaid programs pay little of the Medicare copayment for dually covered patients with Medicare and Medicaid. This means that, except for patients with Alzheimer’s Disease, for whom Medicare reimburses at 80 percent of the fee schedule, psychiatrists may have to settle for 50 percent of the Medicare fee schedule as payment-in-full. As a result of these factors, psychiatrists may have to give up some income in order to care for such patients.

BREAKING DOWN THE FINANCIAL BARRIERS

There are, however, some positive aspects of being a psychiatric consultant to long-term care residents. For example, there is essentially no problem with “no shows” as there may be in the office practice. On the rare occasion when a patient is out of the facility, one can easily see another patient who may have been added to his or her list of consults. Additionally, with proper education and training, the facility staff can be instrumental in providing data on patients through their direct observations and working with the patients on a regular basis. By seeing nursing home patients, a psychiatrist helps to build better working relationships with primary care physicians. This may lead to an increase in outpatient referrals.

To prevent the negative reimbursement issues from outweighing the positive aspects of working in long-term care settings, it is imperative to be on top of the financial issues. Over many years I have been involved in various arrangements with area nursing homes. The most...
satisfying of these have been arrangements where I have been paid a stipend for some of the non-patient centered activities. One of the primary purposes of this stipend is the education of facility staff. This includes formal in-service education and more importantly the informal liaison that occurs regularly when I am rounding on patients. I often work with front-line caregivers who display behavior that might provoke an Alzheimer Disease patient. I provide examples of behavioral approaches or communication styles that might work better with that particular resident. I often take time to explain to nursing staff about the various treatment interventions I make. Staff are often quite appreciative for these efforts. Receiving a monthly stipend covers such efforts as this is not a service that is covered by Medicare or other insurance.

Unfortunately the availability of such stipends depends on a variety of market forces. The availability of providers willing to provide mental health services to nursing homes creates supply and demand dynamics that affect facilities’ willingness to pay stipends. Facilities’ budgets may be limited by state rate setting policies and the percentage of their private paying residents who pay a higher daily rate. Nursing homes have been under increased pressures to better manage their budgets with their reimbursements having shrunk, especially since the Prospective Payment System, (PPS) came into being in 1997. With PPS many services are “bundled” into a daily rate paid by Medicare and Medicaid, which includes social work services but not physician services. Thus, nursing homes are expected to have salaried social workers, but often these social workers are not clinically trained and cannot competently offer psychotherapy services. Still, I believe it is easy to argue how the stipend “pays for itself” with the provision of improved communication and care leading to fewer injuries to patients and staff, fewer hours of sick time and disability claims by staff, and improved morale among staff. Despite these arguments, stipends are still difficult to arrange.

BILLING NUTS AND BOLTS
Let me review some of the nuts-and-bolts issues with regards to billing and coding, beginning with some of the newer issues with Assisted Living Facilities (ALFs). There is now a new code for the place of service (POS) for ALFs, specifically code 13. Prior to this being available, carriers differed in their approach to what POS code should be used. Some would allow clinicians to use the evaluation and management (E&M) codes for home visits (99344-99350). This might not work if the individual had not notified Medicare of the ALF address as their new home address. The patient’s zip code might not register with Medicare and the claim would not be paid. Other carriers suggested or mandated clinicians to use the domiciliary codes (99321-99333). Unfortunately, these codes reimburse very little compared to many other codes psychiatrists might use in other settings such as in the office, at the hospital, or at a nursing home setting. There are no new Current Procedural Terminology (CPT) codes for POS 13. Hopefully this will be addressed at some time by the American Medical Association, which sets the CPT codes.

This leaves some question as to what codes to use. It seems reasonable to use psychiatric service codes 90801 (psychiatric diagnostic evaluation), 90862 (psychopharmacologic management), and psychotherapy with E&M (90805 and 90807). One could use a consultation code using the codes 99241-99245. These codes are for office or other outpatient places of service and can be used in domiciliary, nursing home, and custodial care assuming the service was requested by a referring physician and a consultant’s report is sent. It is vital to check with your carrier to see what codes they suggest to use in the ALF setting. It may be necessary to be a bit assertive here. When I contacted my carrier I advised them of my plans to use the 90801 and 90862 codes as opposed to the domiciliary codes. Keep in mind that often the carrier representative you talk to may not know the current policy with regards to coding.

Lastly, one attractive aspect of treating ALF patients, at least from a financial perspective, is that there are far fewer Medicare-Medicaid patients in these facilities, so collection rates for the Medicare copayments are much higher. This certainly may not be the case uniformly across the country as there are regional changes where Medicaid patients are filling ALF beds.

What about billing and coding issues in nursing home settings? Clinicians should evaluate what services they are offering and then compare this with the possible CPT codes that could be used. For example, there are a number of different ways that an initial visit can be coded. One can use the initial nursing home visit codes for evaluation and management (codes 99301-99303), the initial psychiatric evaluation code (90801), or the inpatient consultation codes (99251-99255) which apply to nursing home services even though nursing homes are considered outpatient places of services. Review of the fee schedule will demonstrate that fees vary. Providing that you are delivering and documenting the higher level consultation by using the higher consultation codes, you will maximize your reimbursement for this initial visit. Please be certain when using the consult codes that there has been an order for your consultation and that you provide a written consultation report to the referring physician. Writing your consultation note, filed in the patient’s chart, meets this requirement in the nursing home.

For follow-up visits it is typically more reasonable to use a subsequent nursing home visit code (99311-99313) or psychopharmacologic management code (90862) as opposed to the follow-up consultation codes (99261-99263). These codes are intended for infrequent use to complete the initial consultation or for a new visit in response to a new order for a re-consultation. Additionally, I am often asked to provide a second opinion on issues of medical-decision capacity. In many states there is a requirement for the opinion of two physicians in this area. The 9927X series could be utilized for this purpose. These are codes for “confirmatory consultations.”

REGULAR REVIEW TO MAXIMIZE REIMBURSEMENT
Finally, it is always advisable to perform some regular review of your long-term care practice. Reviewing the mix of patients you see, the codes you use, and the rate of reimbursement for such patients can help guide appropriate changes to maximize your reimbursement, and in turn, help you maintain a fiscally viable nursing home practice.
Assisted living is a rapidly growing segment of the senior housing industry. The Assisted Living Quality Coalition, representing both consumer and provider associations, defines assisted living as: a congregate residential setting that provides or coordinates personal services, 24-hour supervision and assistance (scheduled and unscheduled), activities, and health-related services. They are designed to minimize the need to move; to accommodate individual residents’ changing needs and preferences; to maximize resident’s dignity, autonomy, privacy, independence, and safety; and to encourage family and community involvement.

In spite of the growing popularity of assisted living, little attention has been given to the mental health concerns of the residents of ALFs. However, assisted living may provide a supportive environment for these individuals, offering supervision, assistance and health care services in a home-like setting. In this somewhat structured setting, older adults experience a unique mix of security and independent living, privacy and companionship, as well as physical and social well being.
Mr. W Leaves Home

Mr. W was a 79-year-old widower living alone in a home in a neighborhood experiencing gentrification. He had no known family. No one visited his home. A new neighbor noted Mr. W struggling to cut his grass, and subsequently visited his home finding him without heat and electricity and living in squalor. The neighbor brought him to the attention of authorities and eventually, Mr. W was assigned a guardian who moved him to an Assisted Living Facility (ALF). Mr. W was unhappy with the placement, feeling that “crooks” had “kidnapped” him. He began scouring the alleys of his new neighborhood, collecting the materials he needed for the day he would move back home. He returned regularly to his old home and was deeply distressed when he discovered a “For Sale” sign out front. He returned to the ALF angry and belligerent. Mr. W’s behavior became increasingly erratic and included hoarding newspapers and old food. Concerns that people would steal things resulted in Mr. W’s refusal of any housekeeping help. Administrative concerns regarding the risk of vermin and the impact on other residents grew daily. The administrator asked the primary care physician (PCP) for help with the problem. The primary care physician asked for an evaluation by a geriatric psychiatrist.

The geriatric psychiatrist entering Mr. W’s apartment found an elderly man who enjoyed talking about philosophy and music. He would not share any information about his past other than to say he left his country because of war. His environment was disorganized and malodorous. Mr. W spoke English as his second language and would not cooperate with a mental status examination due to his concern that this information would be used against him. He did agree to a complete physical exam that revealed diminished vision but no other physical problems. Following consultation with the guardian, staff, and the PCP, an attempt to build an alliance began with weekly visits to Mr. W’s apartment. These visits eventually convinced Mr. W to reluctantly allow the removal of old food items from his apartment. He refused psychotropic medication. He lived continuously on the edge of posing a definitive risk to himself and others. The treatment team monitored closely but never felt the criteria for involuntary hospitalization were met. Concerns regarding apartment cleanliness eventually extended to concerns regarding Mr. W’s personal hygiene. Mr. W did not agree with these concerns. A fall and subsequent hip fracture led to hospitalization and the patient was discharged to a nursing home.

Mr. W’s story illustrates the role of assisted living in providing shelter for the older adult. Although he felt imprisoned, the ALF provided Mr. W with a level of independence impossible in a more structured setting. The care team worked in concert to provide personalized care that maximized Mr. W’s autonomy while recognizing his needs and limitations and simultaneously respecting the needs and rights of his ALF neighbors.

Mental Health in ALFs

Older adults in assisted living endure multiple losses and changes prior to their arrival, making them vulnerable to depressive illness. Evidence has been reported of the increasing prevalence of depression occurring in older adults as they move from independent living (10 percent) to the more structured setting of the nursing home (40 to 90 percent). Little is known about the prevalence of clinical or sub-clinical depression, dementia, or behavioral disorders related to dementia in the assisted living population. A recent national survey of ALFs estimated that one-third of ALF residents suffer moderate to severe cognitive impairment.

Results from a four-state study (Watson et al, 2003) suggest that depression is common, frequently untreated, and related to an increased rate of nursing home placement and mortality. Depression was independently associated with high medical co-morbidity, social withdrawal, psychosis, and agitation. Severely depressed assisted living residents had twice the number of deaths within the year, compared with non-depressed residents. Fewer than 20 percent of the depressed assisted living residents received antidepressant medications.

When the administrators of 94 ALFs in Michigan were questioned about mental health problems, they reported dementia and depression as the two most common mental health problems. The most common behavior problems were resistance to care and wandering (Wagenaar, 2003).

ALFs Gain in Popularity, Lack Consistent Regulation

Derived from a Scandinavian model for senior living, assisted living first emerged in the United States during the mid-1980s. In 1998, assisted living units accounted for about 75 percent of new senior housing. Today, there are nearly 40,000 facilities housing almost one million individuals in this country. Nearly all facilities provide 24-hour staff, three meals daily, and housekeeping. Many provide medication reminders and help with bathing and dressing. Fewer than half report having a full-time registered nurse on staff.

Admitting criteria generally restrict admissions to older adults with mild to moderate impairments. More than half of new assisted living residents move in directly from their homes. Most require assistance with one or two activities of daily living (ADL), as compared with nursing facility residents who require assistance with three or more ADLs. Assistance with medications may take the form of a reminder, supervision or administration by the staff. Facility staff may supervise, assist or administer medication for approximately 86 percent of the assisted living facility residents. Assistance often becomes a point of contention for the previously independent older adult who is struggling to maintain a sense of personal dignity and autonomy. This

Viable Long-Term Care Practice
places special demands on the facility staff to employ sophisticated behavioral intervention techniques to ensure that patients receive their medication.

In spite of those demands, no national educational and training minimum requirements exist for unlicensed personnel charged with caring for older adults in ALFs. Minimum requirements specified in individual states vary from no training at all to that required of nursing assistants in skilled nursing facilities. Staff training is needed to ensure quality of care, quality of life, and resident safety. Geriatric psychiatrists provide an important resource for consultation and education, assisting facilities in developing a plan for dealing with mental health issues in their facilities.

Unlike nursing homes that are federally regulated, state government oversees assisted living facilities; therefore, regulations and services vary widely. To date, the involvement of state and federal governments with assisted living has been minimal when compared to other segments of long-term care.

In many areas, assisted living is a long-term alternative available only to older adults with significant financial reserves. Currently, 75 percent of all assisted living residents are self-pay. Out-of-pocket monthly expenses range anywhere from $1,500 to $5,000, beyond the means of the individual with little more than Medicare or Medicaid as their support.
Medicare does not cover assisted living expenses. Some of the services provided in assisted living may be paid under Supplementary Security Income (SSI) and Social Services Block Grant programs. Many states presently reimburse or plan to reimburse for assisted living as a Medicaid service. Less than 10 percent of residents currently receive Medicaid assistance.

As relatively healthy residents become increasingly impaired, they require more staff assistance. The restrictive discharge criteria of many ALFs guarantee that the most impaired residents will eventually be transferred to a different site, perhaps the home of a relative or to a nursing home. Residents who have moderate to severe cognitive impairment, have behavioral symptoms or need nursing care are frequently asked to move to a long-term care facility. The philosophy of individual ALFs differs greatly and thus, while one facility may promote transfer to a higher level of care, other ALFs will strive to provide appropriate services for the older adult aging in place.

The Committee on Aging of the Group for the Advancement of Psychiatry (CAGAP) proffers 10 principles for mental health care in ALFs (published in Geriatrics by Cohen, GD et al). These principles encourage personalized care that maximizes independence while recognizing each resident’s mental health strengths, needs, and limitations. CAGAP advises facilities to incorporate mental health care concepts into facility policies including ongoing education of staff regarding the identification and treatment of mental health problems, regular screening of residents for mental illness, active collaboration between the patient, family, the staff, primary care provider, and geriatric psychiatrist.

ALFs represent a promising housing opportunity that will allow older adults to maintain a measure of independence while receiving necessary support and assistance with daily activities. Residents of these settings experience mental health problems that may go unrecognized or untreated, resulting in significant, possibly life-threatening, emotional distress. Acting as consultant, educator or treating physician, the psychiatrist can make a significant contribution to the health and well being of the ALF resident suffering from mental illness.

Advice for Patients and Their Families

Geriatric psychiatrists often participate in the transition their patients make into ALFs. In advising patients and families about long-term care decisions it is important to urge them to look beyond glossy marketing materials. Assisted living is a varied and evolving concept.

Consumers should identify the services they want and need, then shop around. Those evaluating assisted living should:

- Make multiple visits at different times of the day and week.
- Talk to staff and residents and their family members. Ask whether the services offered are actually delivered.
- Discuss psychosocial activities and support as well as mental health services.
- Examine prices and ask which services are included and which services might initiate a price increase.
- If medication services are utilized, determine who communicates medication changes to the facility and how they will be monitored.
- As some older adults have difficulty living with persons more disabled than they are, it is important to inquire about the criteria for discharge. This will alert the consumer to the level of disability they will be expected to tolerate in their environment.

References


Other Resources
National Center for Assisted Living (NCAL) www.ncal.org.

Medicare coverage of mental health services is fragmented and subject to arbitrary and discriminatory limitations. Although the copayment for most services covered by Medicare is 20 percent, current law requires a 50 percent copayment for services furnished by psychiatrists and other health care professionals for the treatment of ICD-9 mental disorders. This limit, which dates back to the inception of the Medicare program in 1965, is based on the outmoded assumption that all mental illness is chronic and requires unlimited therapeutic services.

Nursing home practice poses additional reimbursement challenges that require clinicians to exercise greater diligence in claims submission and payment collection. This discussion will provide guidelines and tips for implementing collection procedures that should improve compensation for the clinician’s services.

For payment purposes, Medicare treats nursing homes as outpatient places-of-service subject to the 50 percent psychiatric reduction. One exception to this is medical management services to patients with Alzheimer’s Disease, (ICD-9 codes 290.xx or 331.0) and related disorders. Secondary insurance might cover the other 50 percent of the Medicare outpatient copayment or may only pay 12.5 percent (see the Medicare Billing Primer on page 3 for an explanation of the 12.5 reimbursement rate). The amount paid depends on whether the secondary insurance policy (sometimes referred to as coinsurance) is a Medigap policy and subject to governmental policy, or is an independently provided Medicare supplemental policy, such as insurance provided by a former employer or by a trade union. At times, payment might be handled by a behavioral health carve-out subdivision of a company or by an outside managed care organization (MCO) subcontractor.
**Psychiatric Coverage by Secondary Payers**

**Secondary payers**
Medicare Supplemental Insurance is variously called “Coinsurance” or “Secondary Insurance.” A certain type of secondary insurance plan, known as Medigap meets a specific set of federally mandated guidelines for coverage. Secondary insurance policies may be purchased by the patient or paid for by others, such as a former employer that provides this coverage as a retirement benefit. Secondary insurance policies typically pay the 20 percent copayment. There may be deductibles, however, as well as limitations on mental health benefits. The insurance policy may or may not be a managed plan. Medigap plans are required to cover the copayment for any services covered by Medicare.

**Medigap payment**
In late December 2002, the Centers for Medicare and Medicaid Services published a program memorandum clarifying that “the Medigap issuer is generally responsible for the 50 percent of the Medicare allowed amount for Medicare Part B outpatient mental health services.”

The requirement that Medigap insurers cover the 50 percent copayment has actually been in force since 1990, but inconsistently applied by Medicare carriers. As a result of advocacy by the American Association for Geriatric Psychiatry (AAGP), the American Psychiatric Association (APA), the National Association of Insurance Commissioners, the federal government, and others, the new memorandum directly addresses the issue and should clarify once and for all that Medigap insurance is to cover the 50 percent copayment. Your local Medicare carrier should have published listings of their Medigap partners.

**Tips for Coinsurance Billing**

Developing procedures that follow the suggestions below should ensure appropriate reimbursement. The process may be time consuming and, at times, frustrating, but if approached with diligence and organization, it can result in proper reimbursement.

**Verify the patient’s insurance information**
The billing information on the face sheet of the nursing home chart may be incomplete or inaccurate. It may be helpful to verify the insurance company information directly with the patient’s family or responsible party before a claim is submitted. At each subsequent visit ask about, and note, any changes in a patient’s insurance coverage. Individuals may change insurance companies or go on Medicaid or company policies may change.

When a patient’s insurance is based on employment, verify the name of the patient’s former company, and even the division where they worked. Policies based on employment may have special billing addresses, coverage, and review provisions.

**Contact the insurance company at the first visit**
Regardless of where the patient is first seen, always contact the secondary insurance company at the time of the first visit to verify the company’s billing address. It is helpful to verify that the patient’s insurance identification number is correct and that they are still eligible for services under the plan. Ask if prior authorization is required (generally needed for managed carve-outs). At that time, always request an authorization number, which is often required in order to receive payment. Furthermore, ask if separate authorization numbers are required for inpatient and outpatient services, or for services provided at other locations. Some companies require a number in one location, but not in another. If you are told that an authorization number is not required, record the name of the individual who provided the information and keep this information with the patient’s records. Also request that the individual responding at the insurance company enter into the patient’s computer file that no authorization is required. If you are at all uncomfortable with the responses you receive, ask to speak to a supervisor to verify the information.

**Verify company billing addresses**
Some insurance companies have one billing address for office visits and a different one for hospital visits. Some companies have different billing addresses for mental health claims. Remember that an insurance company generally will not forward a claim that is sent to the wrong address. In order to receive payment, it is your responsibility to make sure the billing address is correct. If you do not receive payment within a reasonable amount of time, follow up to verify the billing address.

**Find out about variability among policies**
Insurance policies, even within a single company, vary and you should become familiar with these policy variables such as:

- Deductible amounts may vary.
- Mental health care may be covered in an outpatient setting by some policies and in an inpatient setting by others.
- Some policies/companies pay patients directly for office-based services, but then may pay the doctor directly for hospital-based services.
Dealing with Coinsurance Payers

File claims on time
Timely filing is vital for many secondary insurance policies and companies. Some companies, such as Group Health Incorporated (GHI) and Value Options, may have policies that will not pay any claim filed more than 90 days after the date of the Medicare payment. If a patient's bill is not paid within 30 days of billing, call the insurance company to verify that they did receive the claim.

Retain records of all correspondence
A company may indicate that they never received the claim, or that the person or the service is not covered or that they have already paid you or they have already paid the patient.

Follow up with the secondary insurance company
Secondary insurance usually pays within 30 days. Some companies take as long as 60 days to pay, but after 30 days you should follow-up. Though your records may show a Medicare crossover billing took place, the secondary insurance company may tell you they never received a bill. This can happen even when a paper claim was submitted.

Secondary insurance may be carved out to a managed care organization in which you do not participate. In addition, the secondary mental health carve-out company may not pay for patients with a diagnosis of dementia, while, at the same time, the patient's secondary insurance company does not pay for psychiatrists.

Watch for inconsistent practices
Sometimes the insurance companies will pay for some days of service and refuse to pay for other, identical, services. When you call again, you may get many different, or even contradictory, explanations for denying the same claim. Some excuses include: “didn't receive it,” “not eligible,” “need records sent,” or “Medicare already paid more than the insurance fee.” Sometimes they just do not process the claim, but may fail to tell you so when you inquire, in hopes that you will not follow-up further.

Other Steps You Can Take to Ensure Payment

Communicate with the patient, family or guardian
Encourage the patient to be your ally in dealing with the insurer. Sometimes a phone call from them to the insurance company will result in you getting paid. After all, they are the insurance company's customers. Also, unless you have an agreement not to bill them, they are going to get the bill if the insurance company does not pay you.

The patient or family can help. If the secondary insurance is through a person's former employer, ask the patient to contact the employer to file a complaint. Remember the employer is paying the insurance premium, so a call from them to the insurer may have more effect than a call from you.

Write letters of complaint
You will need a written release from the patient or legal guardian to write a letter of complaint. You can write to your state insurance commissioner to complain about how your claim was handled by the insurance company. You also can write to the attorney general in your state if you believe the company is guilty of fraudulent practices.

If the insurance is from employment and the patient cannot contact the employer, write to the U.S. Department of Labor and include a copy of all of your notes showing your attempts to collect payment. Also, attach billing summaries showing services provided, amounts billed, and Medicare remittance notices indicating the amounts due from the patient's coinsurance.

Notify the patient or their family about their responsibilities for payment
Give your patient a notice about the 50 percent Medicare psychiatric fee reduction. Have your patients sign a notice that they have been informed of their responsibility for the 50 percent copayment, if their coinsurance or secondary insurer does not pay you in a timely manner. This responsibility notice indicates that even though you have accepted Medicare assignment, your acceptance of their secondary insurance has some limitations.

Billing Codes for Long-Term Care

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NURSING HOME</strong></td>
<td></td>
</tr>
<tr>
<td>Initial Visits</td>
<td></td>
</tr>
<tr>
<td>Initial inpatient consultation</td>
<td>99251-99255</td>
</tr>
<tr>
<td>Initial nursing home visit</td>
<td>99301-99303</td>
</tr>
<tr>
<td>Initial psychiatric diagnostic evaluation</td>
<td>90801</td>
</tr>
<tr>
<td>Subsequent Visits</td>
<td></td>
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<tr>
<td>Psychopharmacologic management</td>
<td>90862</td>
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<tr>
<td>Subsequent nursing home visit</td>
<td>99311-99313</td>
</tr>
<tr>
<td>Subsequent inpatient consultation</td>
<td></td>
</tr>
<tr>
<td>Individual psychotherapy with E&amp;M</td>
<td>90817/90819</td>
</tr>
<tr>
<td><strong>ASSISTED LIVING FACILITIES</strong></td>
<td></td>
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<tr>
<td>Initial Visits</td>
<td></td>
</tr>
<tr>
<td>Initial psychiatric diagnostic evaluation</td>
<td>90801</td>
</tr>
<tr>
<td>Domiciliary or rest home visit</td>
<td>99321-99323</td>
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<tr>
<td>Subsequent Visits</td>
<td></td>
</tr>
<tr>
<td>Psychopharmacologic management</td>
<td>90862</td>
</tr>
<tr>
<td>Individual psychotherapy w/E&amp;M</td>
<td>90817/90819</td>
</tr>
<tr>
<td>Domiciliary or rest home visit</td>
<td>99331-99333</td>
</tr>
</tbody>
</table>

NOTE: This information has been carefully reviewed and represents the most current opinions of this issue’s authors. However, please consult your local carrier as policies may vary. Table does not include office or other outpatient codes or home visit codes, which may be used by some providers under some conditions (please see editor’s introduction and article by Dr. Anderson).
Bill the patient
If you make a good faith effort to bill and collect this insurance and still have not been paid (e.g., after 60 days, or 90 days, whichever you decide), then the patient’s acknowledgment that they are responsible for the payment now applies. If the coinsurance does not pay in a timely manner, bill the patient. If the patient is covered by Medicaid, however, you cannot bill them for the 50 percent copayment.

You are entitled to be paid for your work. You accepted assignment of Medicare payment and are not permitted to bill the patient for the portion Medicare is supposed to pay, per the fee schedule. However, you are not required to accept the secondary payment. You are doing that as a courtesy or because it is convenient, and it usually works out. If the secondary insurance company does not pay as it should, it will cost you time and money to pursue this claim. If you have persistent problems with a secondary insurance company, you may want to let the patient know you are going to bill them up front. Then, file a claim and return the money to the patient if you get paid.

Determine whether the patient received payment
There are some companies that will only pay the patient, particularly if the services took place in an office. It is not uncommon for the patient to receive the copayment check from the insurance company and then fail to turn it over to you. This is especially common in nursing home practice. You may be in communication with one family member who serves as healthcare proxy or guardian. There may be another person, not uncommonly in a distant state, who handles the patient’s financial affairs. This person may receive your copayment check. They may not know what it is for or they may make no effort to give it to you unless you ask for it. You can determine whether this occurred by a follow-up telephone call to the insurance company. To avoid this situation, it is wise to check ahead of time with a new patient’s insurance company to determine their policies.

Waive the co-payment
Finally, you are permitted to waive collection of the copayment, but only on a limited case-by-case basis. You must have some supporting documentation in your patient file, e.g., that “after discussion with the patient of their responsibility for the Medicare 50 percent copayment, you have agreed to waive collection of the copayment for this patient because of the patient’s current economic situation”.

Summary–Be Proactive
Be aware of some potential obstacles that you may encounter. This will help you prepare claims correctly and reduce the frustrations of dealing with some insurance companies. Do not expect the insurance company to let you know what is wrong with a claim. As the submitter, you need to be proactive and persistent.

- Always call the company.
- Document to whom you spoke and exactly what they told you. Get the person’s name. If they say there is no claim on file, get the fax number and verify the billing address.
- Fax the claim and then call to make sure it is received, even if you have a fax verification. Ask to fax the claim directly to the person with whom you are speaking.
- Call back in two weeks if you do not receive payment.
- Persistence counts. Companies usually record every telephone call with you. Again, get the representative’s name and keep notes.
- If, for some reason, they refuse to pay you, do not let it end there. Let them know you intend to file a complaint.
- Before filing a complaint, ask to speak to a supervisor and go up the chain of command within the company.
- Secondary insurance companies frequently delay payment by asking you for copies of your treatment notes, hospital records, and so forth. You must obtain these in a timely manner and comply with their request.
- You should already have a patient release of information on file for purposes of obtaining payment.
On the answer form located on the next page, please circle the letter that corresponds to the single most appropriate answer for each of the following questions.

The deadline to receive credit is one calendar year from the date of publication. A CME Certificate will be sent to you, should you earn a passing grade of at least 70 percent.

1. For the purposes of billing, Medicare considers psychiatric care administered in nursing homes to be:
   A. An office visit
   B. A hospital stay
   C. An inpatient place of service
   D. An outpatient place of service

2. Generally, you must file claims with secondary insurance payers within:
   A. 30 days
   B. 60 days
   C. 90 days
   D. Six months

3. If, after several attempts, you have been unable to collect on a claim, you should:
   A. Ask your patient’s family to intervene
   B. Write your state insurance commissioner
   C. Have your patient sign a clause acknowledging their responsibility if the claim goes unpaid
   D. Drop your efforts because your staff has already spent too much time trying to collect

4. One advantage of practicing in a long-term care setting is
   A. There is no problem with "no shows"
   B. The cost of delivering the service
   C. Medicare reimbursement is adequate
   D. Long-term patients also receive Medicaid, increasing the rate of reimbursement

5. Stipends offered to psychiatrists practicing in a nursing home are rare opportunities because
   A. Nursing homes are under pressure to keep costs down
   B. The same services are covered by Medicare
   C. A stipend does not "pay for itself" through fewer injuries and staff hours lost
   D. They are not allowed under government regulations

6. The new place-of-service (POS) code for patients in assisted living facilities is
   A. 9
   B. 11
   C. 13
   D. 15

7. Assisted Living Facility administrators in Michigan report the two most common mental health problems among their patients are
   A. Resistance and wandering
   B. Depression and dementia
   C. Schizophrenia and Alzheimer’s Disease
   D. Sexual disinhibition and screaming

8. The increased prevalence of depressive illness occurring in older adults as they move from independent living to the more structured setting of the nursing home is:
   A. 40 to 90 percent
   B. 10 to 40 percent
   C. 40 to 70 percent
   D. 50 to 80 percent

9. Of all ALF residents, the percentage of those who are self-paying is:
   A. 25 percent
   B. 33 percent
   C. 50 percent
   D. 75 percent

10. A national survey of ALFs estimates that the number of their residents who suffer moderate or severe cognitive impairment is:
    A. One-half
    B. One-third
    C. One-fourth
    D. One-fifth
**Personal Information**

I certify that I have completed this educational activity and test. Expiration date: August 2005

Name

Degree

Address

Address

City

State Zip

Phone Email

**Activity Evaluation**

You must complete this evaluation to ensure processing of your self-assessment test.

*Please circle your answer.*

Have the following educational objectives of this activity been met?

Describe the positive aspects of psychiatric consultation in long-term care facilities. **Yes No**

Adopt strategies that will help ensure a fiscally viable nursing home practice. **Yes No**

Identify opportunities for geriatric psychiatry practice in Assisted Living Facilities, (ALFs). **Yes No**

Discuss mental health care practice challenges in serving assisted living residents. **Yes No**

Provide practical information for consumers evaluating ALFs. **Yes No**

Establish effective procedures to garner appropriate reimbursement from coinsurers. **Yes No**

Review methods that could improve collection rates for long-term care services. **Yes No**

Comments:

**Viable Long-Term Care Practice: CME Self-Assessment Test Answer Form**

Please circle the letter that corresponds to the single most appropriate answer and fax this page to the American Association for Geriatric Psychiatry at 301-654-4137 or mail your response to:

American Association for Geriatric Psychiatry
Education Department
7910 Woodmont Avenue, Suite 1050
Bethesda, MD 20814

Expiration Date: August 2005

1. a b c d
2. a b c d
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Fax: 301-654-4137
Eclecticism in Nursing Home Psychiatry: Using Your Whole Bag of Tricks

- Psychotherapy in the Nursing Home
- Dealing with Difficult Personality Disorders
- Behavioral Interventions