



Long-term Care Forum

Reimbursement Realities: The Business End
of Psychiatric Consultation in Nursing Homes

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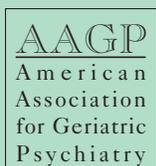
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Introduction

Many practitioners think of paperwork as an annoyance that interferes with their *real* work—taking care of patients—and that should be disposed of as quickly as possible. But the reality is that psychiatrists in the nursing home setting usually need to be reimbursed by a third party for their services, and proper paperwork is necessary for reimbursement. Complete record keeping, accurate coding, and a clear understanding of payers' procedures are essential to receiving fair reimbursement without hitches, and it can benefit your practice in other ways. If the paperwork is organized well, it needn't take too much time.

The current issue of *Long-term Care Forum* offers guidance from three experts in this area. We start with an editorial by David Greenspan, MD, that explores record keeping and how to do it right, both for the sake of patient care and medicolegal protection. We then interview Elliott M. Stein, MD, for tips on coding of diagnoses, treatments, and consultations to ensure proper reimbursement. Finally, Gary S. Moak, MD, explains the Medicare claims process, why denials happen, and what to do when a claim is denied.

No matter how good a practitioner you are, if you don't pay close attention to coding and record keeping then your claims for reimbursement may be questioned or denied. The contributors to this issue of *Long-term Care Forum* can help you make sure that you're reimbursed fairly for the services you provide.

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Faculty Disclosures

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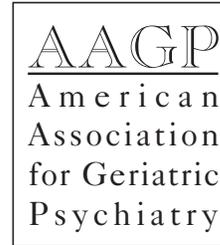
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Purpose and Overview

Complete record keeping, accurate coding, and a clear understanding of payers' procedures are essential to the continued provision of patient care, and the physicians' medicolegal protection and fair reimbursement.

Learning Objectives

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

- List the elements that Medicare carriers require for inclusion in the patient's medical record
- Appraise and critique medical documentation for its suitability for interdisciplinary communication, reimbursement, and medicolegal protection
- Choose the appropriate code for various psychiatric services
- Identify documentation and coding practices that are most likely to lead to the denial of a claim
- Discuss ways of preventing claim denials

Dealing With Documentation: Making Your Paperwork Work

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Few tasks are more arduous for the physician than medical records documentation—but few tasks are more vital. Done properly, documentation can save the day in a court of law, and it unquestionably increases the likelihood of fair reimbursement. Done expediently, it need not occupy an inordinate amount of clinical time.

Let's start with the truth: Most clinicians believe that medical record documentation is little more than a necessary evil. Ask the majority of geriatric psychiatrists what they think of the task of documentation and you're likely to hear words like *onerous*, *burdensome*, *time consuming*, and *tedious*. At the same time, however, documentation is crucial not only to effective patient care, but also to fair reimbursement and medicolegal security. The medical record is the tangible representation of both the need for care and the activities of care. As all physicians learn early in the course of their medical education, "If it wasn't charted, it wasn't done." Depending on how you handle it, your documentation can be your best friend, or your most formidable foe (Table 1).¹

The Medical Record: A Multipurpose Document

Charting—that is, entering information into the patient's medical record—isn't just "busywork." The medical record is a document with four very important purposes.^{1,2}

- **The medical record serves as a primary mode of communication among members of the interdisciplinary team.** A multidisciplinary team provides nursing home care. The appropriate coordination of care is therefore crucial. The medical record provides a means for members of the team to communicate about the care they provide. The more information the consulting psychiatrist provides about his or her involvement with the patient, the better informed the other team members will be, the more coordinated the patient's care will be, and the more time will be saved in the long run.
- **The medical record is a quality assurance document.** The medical record is likely to be reviewed by accrediting agencies, quality improvement auditors, and other bodies charged with reviewing the quality of care provided in nursing homes. Any medical record is potentially a public document.
- **The medical record is a medicolegal insurance policy.** The medical record is admissible in a court of law and is often "exhibit A" in medical malpractice and negligence cases. Depending on the state and the situation, the statute of limitations on such cases generally extends well beyond the human capacity for accurate and detailed memory of events. A medical record that

Table 1

The Medical Record: Friend or Foe?

<i>The medical record is your friend when it...</i>	<i>The medical record is your foe when it...</i>
<ul style="list-style-type: none"> • Provides clear, concise communication of what has been done for the patient and why • Reflects that care was given according to current best-practice standards for psychiatric care • Can be used in your successful defense in court 	<ul style="list-style-type: none"> • Contains insufficient information • Contains information that does not support billing codes used or diagnosis listed • Reflects provision of nonstandard care • Points out errors or omissions • Appears to have been altered • Can be used to convict you in court

Adapted with permission from Day N. The medical record: your best friend or worst enemy. *Am Coll Health Care Admin*. December 1998; 9-13.

is complete and coherent, one that reflects adherence to professional standards of practice and to nursing home policy and procedure, can make the psychiatrist's entire defense in a court of law—while one that lacks these characteristics can be his or her undoing.

- **The medical record helps to ensure adequate, fair reimbursement for services rendered.** The vast majority of the psychiatrist's services in the nursing home are paid for by Medicare, under the auspices of the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration). To

satisfy Medicare requirements, there must be sufficient documentation in the medical record to support the services billed by the psychiatrist and the level of service required; furthermore, that documentation must be consistent with, and support, the code used. The Social Security Act, Section 1883(e) of Title XVIII, requires "available information that documents a claim."² As the American Medical Association (AMA) puts it, "Documentation can make or break you in the case of an audit by Medicare or a private carrier."²

Fair Reimbursement Rests on the Record: How Healthy Is Your Documentation?

Medicare has full access to medical records, and nothing will guarantee a claim denial, or a claim down-coding, more surely than an inadequate, unclear, or unsupportive medical record. Each patient's chart should tell a story, providing a clear picture of the following³:

- The patient's need for psychiatric consultation and care
- The rationale for the level of care provided
- The patient's movement from one level of care to another
- The patient's progress under the current plan of treatment
- Any changes made in response to the patient's failure to respond as anticipated and the effects of those changes
- Plans for eventual discharge of the patient from the active treatment plan

It is important to note that in the long-term care setting, a consultation must be ordered, in writing, by the primary care physician. Without this order, the contact will be deemed "not medically necessary" unless a written request is made by the patient or guardian.

Every year, millions of dollars in claims are denied, and millions more are reclaimed from physicians, by Medicare and other carriers simply because the medical record fails to support the services billed. The care provided might be superlative, but from the point of view of Medicare or private insurers, if the documentation for the service is incomplete, unclear, or inadequate, then you did not provide the care, and you cannot bill for it.² The level of documentation provided by the psychiatrist in the nursing home should be every bit as comprehensive as that

which would be provided in the hospital.³

Because of concerns regarding fraud and abuse in recent years (see "Coping With Claim Denials: What to Do When Medicare Says No" in this issue of *Long-term Care Forum*), the number of patient charts being reviewed by Medicare and other third-

party payers has increased greatly.^{2,3} Given this heightened scrutiny, it behooves consultant psychiatrists to conduct an audit of their own documentation practices. Specifically, the AMA recommends using a checklist that is similar to the following to review your documentation policies, procedures, and standards.²

Without a consultation order, in writing, the contact may be deemed "not medically necessary" unless the patient or guardian makes a written request.

- Are your medical records maintained in a manner that satisfies these requirements?
 - Timely
 - Uniform
 - Consistent
 - Legible
- Do all entries include the following items?
 - Date
 - Patient's name
 - Provider's name
 - Chief complaint
 - Clinical findings
 - Diagnosis or clinical impression
 - Tests ordered
 - Medications prescribed
 - Procedures performed
 - Instructions given to the patient
- Are all notes signed?
- Are consultations and advice documented accurately and consistently?
- Do entries clearly document the need for the level of service being billed?
- Does the diagnosis clearly support the need for the services being provided?
- Does the documentation support the billing codes being used?

Documentation Through the Continuum of Care: Anatomy of a Complete Medical Record

Documentation begins with the first patient encounter and continues until the patient is no longer in the psychiatrist's care. However, each stage of the care process necessitates different levels of documentation.³ The completed consultation documentation should include the following:

- The **initial note** is a brief entry noting the findings and recommendations of the initial psychiatric evaluation. The initial consultation can be documented in parts, if time limitations require, or it can be completed as a whole. The details

requiring documentation should conform to the procedure code selected for describing the thoroughness and complexity of the decision-making. The note should include:

- The reason for the consultation
- The results of a brief mental status examination (unless a comprehensive evaluation is bundled in a single note)
- A list of current medications
- A list of medical comorbidities
- A preliminary treatment plan (unless a master plan is included)
- The **comprehensive psychiatric evaluation** is a fully detailed report of the psychiatrist's findings regarding the patient's mental status; it should be completed as soon after the initial evaluation as possible. If the patient already has an evaluation on record, an updated evaluation is sufficient.
- The **master treatment plan** outlines in detail the planned therapeutic regimen. It is required for every patient for whom active treatment is planned and should include:
 - Data identifying the patient
 - Reason for the consultation
 - 5–Axis diagnosis
 - Presenting problem(s)
 - Patient objectives
 - Short and long-term goals
 - Interventions
 - Criteria for treatment discontinuation
- The **progress note**, to be written after each visit, should summarize the physician–patient interaction and include:
 - A brief description of the patient's mental status
 - A list of interventions ordered or recommended
 - A statement about the patient's response to treatment and progress, or lack thereof, toward stated goals

Any of several formats can be used for charts (Table 2), as long as they include all requisite information.¹ Some “documentation do’s” are listed in Table 3.

Table 2

Suggested Charting Formats¹

Acronym	Charting Elements
AIR	Assessment, Implementation, Responses
APIE	Assessment, Plan, Implementation, Evaluation
PIE	Problem, Intervention, Evaluation
SOAP	Subjective data, Objective data, Assessment data, Plan
SOAPIE	Subjective data, Objective data, Assessment data, Plan, Intervention, Evaluation

Taking the Pain Out of Paperwork: Tips for Time-Efficient Documentation

The most painful part of paperwork for most physicians is that it is tremendously time-consuming. Time is a commodity in woefully short supply for today's pressured physician, and when documentation time competes with patient treatment time, it places the physician in a state of conflict. But there are ways to improve both accuracy and efficiency, thereby reducing the time it takes for documentation.

Dare to double-task; document while you work. Most physicians scribble notes during patient visits and then write their progress note from their notes, in a two-step process. One way to cut out some time and ensure completeness is to document straight onto the consult form as you work. Your documentation has to be comprehensive, but it doesn't necessarily have to be meticulously organized. As long as the information is legibly included somewhere on the form, you've documented it—and you can get credit for it.

Simplify by standardizing. Unlike hospitals, most nursing homes are willing to accept documentation in any form the physician provides as long as it fits on the chart. Thus, many consulting psychiatrists create their own preprinted template forms for documentation. Such forms, which often use checkboxes and other devices to simplify documentation of items that are routinely recorded, not only save time but also compel comprehensiveness because they trigger the writer to document all the essential aspects of the evaluation. A caveat to using standardized forms is to make sure that there is plenty of opportunity for individualization. Each note should be unique to the patient and the visit. A simple way to ensure such individualization is to include some subjective information—verbatim quotes from the patient, for example—in each note.

Turn to technology. Computers can be a tremendous time saver for the consultant. Whether you choose to use a word processor with a template or a database, computerized documentation facilitates the record-keeping process in a number of ways. First, like a paper-copy standardized form, it ensures documentation of all of the necessary elements of the evaluation and care process, so that nothing is left out. Second, it saves time by enabling the psychiatrist to edit the previous note so that it becomes today's note, rather than having to rewrite standard items repeatedly. (For example, if only the dose of a medication is changing, it is much quicker to simply change a number than to write the name of the medication again.) Finally, it dramatically improves the legibility of documentation.

Dictate your documentation. Dictating notes and having them transcribed may seem too costly for some psychiatrists. However, it may be a very cost-effective option for group practices or for extremely busy solo practitioners who simply find that too much time is being eaten up by the process of writing. Some services may even be willing to edit prior notes instead of typing each note anew, thereby saving some time and resources.

Table 3

Documentation Do's

Do's	Rationale
Do ensure that the patient's name is on every page.	If a page becomes separated from the entire document and the patient's name is not on it, it be impossible to prove that the recorded information applies to that patient.
Do conclude every entry with your signature and medical	The signature identifies the note as having been written by the physician and is considered a crucial part of the note. Even word-processed notes should be degree-signed. Do <u>not</u> allow anyone else to sign the note or sign one for someone else.
Do make sure that your note matches the code you've billed.	When it comes to reimbursement, the purpose of your note is to justify the code you've used. If you're asked to produce a note to justify a claim, and the note doesn't match the code, your claim will almost certainly be denied.
Do include a time notation.	While some codes have no time specification, others are time specific, and still others are time approximate. Therefore, it's a good idea to get into the habit of noting the amount of time spent in a given clinical interaction.
Do document with the future in mind.	Medicare carriers have the right to pay you today—and ask you to prove that that payment was justified tomorrow. The current statute of limitations is 3 years, so bear in mind that they may come back to you at any time during that period.
Do believe that neatness counts.	It's frustrating to have to struggle to read a written document—and a frustrated claims reviewer (or legal reviewer) is unlikely to be an objective, favorably disposed reviewer. The story of your care should be easily accessible from your documentation, and that means paying attention to seemingly minor details, like legibility and proper spelling, grammar, and punctuation.
Do consider a consultant.	It can be difficult to spot the flaws in one's own work. That's why there are consulting firms who do nothing but review and advise on documentation and coding. They will do a mock audit and let you know where your potential problems lie. Such a service can be costly, but it may more than pay for itself if it avoids a few claim denials.

Write with the reviewer in mind. If documenting seems time consuming, try coping with claims denials—or worse still, an audit for which the necessary documentation is lacking. You can save considerable time over the long run by documenting as though 100% of your charts will be reviewed.³ Then, in the event that any are, you'll be ready.

Conclusion

While few psychiatrists will ever look forward to documenting, or view it as the most satisfying part of the consultation, there are many ways of minimizing the burden. You can change your perspective on the documentation imperative by taking advantage of timesaving tips and by recognizing your paperwork's power to protect your medicolegal status *and* your reimbursement stream.

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Coding: The Key To Fair Reimbursement, An interview with Elliott M. Stein, MD

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Rail against it if you will, but coding is a reality of psychiatric consultation that is almost certainly here to stay. Get it right, and you're far more likely to receive fair reimbursement for your services. Get it wrong, and you won't receive the reimbursement you've earned. Long-term Care Forum spoke with Dr. Elliott M. Stein for some advice on how to get it right.

Choose the correct code based on the type of psychotherapy provided, the site of service, the amount of time spent with the patient, and whether or not evaluation and management services were provided on the same day as the psychotherapy.

Introduction

With an estimated 91% to 94% prevalence of psychiatric disorders in U.S. nursing homes, the provision of psychiatric services to nursing home residents is an imperative. Two models of reimbursement for such services are currently in use.^{1,2} In the first model, which is rarely used, the nursing home contracts with the psychiatrist for the provision of services and compensates him or her directly. In the second, far more frequently used model, the consultant seeks reimbursement on a fee-for-service basis from Medicare (in the vast majority of cases), Medigap, and Medicaid, in the appropriate sequence. In this model, coding is king.

Coding is the assignment of a number to the medical services a physician provides. Physician practices use two coding systems.³ Services or procedures are coded using the HCFA Common Procedure Coding System (HCPCS); these codes include the AMA's Current Procedural Terminology (CPT) codes⁴ as well as other codes created internally by Medicare. Diagnoses are coded using the International Classification of Diseases 9th Edition Clinical Modification (ICD-9-CM).⁵ The two need to match; failure to link ICD-9 diagnosis codes and CPT-4 procedure codes can result in claims denial.³ On the other hand, understanding current coding procedures and applying them properly increases the likelihood of fair reimbursement and saves a considerable amount of time.

LTC Forum: How are services performed by a psychiatrist in a nursing home generally categorized?

Dr. Stein: Services provided by a psychiatrist in a nursing home can fit into two groupings—those services that are designated in the CPT coding book as psychiatric services, and those services that are designated as medical services. Psychiatrists are physicians, so they are eligible to provide any of the standard services that any physician can provide. Often, though, the psychiatrist will be providing services that are considered psychotherapy in the CPT coding manual.

LTC Forum: How is psychotherapy defined according to the CPT coding manual?

Dr. Stein: The coding manual defines psychotherapy as “the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.”⁴ But psychotherapy isn't just psychotherapy; it's one of a series of 24 different codes that are defined in different ways, all of which need to be considered in choosing the correct code (Table 1).^{2,4}

LTC Forum: What factors does the physician need to consider to choose the correct code?

Dr. Stein: You choose the correct code based on the type of psychotherapy provided, the site of service, the amount of time spent with the patient, and whether or not evaluation and management services were provided on the same day as the psychotherapy.⁴

LTC Forum: Let's discuss types of psychotherapy first. What are the possible types of psychotherapy that can be provided?

Dr. Stein: There are two broad types: one is interactive psychotherapy, and the other is insight-oriented, behavior-modifying, and/or supportive psychotherapy.

LTC Forum: What's the difference between the two for coding purposes?

Dr. Stein: “Interactive psychotherapy” is a category that was developed primarily to describe play therapy with children—although millions of units of interactive psychotherapy have been billed to Medicare.² Interactive psychotherapy involves the use of other-than-verbal methods of communication—whether nonverbal communication or physical aids—to enable the physician to communicate with a patient who either has not yet developed or has lost expressive or receptive adult language skills.⁴ While that clearly applies to children, it can also apply to adults—and to many nursing home patients (a patient who becomes aphasic following a stroke, for example). The interactive psychotherapy code pays a little bit more than the other category, so some psychiatrists like to try to use it. And they should do so by all means if they believe it's appropriate. But it's a bit of a red flag when used outside a pediatric setting, so they should be ready to defend its use and have the documentation to back it up.

Probably the most important thing to keep in mind about ICD-9 coding is that it has to be consistent with your CPT coding.

The more frequently used category—“insight-oriented, behavior-modifying, and/or supportive psychotherapy”—refers to psychotherapy that makes use of development of insight, behavioral modification techniques, emotional support, and/or

cognitive discussion to effect therapeutic change.⁴

LTC Forum: You mentioned sites of service next. What are the possibilities there?

Dr. Stein: Again, there are two: office or other outpatient facility is one, and inpatient hospital, partial hospital, or residential care facility is the other.⁴ “Office or other outpatient facility” codes are used for care provided in a physician's office, community mental health center, emergency room, hospital outpatient clinic, observation program, domiciliary or rest home, custodial care setting, home care setting, or any structured outpatient program other than in a partial hospital.² These codes are often reimbursed at different rates.

LTC Forum: How about the issue of face-to-face time spent? Can time spent reading the patient's chart or consulting with the patient's nurse be included?

Dr. Stein: No; face-to-face time means time spent in direct contact with the patient—not the chart, and not the nursing home staff.² However, consulting with the nursing home staff and reviewing a patient's chart or laboratory results can be considered evaluation and management, or E & M, services. E & M services may also include reviewing or prescribing medications, carrying out elements of the mental status examination, or any of the other parts of the E & M services as defined in the CPT handbook. When services of this type are provided (and documented) in addition to psychotherapy, a “psychotherapy with E & M” service can be billed. There are some other codes for other types of psychotherapy and for psychiatric services or procedures that may be applicable to the nursing home setting, and others, such as electroconvulsive therapy, that are unlikely to be provided there (Table 2).⁴ One caveat here, though: Just because there's a code number for a service doesn't necessarily mean that Medicare will pay for it; some of these codes will not be reimbursed. If you're uncertain, check with your local carrier.

LTC Forum: Is there a way to obtain payment for a non-covered service?

Dr. Stein: Yes. You can obtain payment directly from the patient. You have to inform the patient ahead of time, in writing, that you are performing a non-covered service and that he or she will be expected to pay for it privately. The patient must sign a written consent each time a non-covered service is provided.

LTC Forum: What about if you're called in by another physician to consult and are not going to provide treatment yourself. Would that service be coded differently?

Dr. Stein: Yes. If you are not the primary care provider, then you may use the Consultation E & M codes—codes 99241 to 99263.⁴ The selection of the level of the service billed

Table 1

Summary of Current Procedural Terminology (CPT) Codes for Psychotherapy

Site of Service	Face-to-Face Time Spent	Psychotherapy Only*	Psychotherapy With Medical Evaluation or Management
Insight-Oriented, Behavior-Modifying, and/or Supportive Psychotherapy			
Office or other outpatient setting	20-30 min	90804	90805
	45-50 min	90806	90807
	75-80 min	90808	90809
Inpatient, partial hospital, or residential setting	20-30 min	90816	90817
	45-50 min	90818	90819
	75-80 min	90821	90822
Interactive Psychotherapy			
Office or other outpatient setting	20-30 min	90810	90811
	45-50 min	90812	90813
	75-80 min	90814	90815
Inpatient, partial hospital, or residential setting	20-30 min	90823	90824
	45-50 min	90826	90827
	75-80 min	90828	90829

*The psychotherapy-only codes for inpatient, partial hospital, or residential setting codes are restricted codes. Payment for these services is available, but Medicare carriers usually require the submission of a written report with the claim.

Source: American Medical Association. Current Procedural Terminology 2001, Standard Edition. Chicago, Ill: AMA; 2000.

Format adapted with permission from American Psychiatric Association. Manual of Nursing Home Practice for Psychiatrists. Washington, DC: APA; 2000.

is dependent on such things as the level of complexity of the patient's problem, the extensiveness of the history taking and examination performed during the consultation, the complexity of the decision-making and coordination of care required, and the site of service. Diagnostic services (such as an initial

consultation or initial evaluation, whether from the E & M (CPT 99241–99263) or a Psychiatric Diagnostic Evaluation (such as 90801), are reimbursed at 80% of the Medicare allowed amount. Most other psychiatric services for therapy are paid in the nursing home at 50% of the Medicare allowed rate. (In some areas, E & M services are paid at 80%, especially when a non-mental disorder diagnosis or the psychiatric medication management code 90862 is used.)

LTC Forum: That covers the coding for procedures. But what about coding for diagnosis? Is there anything important to keep in mind about ICD-9 coding?

Dr. Stein: ICD-9 coding is more straightforward and less complicated than CPT coding, because it is more familiar to psychiatrists, since it's similar to the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association). Probably the most important thing to keep in mind about ICD-9 coding is that it has to be consistent with your CPT coding. Payment for services may be denied if the diagnosis and the service do not match. For example, a claim for psychotherapy may be denied if the diagnosis submitted is acute delirium, as the intermediary may believe that patients with that diagnosis cannot benefit from psychotherapy. The diagnosis provides justification for the treatment and level of service provided.⁵ It's also important to remember to include the documentation for any existing comorbid conditions, because they, too, can help to justify a higher level of service.⁵

Psychiatrists should keep in mind that they may also select diagnoses that are not usually considered when they select a primary psychiatric diagnosis (that is, one that is not in the group of "Mental Disorders," ICD-9 #290 through 319). For example, they may choose to diagnose a patient as having Alzheimer's disease (331.0) or cognitive deficits associated with late effects of cerebrovascular disease (438.0) or other diagnoses from the ICD-9. This may be particularly relevant if they have provided an E & M service (from the 99241–99263 in the CPT) because Medicare carriers might not subject these to the 50% psychiatric reduction.

Dr. Elliott M. Stein has been in the private practice of adult and geriatric psychiatry for the past 25 years. In addition to serving as medical director of the Geriatric Psychiatry Inpatient Unit at Mount Sinai Medical Center in Miami, Florida, and as clinical associate professor at the University of Miami School of Medicine, Dr. Stein is a psychiatric consultant to a number of nursing homes and adult congregate living facilities in Dade County.

Table 2

Codes for Other Services or Procedures That May Apply to Psychiatric Consultation in the Nursing Home

Code	Service or Procedure
Other Psychotherapy	
90846	Family psychotherapy (without the patient present)
90847	Family psychotherapy/conjoint psychotherapy (with the patient present)
90853	Group psychotherapy (other than of a multiple-family group)
90857	Interactive group psychotherapy
Other Psychiatric Services or Procedures	
90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
90870	Electroconvulsive therapy (includes necessary monitoring)—single seizure
90871	Electroconvulsive therapy (includes necessary monitoring)—multiple seizures, per day
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist the patient
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other physicians, agencies, or insurance carriers
90899	Unlisted psychiatric service or procedure

Source: American Medical Association. *Current Procedural Terminology 2001, Standard Edition*. Chicago, Ill: AMA; 2000.

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1. Gupta S, Goldstein MZ. Psychiatric consultation to nursing homes. *Psychiatr Serv*. 1999;50:1547-1550.
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Coping With Claim Denials: What To Do When Medicare Says No

An Interview with Gary S. Moak, MD

Gary S. Moak, MD

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 University of Massachusetts Medical School
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Every year, millions of Medicare claims are rejected by local carriers. And as scrutiny has increased over the past several years, so has the number of rejections. What is a consulting psychiatrist to do when, despite his or her most conscientious efforts, a claim is denied? Is there any recourse? And is there any way to avoid the aggravation of having your claims denied in the first place? Dr. Gary S. Moak answered these questions and more in an interview with Long-term Care Forum.

LTC Forum: Many consultant psychiatrists perceive a disconnect between the acknowledged need for mental health consultation in nursing homes and Medicare's willingness to pay for such services. With a prevalence of psychiatric disorders in nursing homes of up to 94%,¹ psychiatric services are clearly necessary. But obtaining Medicare reimbursement has become increasingly difficult, and so many claims are denied. What's behind this situation?

Dr. Moak: The disconnect really had its beginnings with the promulgation of the nursing home reform provisions of the Omnibus Budget Reconciliation Act (OBRA) of 1987. The act came about as a culmination of three decades' worth of Congressional hearings about the poor conditions and quality of care in American nursing homes. Among the most serious inadequacies was the lack of availability of psychiatric treatment to nursing home residents, the vast majority of whom had, and continue to have, diagnosable psychiatric disorders, and the widespread and injudicious use of physical restraints and psychoactive medications by attending physicians and staff members who really were not familiar with geriatrics or geriatric psychiatry. The coming to light of this deplorable state of affairs led to the promulgation of policies regulating the use of physical and chemical restraints and requiring nursing homes to take steps to ensure the highest practical level of mental and emotional well-being for their residents. There was also finally some recognition that although nursing homes are designed as medical facilities, they are in fact medical-psychiatric facilities, and that if nursing homes were to comply with these new regulations, much more expertise, including outside consultation, was going to be needed. Nursing homes just weren't staffed, and still are not staffed, to provide psychiatric care. So OBRA 1989 expanded Medicare Part B coverage for mental health services in nursing homes to cover not only physicians, who were already covered, but also psychologists and social workers.

As a result of these forces, the volume of nursing home mental health service expanded drastically, and Medicare experienced a sudden and dramatic increase in claims for such services. This increase occurred in the context of the Clinton administration's launching of Operation Restore Trust, an effort on the part of the Department of Health and Human Services and the Department of Justice to safeguard the integrity of the Medicare program against healthcare fraud and abuse. In 1996, the Office of the Inspector General (OIG) reported that 32% of Medicare-funded psychiatric services in nursing facilities were medically unnecessary and another 16% were questionable.² Most problematic was the provision of services like psychological testing, individual psychotherapy, family therapy, and "gang" psychopharmacologic management. In an effort to address Medicare fraud and abuse throughout the healthcare system, the Balanced Budget Act of 1997 appropriated funds for additional FBI agents to investigate providers under Operation Restore Trust. Congress also enacted legislation that made it a federal crime to knowingly submit a fraudulent or inaccurate claim to Medicare or Medicaid. So in general, forces have combined to dramatically increase the index of suspicion about psychiatric consultation to nursing homes, which has led to a significant increase in the number of claim denials.

LTC Forum: What are the most common reasons that carriers deny claims?

Dr. Moak: Probably the single most common reason for claims denial for any service, whether it's psychiatric or surgical or medical, is submitting a claim that isn't "clean"—meaning that the claim isn't filled out properly. It can be something as simple as a typographical error, or a missing field, or a

missing universal provider identification number (UPIN) for the referring physician, or a missing facility code for the nursing home.

Another common trigger for claims denial is appearing to provide too many services or too much service. For example, billing for 40 weeks of once-weekly psychotherapy services for a patient with a diagnosis of Alzheimer's disease is going to raise suspicion.

Finally, claims will be denied when they trigger a carrier edit—that is, an incompatibility between the patient's diagnosis and the service provided or the place of service. For example, in New England, psychotherapy is not a covered service for patients with delirium, so if you submit a claim for service code 90817 or 90819 with a diagnosis code of 293.0, the claim will automatically be denied.

LTC Forum: When carriers want to deny a claim, what actions can they take?

Dr. Moak: In the case of a claim that is being denied because it's not "clean" or is being rejected because of an edit, they'll send you a letter indicating that there is information missing or that the service is not consistent with the diagnosis you've listed and they're therefore denying payment. Under those circumstances, you can simply correct your mistake and resubmit your claim, and they may pay you—assuming that what you're doing is legitimately correcting an error as opposed to changing the information to make it compatible with what the carrier wants; that is fraud. A carrier can also decide to suspend payment, in which case they'll send you a letter saying that they're not going to adjudicate the claim until they see some documentation.

Claims can also be denied in connection with a random audit. As part of Operation Restore Trust, the Health Care Financing Administration, now the Centers for Medicare and Medicaid Services (CMS), ordered all carriers to conduct monthly audits, on a specified day of the month, of a random sample of claims with a given procedure code. These audits require carriers to review clinical documentation to ascertain how well it meets documentation requirements prior to paying a claim. So your claim may be audited on a random basis, and if your documentation doesn't meet the standards for the service you've provided, the claim will be denied.

Finally, claims can be denied in connection with a retrospective review—what's known as a focused medical review, or FMR. An FMR is a detailed examination of a particular provider or group, based not on a single claim, but on a computer's identification of an aberrant pattern of billing or service provision—that is, a pattern that's different from what is typical among providers in your specialty in your geographic area. The aberrance can be related to volume of services

(for example, you're billing for 50 hours of work each week, when other consultant psychiatrists in your area are billing for only 20), or it can be related to excessive billing for a particular service, intensity of service (all services billed at the highest level of intensity, for example), or diagnosis (for example, listing every patient you see as having a diagnosis of Alzheimer's disease with depression).

Historically, this was a very intrusive, intimidating, and costly process; the auditors would come into your office and pore over your records for days, and it usually meant having to close down your practice for the duration. Either they could find that there was in fact no problem with your billing and just go

away, or, assuming they found no fraud but just erroneous billing, they could extrapolate back and estimate the amount of money Medicare might have overpaid you and then try to collect it from you. But the system has changed as of 2001.

LTC Forum: What does the change involve?

Dr. Moak: It involves an initiative called Progressive Corrective Action, or PCA,

and it's intended to make the system less punitive and more educational. That is, instead of being based on the assumption that every provider is out to defraud the Medicare system, PCA is based on an acknowledgment that the rules and regulations are complex and difficult to follow, and that providers are by and large trying to bill correctly but are making honest mistakes. If a carrier decides, for whatever reason, to audit your practice, they are now supposed to select a smaller sample of charts, called a probe, and if they detect a systematic problem that looks like an honest error, they are expected to educate you to help bring your billing practices into compliance. One of their mandates is that if they detect a pattern of under-coding, they're supposed to correct that as well, and there have actually been cases in which they've *up*-coded a claim and paid the provider *more* than he or she had billed.

LTC Forum: Even with this "kinder, gentler" policy, the best way to deal with audits and claims denials, of course, is to keep them from happening in the first place. Is there any way to do that?

Dr. Moak: Yes, there really is a way to take a prophylactic approach. The best thing to do is to carefully examine your service provision and billing practices for anything that is likely to appear aberrant to your carrier. Are you providing a service that's new to your area, for example, or addressing a special need, so that your volume will be different from that of your peers? If so, explain what you're doing ahead of time. It helps a lot to actually schedule a meeting with your carrier and visit them at their offices, or invite them to come to yours. When they meet you and get a feel for who you are and what

Probably the single most common reason for claims denial for any service, whether it's psychiatric or surgical or medical, is submitting a claim that isn't "clean"—meaning that the claim isn't filled out properly.

you're doing, and see that you're a professional, decent person who's just trying to provide a needed service, it can do a lot to reassure them and assuage their concerns. There are various people you can meet with, but the medical director or the director of provider relations is generally your best bet.

The other thing you can do is try to mix up your services. Don't use the same service and diagnostic codes every time, and don't always bill for the same level of service.

LTC Forum: What if, despite your best efforts, you face a claim denial anyway? What's the best approach?

Dr. Moak: The first step is to take an honest look at the claim to see whether the denial was valid—that is, your mistake. If your service was medically necessary and was well documented, but your claim contained errors, then you can correct your mistake and resubmit the claim. You don't want to procrastinate, though, because most carriers give you a limited window—usually 45 days—to resubmit. If your documentation doesn't meet the carrier's requirements, then it's best not to appeal. It's important to be familiar with the carrier's local medical review policies for the services you provide.

LTC Forum: If you disagree with the carrier's determination on your claim, what can you do?

Dr. Moak: You have three levels of recourse. The first level is a review. You must request a review within 6 months of the date of the Provider Remittance Advice (formerly called the Explanation of Medicare Benefits, or EOMB). You can do this in writing, usually with a specific form, or, in most cases, over the phone. With telephone reviews, the carrier may inform you of their decision immediately. There are some pieces of information you will need to provide regardless of the type of denial, and then there is specific information you may need to provide depending upon the type of denial (Table 1).³

The second level of recourse is a hearing. You must request a hearing in writing, but you have three choices for the hearing itself: It can take place in person, over the phone, or as an on-the-record decision (Table 2).³ Hearings are conducted by a hearing officer, who is an employee of the carrier, and a decision must be made within 120 days in the case of in-person or telephone hearings.

The highest level of recourse is a hearing with an administrative law judge, who is independent of the carrier. In order to get an administrative law judge hearing, you have to go through a regular hearing first, and you have to make a request in writing within 60 days of the post-hearing denial. In addition, the amount you're disputing has to be in excess of \$500.

Progressive Corrective Action is based on an acknowledgment that the rules and regulations are complex and difficult to follow, and that providers are by and large trying to bill correctly but are making honest mistakes.

Table 1

Information and Documentation to be Provided to Appeal the Most Common Kinds of Medicare Denials

Type of Denial	What to Provide
Any denial	<ul style="list-style-type: none"> • Patient's name and the date of service on each page of documentation submitted • Claim control number • Patient's health insurance claim number (HIC) • Date of service • Your provider identification number • Your current billing address • ICD-9 diagnosis • Procedure code used • Copies of progress notes, if requested
Concurrent care denials	<ul style="list-style-type: none"> • Narrative documentation to support that you and the other physician are in different specialties and treating different needs • Documentation, such as progress notes, to support the need for services
Overutilization denials	<ul style="list-style-type: none"> • Documentation to demonstrate why the patient required more than the standard number/amount of services during the specified time period
Services denied as not necessary	<ul style="list-style-type: none"> • Specific ICD-9 diagnosis code or narrative documentation explaining why the service provided was medically necessary based on the diagnosis code
Routine screening denials	<ul style="list-style-type: none"> • ICD-9 code or narrative describing the sign, symptom, complaint, or diagnosis necessitating the service

Source: Part B News. Part B Answer Book: Medicare Billing Rules from A to Z, 2001 Edition. Rockville, Md: Part B News Group; 2001.

Table 2

Choosing the Best Kind of Hearing

Type of Hearing	Description	Pros	Cons
In-person hearing	<ul style="list-style-type: none"> • Face-to-face meeting; you or a representative provides verbal testimony and/or written evidence 	<ul style="list-style-type: none"> • “Humanizes” the process • Allows you or your representative to respond to hearing officer’s questions immediately 	<ul style="list-style-type: none"> • Time consuming and inconvenient • May be unnecessary if you have strong documentation to support your position • May be disadvantageous for those who have difficulty articulating their position
Telephone hearing	<ul style="list-style-type: none"> • Verbal testimony is provided over the phone; supporting documentation can be sent to the hearing officer ahead of time, and information in his/her file must be sent to you in advance 	<ul style="list-style-type: none"> • Preferred by CMS • More convenient and less time consuming • Less expensive 	<ul style="list-style-type: none"> • Loss of “human touch” • Difficult to evaluate impact of your testimony • May be disadvantageous for those who have difficulty articulating their position
On-the-record decisions	<ul style="list-style-type: none"> • Decision is made based on past record of the case, along with any new evidence you present; no verbal testimony is given 	<ul style="list-style-type: none"> • Can be held more quickly than either in-person or telephone hearing • Generally provides much more rapid decision • Less expensive and less time consuming • Preferred by CMS 	<ul style="list-style-type: none"> • May be more difficult to prevail without opportunity to present verbal testimony • No opportunity to answer questions or clarify misunderstandings

Source: Part B News. *Part B Answer Book: Medicare Billing Rules from A to Z*, 2001 Edition. Rockville, Md: Part B News Group; 2001.

LTC Forum: Is the whole thing as onerous as it sounds?

Dr. Moak: The truth is that Medicare is really much easier to deal with than managed care, which requires preauthorizations, certifications, concurrent reviews, and the submission of written treatment plans. And becoming familiar with the carrier’s expectations and getting the process straight up front can prevent a lot of the hassle of denials. But maybe most important is that Medicare appears to be making a genuine effort to be more fair; the PCA approach is evidence of that. The pendulum had swung pretty far in one direction, but it’s beginning to swing back a bit, in favor of the provider and in favor of good patient care.

Dr. Gary S. Moak is in the private practice of geriatric psychiatry in Westboro, Massachusetts, and is an owner of Custom Medical Billing, Inc., a medical billing company specializing in healthcare billing and practice management consultation. In addition, he is a member of the Board of Directors of the American Association for Geriatric Psychiatry and sits on the Medicare Carrier Advisory Committee for northern New England, representing the Massachusetts Psychiatric Society. Dr. Moak lectures frequently on issues related to geriatric psychiatry, nursing home practice and regulatory compliance, geriatric psychiatry practice management, and fraud and abuse prevention.

References

1. Gupta S, Goldstein MZ. Psychiatric consultation to nursing homes. *Psychiatr Serv.* 1999;50:1547-1550.
2. Department of Health and Human Services Office of Inspector General. Mental Health Services in Nursing Facilities. May 1996, OEI-02-91-00860.
3. Part B News. *Part B Answer Book: Medicare Billing Rules from A to Z*, 2001 Edition. Rockville, Md: Part B News Group; 2001.

CME Self-Assessment Test

Reimbursement Realities: The Business End of Psychiatric Consultation in Nursing Homes

On the answer form (page 15), please circle the letter that corresponds to the single most appropriate answer for each of the following questions. A passing grade of 70% is required to receive credit. The deadline to receive credit is one calendar year from date of publication.

1. Which of the following functions does the medical record serve?
 - a. It is a method of interdisciplinary communication
 - b. It helps to ensure adequate, fair reimbursement
 - c. It serves as a medicolegal document
 - d. All of the above
2. Where in the progress notes should the patient's name appear?
 - a. At the top of the first page
 - b. At the end of the last paragraph
 - c. On every page
 - a. None of the above
3. In order to be acceptable to Medicare, all supporting documentation must be provided in narrative form; use of checklists is prohibited.
 - a. True
 - b. False
4. How is "interactive psychotherapy" defined by Medicare?
 - a. Interactive psychotherapy is psychotherapy that aims to assist the patient in developing insight.
 - b. Interactive psychotherapy is psychotherapy that aims to increase the patient's level of functioning.
 - c. Interactive psychotherapy is psychotherapy involving other-than-verbal methods of communication.
 - d. Interactive psychotherapy is group psychotherapy.
5. The fact that a CPT code exists for a given service means that Medicare covers that service.
 - a. True
 - b. False
6. Which of the following can *not* be taken into account when calculating face-to-face time for coding purposes?
 - a. Time spent conferring with the charge nurse regarding the patient's care
 - b. Time spent reviewing the chart for an update on the patient's case
 - c. Time spent conferring with the nursing home administrator regarding the patient's status
 - d. All of the above
7. How many psychotherapy codes are listed in the CPT coding manual?
 - a. 12
 - b. 24
 - c. 36
 - d. 52
8. What federal act mandated the provision of mental health care to patients in the nation's nursing homes?
 - a. The Federal Nursing Homes Act of 1989
 - b. The Omnibus Budget Reconciliation Act of 1987
 - c. The Omnibus Budget Reconciliation Act of 1989
 - d. The Long-term Care Act of 1987
9. The procedure instituted by Medicare in 2001 as a means of making the provider review process less punitive and disruptive is referred to as:
 - a. Educationally Focused Review Process
 - b. Technical Assistance Review Procedure
 - c. Progressive Corrective Action
 - d. Limited Focus Review
10. In order to qualify for a hearing with an administrative law judge to contest a claim denial, the amount in dispute must be in excess of what amount?
 - a. \$250
 - b. \$500
 - c. \$1000
 - d. \$1500

Personal Information

PERSONAL INFORMATION

I certify that I have completed this educational activity and post-test.

Expiration date: August 2003

Name _____ Degree _____

Address _____

City _____ State _____ Zip _____

Phone Number _____ Specialty _____

ACTIVITY EVALUATION

Have the activity's educational objectives been met?

List the elements that Medicare carriers require for inclusion in the patient's medical record Yes No

Appraise and critique medical documentation for its suitability for interdisciplinary communication, reimbursement, and medicolegal protection Yes No

Choose the appropriate code for various psychiatric services Yes No

Identify documentation and coding practices that are most likely to lead to the denial of a claim Yes No

Discuss ways of preventing claim denials Yes No

Did you find this activity to be fair, balanced, and free of commercial bias? Yes No

Comments: _____

Relevance to your practice:

Very relevant 4 3 2 1 Irrelevant

Amount of knowledge gained:

Great 4 3 2 1 None

Level of material presented:

Too advanced 4 3 2 1 Too simple

Overall evaluation of activity:

Excellent 4 3 2 1 Poor

Hour(s) spent reading this issue (circle one): 1.0 1.25 1.5

Would you recommend this publication to a colleague?

Yes No

Ideas for future publications and/or your comments:

Reimbursement Realities: The Business End of Psychiatric Consultation in Nursing Homes

CME SELF-ASSESSMENT TEST

ANSWER FORM

Please circle the letter that corresponds to the single most appropriate answer and fax the Personal Information and CME Self-Assessment Test Answer Form 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 Ave., Suite 1050
Bethesda, MD 20814

Expiration date: August 2003

1. a b c d
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9. a b c d
10. a b c d

Review Checklist

Documentation Policies, Procedures, and Standards

- Are your medical records maintained in a manner that satisfies these requirements?
 - Timely
 - Uniform
 - Consistent
 - Legible

- Do all entries include the following items?
 - Date
 - Patient's name
 - Provider's name
 - Chief complaint
 - Clinical findings
 - Diagnosis or clinical impression
 - Tests ordered
 - Medications prescribed
 - Procedures performed
 - Instructions given to the patient

- Are all notes signed?
- Are consultations and advice documented accurately and consistently?
- Do entries clearly document the need for the level of service being billed?
- Does the diagnosis clearly support the need for the services being provided?
- Does the documentation support the billing codes being used?

Based on an AMA recommended list.

• American Medical Association. *Current Procedural Terminology 2001*, Standard Edition. Chicago, Ill: AMA; 2000.