Report on
Medicare Compliance

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Weekly News and Analysis on New Enforcement Initiatives and Billing/Documentation Strategies

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New Mental Health Codes Invite Claim Denials, but Open Door to More Revenue

In two months, billing for mental health services will be a whole new ballgame. The American Medical Association has revamped longstanding CPT codes for psychotherapy and introduced the use of evaluation and management levels of service for medication management. Unless providers adapt, they risk claims denials and future audits, and may sacrifice revenue from new codes for patients in crisis and for "interactive complexity," which can't quite be captured under the current system.

The annual update to the CPT code book, which takes effect Jan. 1, affects the way that psychiatrists, psychologists and social workers report their services, says Stephen Gillis, director of billing compliance for Massachusetts General Hospital in Boston. "The CPT changes are really significant," he says. "If you ignore them or don't implement them well, you'll get claims denied."

In the change with the greatest compliance implications, the CPT 2013 code book dumps 90862 for medication management in favor of evaluation and management levels of service. That means psychiatrists (and nurse practitioners) will have to get up to speed on Medicare documentation guidelines, which govern their selection, Gillis says. "This is foreign to them but they have no way around it," he says. "They will have to document more than they document now to get approximately the same reimbursement."

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OIG Noses Around Hospital Purchases of Spinal Implants from MD-Owned Entities

Hospitals are now being questioned by the HHS Office of Inspector General about their use of physician-owned distributorships (PODs) that supply spinal implants. In letters to some hospitals, OIG is asking hospitals about their purchasing decisions for spinal implants and the ownership of companies that sold spinal devices that were implanted in their patients.

PODs sell medical devices to hospitals, where they are often implanted by the surgeons who own the PODs. These relationships have come under fire from the Senate Finance Committee's minority staff, led by Orrin Hatch (R-Utah), and Democratic chairman Max Baucus (D-Mont.), who are concerned that PODs may be used by hospitals to reward surgeons for referrals, invite overutilization and possibly lead to medically unnecessary procedures. In June 2011, the lawmakers asked OIG to investigate PODs and recommend strategies for regulating them *(RMC 6/20/11, p. 1)*.

More than a year later, letters are showing up at hospitals. They are signed by the regional inspector general for evaluations and inspections, which means OIG is not conducting hospital-specific audits in search of overpayments. Instead, OIG wants to know how many hospitals buy implantable spinal devices from physician-owned

entities "and what hospitals may derive from these distribution models," according to a copy of the letters obtained by *RMC*.

Hospitals were selected for OIG's "data collection effort" because they billed Medicare for one or more spinal surgeries. The letter includes a questionnaire and invoice review, which hospitals should submit to OIG along with "supporting documents that show the quantity and acquisition process of the spinal devices implanted during the sampled surgery." OIG says the hospital's director of surgery or procurement manager should handle this paperwork. Here are a few of the OIG questions included in the letter:

◆ "To what extent did the following factors influence the hospital's decision to purchase implantable spinal devices from physician-owned entities: cost savings on devices; quality of devices; clinical effectiveness; preference of surgeons; additional services…. Have any other factors influenced this hospital's decision to purchase implantable spinal devices from physician-owned entities?"

◆ How often does the hospital get other services — inventory management, operating room technical support and coding assistance — from the physician-owned entities that it buys implantable spinal devices from?

◆ "Does this hospital have a policy in place that requires physicians to disclose to the hospital whether they have an ownership stake in medical device companies, such as manufacturers or distributors?...Does this hospital have a policy that requires surgeons to disclose to patients whether they have an ownership stake in medical device companies, manufacturers or distributors?"

◆ Regarding an actual claim referred to in the letter, OIG asked: "Did the hospital purchase any of the spinal devices implanted during this surgery from entities in which physician(s) practicing in the hospital have an ownership stake?" The same question was asked about physician(s) who do not practice in this hospital having an ownership stake.

Hospital Policies on PODs Vary

Some hospitals have adopted policies against doing business with PODs, while others are open to PODs but place limits on them. Margaret Hambleton, senior vice president of ministry integrity for St. Joseph Health in Orange, Calif., says her organization doesn't generally permit purchases of POD devices for use by physicians with an ownership stake. But if the POD is a side business for referring physicians and they are not the implanting surgeon, the POD will face at least the same scrutiny as other vendors. "We have a fairly rigorous process in our supply chain for all new products," she says.

When considering a new product, St. Joseph's starts with an evaluation by "a team of stakeholders," which would look at effectiveness and efficiency, she says. If the product were an implant, the team would include surgeons, pharmacists and nurses. They discuss the product and look at the literature. "If someone makes a request to buy an item, it goes through a quality assessment and then a cost assessment," Hambleton says. "Is it equal cost? Better quality?" Then St. Joseph does a company search for potential conflicts. For example, are physician-owned entities, such as PODs, also referral sources? If the answer is "yes," the relationship will be subject to a thorough compliance, legal and purchasing review.

Hambleton says the hospital is reluctant to buy a product from a physician-owned entity when the physician is the sole user of the product. "Because we go through such rigorous front-end quality review, even when we have PODs, and we don't have many, we can clearly justify them from a cost and quality perspective — whether it's the best product on the market. That's what we base purchasing decisions on," she says.

This is all front-end stuff. Saint Joseph also does back-end compliance reviews to identify the extent to which products are purchased outside the supply chain

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process. Those products are subject to audits. "You don't want to bring products in exclusively to benefit a physician's company outside their practice," Hambleton says. "There are some niche products that only exist through a POD, but it's rare."

Although questions have been raised about using PODs to keep physicians happy, which could violate the anti-kickback law, Hambleton sees the focus on PODs and physician relationships with device and pharmaceutical manufacturers in general as a reflection of the emphasis on transparency to protect the sanctity of medical decision making. "This speaks more to quality of care and the medical necessity of the care delivered to patients. We want to make sure the medications and devices we buy are those that best benefit our patients and are appropriate in terms of how they are used and how much we spend on them," she says.

Contact Hambleton at Margaret.hambleton@stjoe.org. ✧

ICD-10 Need Not Be Apocalyptic; Half of New Codes Are Orthopedic

It's probably not a good idea to sell physicians on ICD-10 by talking about the potential it has to improve quality of care and patient outcomes. But there's a way to defang ICD-10 for doctors now that implementation is less than a year away.

"The reality is, it's not that bad," James Taylor, M.D., said at an Oct. 10 webinar sponsored by the American Academy of Professional Coders (AAPC). "There's all the vendor hype about the mystique of ICD-10's complexity" because vendors want to be hired to demystify it, said Taylor, former chairman of the board of Colorado Permanente Medical Group and director of its revenue cycle for Medicare. "But don't tell [physicians] it will save lives and don't try to talk them into liking it. It's coding and it's not in our DNA to like coding."

Instead, break ICD-10 down so physicians can see that in most specialties, it won't be doomsday. "It's not that hard. Half of the codes are related to the musculoskeletal system and are primarily for injuries. If you are a medical specialist not dealing with bones, you don't have to deal with them," said Taylor, who was expressing his own opinions and not necessarily AAPC's.

CMS extended the ICD-10 deadline to Oct. 1, 2014 *(RMC 4/16/12, p. 4).* That's when hospitals and physicians in the U.S. will have to join their counterparts in England, Canada, Germany, Australia and elsewhere, almost all of which moved from ICD-9 to ICD-10 at least a decade ago. While some countries contemplate ICD-11, many providers in the United States are in a panic over ICD-10. *One reason:* ICD-9 has 13,000 diagnosis codes and 3,000 procedure codes and ICD-10-CM has 68,000 diagnosis codes and ICD-10-PCS has 87,000 inpatient procedure codes. With three to seven alphanumeric characters, ICD-10 codes are far more descriptive and require more detailed documentation

It won't rally the troops around ICD-10 to talk about improving health care quality and patient outcomes because there are no studies to support this, Taylor said. "The specificity that it brings isn't really going to help us manage and treat disease," he noted.

Instead, train physicians based on the impact ICD-10 will have on their specialty. Taylor breaks down specialties into high, medium and low impact in terms of how much ICD-10 will shake up the way physicians code their charts and their documentation:

◆ ***High Impact:*** Orthopedists are the most affected physicians because 34,250 of ICD-10-CM procedural codes are related to the musculoskeletal system, Taylor says. A quarter of them relate to fractures. That may seem overwhelming, "but you only have to know three or four things," Taylor says, referring to orthopedic coding:

(1) Is it an initial or subsequent patient encounter;

(2) Is the fracture open or closed; and

(3) Is it healing, delayed, malunion or nonunion.

Also, 62% of the ICD-10 fracture codes distinguish the right from left sides (e.g., right or left femur). "You apply them over and over to every single fracture you do," Taylor says. "It's not as complex as it seems."

ICD-10 has significant changes for OB/GYNs as well. For example, pregnancy codes are categorized by both weeks and trimesters. First physicians will code the pregnancy in terms of weeks, and then they code for the presence of gestational diabetes according to the trimester when it was diagnosed. There is also a new intricacy in coding for mental health. He welcomes this because ICD-9 lacks specificity. For example, physicians could code sexual abuse but the ICD-9 code doesn't indicate whether the patient was the abuser or victim.

◆ ***Medium Impact:*** Family physicians, internists and surgeons will have to deal with some of ICD-10's complexities, since they treat some traumas (e.g., fractures), pregnant women and psychiatric problems.

◆ ***Low Impact:*** Some physicians will see few changes. For example, cardiologists and nephrologists mainly have to integrate ICD-10's demands for specificity in right versus left. For example, when coding nephritis, physicians have to specify left kidney or right kidney or bilateral (both), Taylor says. It shouldn't be a big deal; "cardiologists say right and left ventricle already. The only new thing to them is right or left lung and they know that. It's not a new concept," he said.

continued

Another reason the sky won't fall with ICD-10 is that most terms are mappable in paper records or electronic health record (EHR) systems. Physicians will check off hypertension in the EHR and in most cases the ICD-9 code will map automatically to the ICD-10 code, Taylor said. "It's a one-to-one correlation," he noted.

Cardiologists, for example, may never notice when ICD-10 goes live because the transition from ICD-9 is so easy. Terms match in ICD-9 and ICD-10 — pulmonary edema is still pulmonary edema and congestive heart failure is still congestive heart failure — with an automatic switch in codes. Or cardiologists just have to indicate laterality (right or left side), and for that "we just changed the codes behind the scenes in the billing system for the display names to be compliant," Taylor said. "So on Oct. 1 they won't notice a difference because the description they see in the EMR for that disease went unchanged."

Things get tricky, however, when there are five ICD-10 codes for one ICD-9 code, for example, which stems from ICD-10's greater specificity. "It requires clinical decision making. The machine can't do it," he said. "The one to one is an IT fix on the back end but the one to many is a clinical decision on the front end." At Kaiser Colorado, physicians will get several diagnoses to choose from on a drop-down chart. "You have to choose the new term in an ICD-10 environment, but it is not the disaster that vendors are making it out to be," Taylor said.

ICD-10 is not unlike the annual CPT coding changes in terms of new thinking and deletions and additions — it's just on a larger scale, Taylor said. And, like CPT, "you do it or lose."

Contact Taylor at James.M.Taylor@kp.org. Visit AAPC at www.aapc.com. ✧

OIG Work Plan Is Call for Oversight Of EHRs, Provider-Based Entities

OIG is coming at provider-based entities from another angle, for the third time in four years. The 2013 Work Plan says that OIG will determine whether provider-based entities meet CMS billing requirements and their financial impact on Medicare.

"I wouldn't wait for the results of this study to get a sense of whether your institution is in compliance," Lew Morris, former chief counsel to the Inspector General, said at an Oct. 22 webinar on hospital targets of the Work Plan sponsored by the Health Care Compliance Association. "OIG has been focusing on this area for years." Provider-based status was on the Work Plan in 2009 through 2011, with OIG scrutinizing whether hospitals improperly claimed the designation, which generates higher Medicare payments for services just by virtue of the location where they are performed.

The Medicare Payment Advisory Commission has been dogging this issue as well, because of its financial incentives. The number of Medicare physician visits in provider-based entities grew 40% from 2004 to 2010. With the potential to cost Medicare an additional $10 billion over the next decade, MedPAC has suggested reducing outpatient Medicare E/M payments to the physician practice rates under the Medicare physician fee schedule, says Margaret Hambleton, senior vice president of ministry integrity for St. Joseph Health in Orange, Calif.

Provider-Based Entities Must Be Integrated

When hospitals turn physician practices into provider-based entities, they agree to abide by certain regulatory requirements (see 42 CFR 413.65). If they drop the ball, they put reimbursement at risk. Hambleton suggested that hospitals conduct an inventory of their on- and off-campus entities to evaluate their compliance with requirements for provider-based status. Provider-based entities must be clinically and financially integrated with the hospital and have the same license if consistent with state licensure rules, and physicians should have hospital privileges and face the same quality oversight, Hambleton said. The provider-based entity must share the hospital's governance structure (e.g., medical director) and cost reports. It should be crystal clear to patients that the entity belongs to the hospital, and if they are covered by Medicare, patients should be treated the same as other hospital outpatients for billing purposes (e.g., billed a facility fee), she said. The hospital should do billing reviews of the provider-based entities "so your billing is corrected for place-of-service codes." When medical records are released by the hospital, they should encompass services provided at the provider-based entity. Physician supervision and three-day DRG window requirements must be satisfied.

Provider-based entities are one of the hot spots on the OIG Work Plan, which was unveiled Oct. 2 *(RMC 10/15/12, p. 4).* Another is Medicare incentive payments to hospitals and physicians for adopting electronic health records (EHR) and CMS safeguards to prevent incorrect incentive payments. "Of all the stuff in this Work Plan, this may be the one thing the compliance team wants to move to the front of the list," said Morris, now with Adelman, Sheff & Smith in Annapolis, Md. EHRs are under scrutiny now, with the Sept. 24 letter that Attorney General Eric Holder and HHS Secretary Kathleen Sebelius sent to five hospital associations warning against the dangers of EHR documentation shortcuts. "Law enforcement will take appropriate steps to pursue health care providers who misuse electronic health records to bill for services never provided," according to the letter, which notes that HHS, the Department of Justice and other law

enforcement agencies are keeping an eye on this trend and will take action if necessary.

Another Work Plan priority is place-of-service (POS) coding, which is also a target of at least one recovery audit contractor (RAC), Connolly Healthcare, said Nina Tarnuzzer, assistant dean for physician billing compliance at the University of Florida College of Medicine in Gainesville, at HCCA's Oct. 24 webinar on physician items of the Work Plan. It's an easy RAC target, she says, because RACs can find errors through data analysis without conducting medical-record reviews. OIG's Work Plan, however, is focused on physician coding on Part B claims for services provided in hospital outpatient departments and ambulatory surgery centers to determine whether they reflect the correct place of service. POS codes affect payment rates, and CMS and OIG lately have been all over this topic *(RMC 12/5/11, p. 1).* Medicare pays physicians more when they perform services in their practices than in hospitals, linking this risk area back to provider-based compliance.

Contact Morris at lmorris@hospitallaw.com and Hambleton at Margaret.hambleton@stjoe.org. View the work plan at http://go.usa.gov/Y2Cx. ✧

RACs Hit Services Related to E/M Coding, Unnecessary Admissions

It looks like recovery audit contractors (RACs) are starting to question services stemming from hospital stays that may not have been medically necessary.

"RACs are now going after home health stays because the hospital stay was not medically necessary," said Lori Brocato, product manager for HealthPort Technologies in Alpharetta, Ga. "It's the first time they have made this connection." Connolly, the RAC for Region C, is reviewing the medical necessity of home health services and the conditions to qualify for them in 16 states and the Virgin Islands. "The only way they can do that is to see what hospital records say," Brocato said at a recent webinar sponsored by RACMonitor.com.

That's one new twist with RACs, which are also now auditing evaluation and management coding. Connolly has seven separate reviews on its approved list of audits. Two are outpatient hospital reviews:

(1) E/M services billed on the same day as an endoscopy or minor procedure without appropriate modifiers, and

(2) E/M services billed during global surgery periods although the global surgery fee includes payment for E/M services.

Five other RAC reviews are aimed at physicians, including a modifier -25 review, a big risk area *(RMC 10/1/12, p. 1).* Connolly will identify overpayments associated with E/M services (99211-99215) billed with modifier-25 on the same day as a pulmonary diagnostic procedure (94010-94799).

Brocato also cautions hospitals to pay attention to the way RACs are communicating when they conduct semi-automated reviews, which are a hybrid of automated and complex reviews *(RMC 4/11/11, p. 1).* Because denials are based solely on data analysis, money is recouped automatically unless providers submit medical records to rebut the overpayment determination. "Pay attention to the letter you get from the RAC," Brocato says. "It may say 'informational request' in the header."

Here are Brocato's eight tips to better manage what she calls the "audit tornado," because "sometimes you get hit hard" and "sometimes you barely feel the wind. You can't stop them but hopefully [you] minimize risk and protect yourself."

(1) Educate key stakeholders: They include CFOs, CEOs, chief medical officers, physicians, case management, health information management and the revenue cycle manager, Brocato says. Explain why RACs have been so successful and why everyone is following the RACs' lead.

(2) Identify the RAC team. It should include HIM, compliance, finance, case management, billing, coding compliance, IT and others. Discuss CMS-approved areas on the RAC hit list and new developments, such as CMS's Aug. 27 implementation of RAC prepayment audits *(RMC 8/13/12, p. 3).* Update the outcomes of audits, including repayments per quarter, what lessons were learned and what policies were implemented to prevent future denials.

(3) Track audits: If technology is involved, "use something user friendly and intuitive that can address any type of audit," she says. It should include email and system alerts that flag when something is due (e.g., medical record requests, appeals). The technology also should be able to store and track relevant data, such as billing and coding data and claims and remittance information.

(4) Manage audit requests: "This is the most important part of the process," she says. Hospitals will lose reimbursement to technical denials if they don't meet deadlines for RAC documentation requests. For example, with complex reviews, RACs give providers

45 days to submit medical records (plus five days for the mail to arrive). "It could take longer than 45 days to pull everything together," especially if records are in off-site storage, she says. Medicaid reviews have an even shorter turnaround time, she says. RACs often give you a 15-day extension, but it's important to have a "seamless process" for gathering and reviewing medical records and tracking and confirming their delivery to auditors, she says.

(5) Decision/demand letter management: Access letters at two levels: overall types of denials and patient-specific denials, she says. "For audit tracking, you want to look at the overall types of denials so you can see what areas you may need to strengthen. But the revenue cycle department cares about the denial reason so they can bill the patient," she said.

(6) Appeals management: Use e-alerts to keep everyone on top of deadlines for filing appeals and ensure RAC team members are on top of outcomes.

(7) Real-time financial management: Use dashboards to report to senior management and the board on big-picture RAC status. What audits are pending and how many dollars are associated with them? What is the hospital's win-loss ratio with appeals and how much money do they represent? Brocato recommends the use of a pie chart to explain them. Given the ratio, determine whether appeals are worthwhile if the hospital consistently loses.

CMS Transmittals and *Federal Register* Regulations

Oct. 19 — Oct. 25

Transmittals

Link to transmittals at www.cms.gov/Transmittals/2012Trans/list.asp. ((R) indicates a replacement transmittal.)

Pub. 100-06, Medicare Financial Management Manual

- Medicare Financial Management Manual, Chapter 7, Internal Control Requirements, Trans. 214, CR 8040 (Oct. 19; eff. Oct. 1; impl. Nov. 20, 2012)

Pub. 100-08, Medicare Program Integrity Manual

- General Update to Chapter 15 of the Program Integrity Manual - Part IX, Trans. 435, CR 8019 (Oct. 19; eff./impl. Nov. 20, 2012)

Federal Register Regulations

Link to the rules at www.federalregister.gov/articles/current; in the menu on the right, find the date of publication and Centers for Medicare and Medicaid Services.

Final Rule

- Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 2; Corrections, 77 Fed. Reg. 64755 (Oct. 23, 2012)

Live links to the above documents are included on *RMC*'s subscriber-only web page at www.AISHealth.com. Please click on "CMS Transmittals and Regulations" in the right column.

(8) Preventing future denials: Verify the content and readability of the medical records before you submit them to auditors. Ensure that writing is legible, images aren't too blurry and everything requested is included. Also, coders may be able to rank the likelihood of denial, Brocato says, which is useful for planning and remediation purposes. And it's much better to fix documentation issues before claims go out the door than squander time or money in discussion periods or appeals.

Contact Brocato through Hadiya Reynolds at Hadiya.Reynolds@HealthPort.com. ✧

Mental Health Codes Change Jan. 1

continued from p. 1

Hospital facility fees are affected as well. Outpatient psychiatry departments have been billing the technical portion of medication management using the 90862 code, Gillis says. In January, however, they will assign an E/M level of service for hospital resource use for psychiatric patients, consistent with the way hospitals bill Medicare for other types of outpatients treated in clinics and emergency rooms under the outpatient prospective payment system. This includes administrative and other services that are separately payable (e.g., lab work) and fall outside the APC *(RMC 9/17/12, p. 1).*

"The majority of ongoing visits between psychiatrists and patients are billed with 90862, so when it's your bread-and-butter code and you are asked to change that code and use E/M leveling, that's what's scaring everyone," Gillis says. "It has a major revenue and compliance impact because getting paid accurately and documenting what you do to get paid accurately will be hugely challenging." And E/M leveling may push psychiatry into the path of auditors, who are pounding away at E/M codes, even though selecting a level of service is more art than science.

Psychiatrists and nurse practitioners must document the exam, history and medical decision making of every patient encounter before assigning a level of service — 99201 to 99205 for new patients and 99211 to 99215 for established patients. "A lot of education will be needed to make sure psychiatrists understand how to select E/M levels using the 1995 or 1997 Medicare documentation guidelines," Gillis says. They spell out the required elements of documentation, including the review of systems, past family and social history, history of present illness, and medical decision making, as well as billing based on time spent counseling and coordinating care (see box, p. 7).

The AMA also overhauled codes for diagnostic evaluations and psychotherapy. The long-time code for

diagnostic evaluation, 90801, will be out the window. In its place will be two new codes:

◆ 90791 (for diagnostic evaluations performed by Ph.D. psychologists and licensed clinical social workers, without medical services), and

◆ 90792 (for diagnostic evaluations performed by psychiatrists).

Individual psychotherapy codes used by psychologists and social workers were changed to better capture the amount of time they see patients. Say goodbye to CPT 90804 (20 to 30 minutes) and 90806 (45 to 50 minutes). In January, there will be new codes for face-to-face individual psychotherapy, Gillis says, and therapists are allowed to round up and count time spent with family members:

◆ 90832 (30 minutes, with at least 16 minutes spent face-to-face with the patient and/or family member),

◆ 90834 (45 minutes, with at least 38 minutes spent face-to-face with the patient and/or family member), and

◆ 90836 (60 minutes, with at least 53 minutes spent face-to-face with the patient and/or family member).

CPT 2013 also changed the rules of the game for psychiatrists who do therapy, eliminating 90805 (20 to 30 minutes with medical management) and 90807 (45 to 50 minutes with medical management). Instead, psychiatrists will bill for medication management and individual psychotherapy using an E/M code plus one of the following codes:

◆ 90833 (individual psychotherapy, 30 minutes plus medication management E/M),

continued

What's Old Is New: 1997 Medicare Documentation Guidelines

Come January, psychiatrists will have to join their physician colleagues in using evaluation and management levels of service to report certain services. The 2013 CPT code book deletes the code for medication management and requires psychiatrists to switch to E/M levels of service, which may open a can of compliance worms. The new CPT code book makes other significant changes to coding for mental health services. The revenue impact of the revisions won't be clear until CMS announces payment rates in the 2013 outpatient prospective payment system regulation and Medicare physician fee schedule, says Steve Gillis, director of billing compliance for Massachusetts General Hospital in Boston. They are due out shortly. Contact him at sjgillis@partners.org.

1997 Single Organ Psych Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Musculoskeletal	• Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements • Examination of gait and station
Psychiatric	• Description of speech including: rate; volume; articulation; coherence; and spontaneity with notation of abnormalities (eg, perseveration, paucity of language) • Description of thought processes including: rate of thoughts; content of thoughts (eg, logical vs. illogical, tangential); abstract reasoning; and computation • Description of associations (eg, loose, tangential, circumstantial, intact) • Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions • Description of the patient's judgment (eg, concerning everyday activities and social situations) and insight (eg, concerning psychiatric condition) Complete mental status examination including: • Orientation to time, place and person • Recent and remote memory • Attention span and concentration • Language (eg, naming objects, repeating phrases) • Fund of knowledge (eg, awareness of current events, past history, vocabulary) • Mood and affect (eg, depression, anxiety, agitation, hypomania, lability

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	One to five elements identified by a bullet. (Codes: 99201, 99212, 99231, 99241, 99251)
Expanded Problem Focus	At least six elements identified by a bullet. (Codes: 99202, 99213, 99232, 99242, 99252)
Detailed	At least nine elements identified by a bullet. (Codes: 99203, 99214, 99221, 99233, 99243, 99253)
Comprehensive	Perform all elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border. (Codes: 99204, 99205, 99215, 99222, 99223, 99244, 99245, 99254, 99255)

◆ 90835 (individual psychotherapy, 45 minutes plus medication management E/M), and

◆ 90837 (individual psychotherapy, 60 minutes plus medication management E/M).

The rounding rules apply here as well.

The new year will bring payments for services that are tricky to bill for now, Gillis says. The CPT 2013 code book created two new codes for individual psychotherapy provided to patients in crisis: 90839 (60 minutes) and 90840 (each additional 30 minutes with medication management). "This is an opportunity," Gillis says. "There was no code before." Patients could be in a life-threatening situation and go to the emergency room, which would summon their psychiatrist or psychologist, who may stay with them for two hours. But the only billing option now is a diagnostic evaluation, which has a time limit. Gillis cautions therapists not to alternate codes to bill for crises, sometimes using a diagnostic evaluation code or an E/M and sometimes using a crisis code. "From a compliance perspective, you don't want them going back and forth based on what is financially favorable," he says.

There is also a newly created code for interactive complexity (90785). This add-on code will allow mental health professionals to get a bonus for patients who demand more resources. For example, when an interpreter must be used during therapy or "caregiver emotions or behavior interfere with the caregiver's ability" to implement the patient's treatment plan, the psychologist may bill for both psychotherapy and interactive complexity, Gillis says.

Mass General is taking several steps to minimize billing errors when the CPT mental health code revisions go live, Gillis says. For example, the compliance office created an online training program for the Department of Psychiatry and is giving briefings to mental health professionals in meetings. Mass General also will update encounter forms as well as electronic medical record screens and templates. Hospitals also have to update their chargemaster to ensure that charges entered by clinicians in their departments sync up to the right descriptors.

Contact Gillis at sjgillis@partners.org. ✧

NEWS BRIEFS

◆ **New England Sinai Hospital in Stoughton, Mass., agreed to pay $1.149 million to settle allegations that it violated the civil monetary penalties law arising from Stark and kickback violations,** according to its settlement with the HHS Office of Inspector General. The hospital, which declined to comment through its attorney, self-disclosed to OIG and entered its Self-Disclosure Protocol. According to the OIG website and the settlement, between 2006 and November or December 2011, the hospital "paid remuneration to two physicians in the form of: (1) free, or less than fair market value, space and staff"; (2) payment for services not performed, or payment for services performed under expired medical director agreements or expired personal services agreements; and (3) payment for services performed without a written agreement. The hospital did not admit liability in the settlement.

◆ **The latest Medicare compliance review by OIG found that University of Alabama at Birmingham Hospital made errors on 38 of 177 claims audited (A-04-11-00080),** but its underpayments exceeded its overpayments. The overpayment for the claims, which had dates of service for 2009 through 2010, was $144,423, while the hospital had $167,000 in underpayments. OIG stated that, on the inpatient side, 28 claims had billing errors, including short stays, inpatient transfers, claims billed with high-severity level DRG codes, claims paid for blood clotting factor drugs and claims paid in excess of charges. On the outpatient side, OIG found 10 claims with billing errors, including claims billed for modifier-59, claims billed during inpatient stays, claims paid in excess of charges and claims involving manufacturer credits for replaced medical devices. The hospital agreed to correct and resubmit the overpayments and has described actions it will take to strengthen controls to ensure compliance with Medicare requirements. Visit http://go.usa.gov/YEAG.

◆ **On Oct. 22, CMS notified providers who have Wisconsin Physician Services (WPS) for their Medicare administrative contractor (MAC) that they have a new recovery audit contractor (RAC) if they are located in any state other than Missouri, Kansas, Iowa or Nebraska.** HealthData Insights will be their new RAC because of a contracting transition involving the MAC, according to an announcement on the CMS website. This transition did not impact the providers' MAC, but the transition required the change in the recovery auditor. Providers in Jurisdiction 8, where WPS is also the MAC, are not affected. The change in recovery auditor pertains only to providers who originally had WPS pay their claims as the fiscal intermediary, according to CMS. Visit http://tinyurl.com/8vda5e4.

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