RAC Alert: How to Bill Medicare for Hospice Patients When You Are Not the Hospice Provider

What is Hospice?

Hospice care focuses on improving the quality of life for persons and their families faced with a life-limiting illness. The primary goals of hospice care are to provide comfort, relieve physical, emotional, and spiritual suffering, and promote the dignity of terminally ill persons. Hospice care neither prolongs nor hastens the dying process. As such, it is palliative not curative. Hospice care is a philosophy or approach to care rather than a place. Care may be provided in a person’s home, nursing home, hospital, or independent facility devoted to end-of-life care.
How is Medicare Hospice Care Paid?

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services that are related to the treatment and management of his/her terminal illness during any period his/her hospice benefit election is in force, except for professional services of an attending physician, which may include a nurse practitioner. If the attending physician, who may be a nurse practitioner, is an employee of the designated hospice, he or she may not receive compensation from the hospice for those services under Part B. These physician professional services are billed to Medicare Part A by the hospice.

What is the RAC Issue?

Recovery Auditors recently reported a billing issue for physicians providing services unrelated to a Hospice terminal diagnosis provided during a Hospice period. Hospice claims are filed under Part A, while services not related to a Hospice diagnosis are filed under Part B. In these cases, unrelated care was billed without the accompanying GW modifier. All services related to a Hospice terminal diagnosis are included in the Hospice payment and are not paid separately.

For beneficiaries enrolled in Hospice, Medicare Administrative Contractors (MACs) and/or Medicare Carriers must deny any service furnished on or after January 1, 2002, that are submitted without either GV or GW modifier.

GV Modifier = Attending physician treating a patient with a Hospice related terminal diagnosis, but not employed or paid under arrangement by the patient’s hospice provider

GW Modifier = Service not related to the Hospice patient’s terminal condition
Recovery Auditor Finding

In this audit, the recovery auditors conducted an automated review of claims for physician services. A significant number were deemed to contain improper billing resulting in overpayment.

Claim Example 1: A patient is enrolled in Hospice and goes to a physician’s office for open treatment of a femoral fracture, with internal fixation or prosthetic replacement, CPT code 27236.

Finding: If the procedure is unrelated to the terminal diagnosis (Non-Hospice related), the physician’s bill should contain modifier GW. If this modifier is not appended, the procedure is related to the terminal diagnosis and should not be reimbursed under the part B benefit, instead paid under the hospice benefit.


Finding: The billing of code 45378 would be incorrect since the beneficiary was enrolled in hospice. There can be no separate reimbursement unless the service was unrelated to the terminal diagnosis, which has to be reflected by the proper modifier.

How to Capture Medicare Hospice Information

- Identify patients enrolled in Hospice, and document in your system the Hospice in which they are enrolled.
- If you have referred a patient to Hospice, flag their
account in the computer so anyone performing coding or billing can investigate the of use appropriate modifiers.

- If you have received correspondence notifying you of a patient’s enrollment in Hospice, notify staff and make sure the billing record is flagged for appropriate coding.
- If you become aware during the patient’s care that the patient you are treating is in Hospice, document the name of the Hospice and notify staff, making sure the billing record is flagged.
- Patients sometimes dis-enroll or are discharged from Hospice, so do not assume a patient is continuing care under Hospice. When in doubt, contact the patient’s Hospice to clarify if the patient is or is not enrolled.
- A little extra leg work will not only cause your claim to be paid on time and properly, it will also keep you from having to pay back any money if improperly paid to you.

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**The Medical Manager's 2013 Flu Season Update**

Oh, hello #Flu, you’re a little early this year: sick.io/ksxfm

— Sickweather (@sickweather) October 19, 2012

The tweet above was sent out by a very interesting start up
named Sickweather on October 19th of last year. Sickweather analyzes data from Twitter and Facebook to determine potential public health concerns by listening to the things people post on social media. If a lot of people are posting about coughing, sneezing or other symptomatic behavior, you could make the assumption that increased disease activity is more likely in the area. The tweet welcoming flu season early was not an ironclad prediction, announcement, or warning but six weeks later the Centers for Disease Control issued a press release titled “U.S. Flu Season off to Early Start.”

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The 2012-2013 flu season is shaping up to be “moderate to severe” with 47 states reporting “widespread geographic influenza activity” to the CDC. Outside of the Pandemic 2009-2010 “Swine Flu” season, the reporting of Influenza Like Illness (or ILI) to care providers this year is at levels we have not seen since 2003-2004. Although reports point to this year’s season being at or near it’s peak, we thought it would be a great time to remind or readers and clients about some of the tools and resources you have at your disposal.
Protecting your Staff

- If your staff are rusty on basic flu information you can find a wealth of information for providers at the [CDC](https://www.cdc.gov) and the [Flu.gov](https://www.flu.gov) websites to catch up on basics and preparation measures.
- Rule Number One: **IF THEY ARE SICK THEY HAVE TO GO HOME.** Sick providers and employees are powerless to help patients.
- A stronger flu season is a good time to review your staffing and preparedness plans both for [pandemics specifically](https://www.flu.gov) and [disaster prep in general](https://www.flu.gov).

Protecting your Patients

- If you provide primary care, you are already probably dispensing the most common and effective advice against the flu: vaccination, and prevention, but patients can also be directed to more resources on their own. Tell them to check out of the information available on [flu shots](https://www.flu.gov) and [staying healthy](https://www.flu.gov) at Flu.gov for further research.
- Remember who is most susceptible to flu-based fatalities and hospitalizations: the young, the elderly, and the already sick. Make sure your vulnerable patients get the information they need up front. If you don’t offer flu shots at your facility, make sure they can find somewhere that does close by.
Protecting Your Revenue Cycle

- Make sure your billing and coding departments are up on this year's Flu Shot billing codes.
- With the 1st of the year having already rolled over, many of your patients will have new calendar-year deductibles, co-pays and other patient responsibilities. If you haven’t already, maybe now is the time to start a “Credit Card on File” Program — and we’d love to help!

What other ways do you “flu-proof” your practice each year? Tell us your tips in the comments below!

The Medicare "Billing Bible" Changes Claims Processing Instructions for PAs, NPs, CNSs, CPs, and CSWs

Chapter 12 of the “Medicare Claims Processing Manual” (Medicare Billing Bible) is about to change to reflect deleted and/or corrected information as it relates to Claims Processing Instructions for Non-Physician Practitioners (NPPs), i.e., Physicians Assistants (PAs), Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Clinical Psychologists (CPs), and Clinical Social Workers (CSWs) submitting claims to Medicare contractors (carriers and A/B Medicare Administrative Contractors (MACs)) for services to Medicare beneficiaries.
These changes are effective February 19, 2013.

Key manual revisions/updates are as follows:

- NPP assistant-at-surgery services should be billed with the “AS” modifier only.
- The health professional shortage area (HPSA) payment modifiers, “QB” and “QU” have been eliminated because they are no longer valid.
- The “AH” modifier for CPs and, the “AJ” modifier for CSWs have been eliminated because they are no longer necessary for identification purposes.
- The correct payment amount for the professional services of PAs, NPs and CNSs is 80 percent of the lesser of the actual charge or, 85 percent of what a physician is paid under the Medicare Physician Fee Schedule (MPFS.)
- Additionally, the correct payment amount for assistant-at-surgery services furnished by PAs, NPs and CNSs is 80 percent of the lesser of the actual charge or, 85 percent of 16 percent of what a physician is paid under the MPFS for surgical services.
- Procedures billed with the assistant-at-surgery physician modifiers -80, -81, -82, or the AS modifier for physician assistants, nurse practitioners and clinical nurse specialists, are subject to the
assistant-at-surgery policy. Accordingly, Medicare will **pay claims for procedures with these modifiers only if the services of an assistant-at-surgery are authorized.**

- Medicare’s policies on billing patients in excess of the Medicare allowed amount apply to assistant-at-surgery services.
- When a PA, NP, or CNS furnishes services to a patient during a global surgical period, Medicare contractors shall determine the level of PA, NP, or CNS involvement in furnishing part of the surgeon’s global surgical package consistent with their current practice for processing such claims.
- Billing requirements and adjudication of claims requirements for global surgeries are under chapter 12, sections 40.2 and 40.4 of the “Medicare Claims Processing Manual.”
- PAs, NPs, and CNSs must have their own “non-physician practitioner” national provider identification number (NPI) number. This NPI is used for identification purposes only when billing for PA, NP, or CNS services, because only an appropriate PA, NP, or CNS employer or, a provider/supplier for whom the PA, NP, or CNS furnishes services as an independent contractor can bill for PA, NP, or CNS services. Specialty code 97 applies for PAs enrolled in Medicare. NPs enrolling in Medicare use specialty code 50 and CNSs use specialty code 89.

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**The 10 Essential Health Benefits of the ACA, and Why**
it Matters to Your Practice

In late November, the Department of Health and Human Services published its proposed rules that outline how the insurance market will operate starting in 2014. The rules mean consumers will have access to the information they need to make informed decisions about their health insurance purchases, and will be able to compare plans of similar coverage and price side by side in new federal and state run health insurance exchanges.

The proposed rules cover three areas: Actuarial Value, Accreditation Standards and Essential Health Benefits.

Actuarial value is a calculation of the percentage of the cost of covered benefits that an insurance plan covers. A plan with an actuarial value of 80% pays for roughly 80% of the total costs of covered treatment for the subscriber. Plans that meet certain guidelines will earn “medal” status: plans can be designated gold, silver, or bronze medal and so on based on premiums and actuarial value.

The accreditation standards lay out the process of becoming
certified for the Health Insurance Exchanges (HIEs – not to be confused with Health Information Exchanges!), and a big part of meeting those standards will be providing coverage for the ten benefits that are defined in the rules.

The ten “Essential Health Benefits” benefits are really more areas of coverage rather than specific individual services or procedures, but all plans inside and outside of the HIEs must provide coverage in these ten areas:

1. Ambulatory patient services
2. Emergency Services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventative and wellness services and chronic disease management
10. Pediatric services, including oral care and vision

Each state will have the leeway to define the minimum standards of coverage based on already available plans in the state market, but each state must provide some form of coverage in each of these ten areas.

So what does this mean for your
First of all, these ten essential benefits could represent an expansion of covered care for many of your current patients. Providers know the feeling of advising a patient to seek specialized care or other benefits that are non-covered under their current plans, only to realize that medical expenses have to be balanced against a real-world budget, job market and economy. With these ten essential benefits as part of a minimum insurance package, providers will know that these areas have at least some coverage for their patients, and this could mean long-advised suggestions for physical therapy, behavioral health, or expensive prescriptions could find a more receptive audience.

Your patients are probably already coming to you with questions about healthcare reform, insurance coverage and what it means, and giving them a better understanding of their essential health benefits under the law can help them to participate in their own care. These proposed rules also provide a great excuse for you to review which groups and specialists you refer to in the area: with benefit expansions, you can find new opportunities to connect with other providers for the benefit of your patients and your practice.

And finally, the shift from volume reimbursement to accountable care models means that more than ever, the bottom-line success of a practice is explicitly tied to the healthcare outcomes of their patients. This means that providers need to have all the wellness and treatment weapons in their arsenal that they can find.

What is your practice doing now to get ready for the changes coming to the insurance system in 2014?
The Big Idea for 2013: Show Me Your Fees

Private practices, hospital-owned practices and affiliated group practices are facing big changes from healthcare reform, demographic shifts, and economic and reimbursement pressure. The industry is re-evaluating itself from top to bottom and looking for new business models, ideas and opportunities to make medical practice feasible. Health insurance is changing as employers and payers are reducing benefits and shifting costs to patients. High deductible health plans (HDHPs) are becoming more popular, and with that patients are thinking more like customers, and making their healthcare decisions based on out-of-pocket costs.

Patients want access to pricing info, and are not satisfied with “it’s complicated” as an answer. The industry as a whole is moving towards rewarding performance over volume, and patients will also be armed with more publicly available performance and safety data.

In short, bedside manner and reputation are not enough anymore: practices now have to compete on price and quality in a more explicit way than ever before. We are advising our medical practice clients to take a long hard look at how they set their prices. Setting your prices does not have to be a complicated exercise when you have a basic understanding of
your overhead. If you understand what it costs to produce each RVU of service to your patients, than you can understand what a self-pay or high-deductible patient needs to pay in costs and margin. **Then tell your customers what your services cost.** This is what what other businesses do.

Price transparency improves patient satisfaction and trust because patients can relate what they are paying for to the value they are getting. It eases conversations about patient financial responsibility. Patients want to understand the money behind the treatment they are getting, because they have more financial “skin in the game” than ever before. Engage your patients in this process immediately by publishing your fees!

**For almost as long as I’ve been in healthcare, telling patients what services cost has been an issue and here’s why –**

**Fee schedules are set for insurance companies, not for patients.** When a practice signs a contract with an insurance company, the assumption is that in exchange for the insurance company delivering volume (lots of patients) the practice can afford to deeply discount their fees. The practice supplies their fee schedule and the insurance company cuts it down. The practice wants to start with a high enough fee schedule that a significantly cut schedule will still be much better than Medicare. This is what is referred to as “not leaving any money on the table” – setting your fee schedule high enough to capture everything an insurance company will potentially pay.

**Medicare and Medicaid don’t pay physicians enough to cover expenses.** To make up for this, practices charge commercial payers more to cover what government payers don’t pay.
Every payer/insurance company negotiates a different rate. Unless the practice has negotiating power, the physicians are usually forced to take what the insurance company is offering. Especially if the insurance company has a strong presence in the community, the physician may feel s/he has no choice but to take what is offered. This is why many physicians are opting to join megapractices or hospital organizations.

The rise of uninsured patients and high-deductible insurance plans has changed the number of patients paying 100% for their healthcare. For the past 5 years, the payment for healthcare has dramatically shifted and medical practices and patients have not been ready. Against rising healthcare costs, insurance plans and employers have shifted payment to patients in the way of increased cost-sharing, increased deductibles, increased co-pays and co-insurance and decreased benefits. Patients have often been the only ones paying the full retail cost for healthcare – the full fee schedule.

How do you place a price on healthcare services?

1. **Calculate what your services really cost.** One way is to take the last 12 months of practice expenses and divide them by the work Relative Value Units (wRVUs) you produced over the same period. This will tell you what it costs you to produce each unit of work. Look at it with the physician’s pay included and without the physician’s pay included.

2. **Calculate what portion of your expense is related to filing and collecting insurance payment.** This is primarily your coding, billing and insurance staff, their workspace and equipment and everything related to filing insurance and collecting. Reduce your fees by this cost for uninsured patients.
Why should you take this radical advice?

1. Consumers deserve to know what your service costs. Why would anyone buy anything without knowing what it costs? Consumers should know both the value of the service as well as knowing what is their personal responsibility to pay. Does the fact that healthcare sets their prices above what the market can bear mean we are part of the healthcare problem?

2. Publishing fees makes you justify them. Medical practices may not want to post their fees if they aren’t sure what their services truly cost. Other businesses charge what their services or goods cost plus a profit, why don’t we?

3. You will find out if your prices are not competitive in the market. Patients will tell you. Then you will have to decide if you want to be competitive. If you are worried you can’t compete with a hospital-sponsored practice if they know your prices, stop worrying. The hospitals already know your prices.

4. Publishing your prices will open the door for things to be simpler. Publishing fees will liberate you and your staff to talk much more openly with patients about their financial responsibility.

Part of this post was originally published under “The Big Idea: Healthcare Price Transparency” on LinkedIn.
The Part B Medicare deductible for 2013 is $147.00.

What should you do with this information? You should avoid taking a **big financial hit** in the first quarter of 2013 by collecting deductibles at time of service. How do you do that?

- Let all patients know in advance that you collect deductibles by making it part of your communication with them. Put it in your financial policy (get a copy of my preferred financial policy below), put it on your website, and let patients know when you schedule their appointment, or make an appointment reminder with verbiage like:

  “We look forward to seeing you at your appointment. Please bring your insurance cards and all medications to your visit. We will collect your co-pay, your deductible, and any co-insurance required by your insurance plan.”

- Explain what a deductible is. Get my sample patient
handout explaining deductibles below.

- Train front desk staff on deductibles and get them comfortable discussing deductibles with patients and answering their questions.
- Do not collect deductibles for Medicare patients who also have Medicaid, or for Medicare patients with supplemental insurance as there most likely will not be a balance that the patient will owe.
- It is ideal to use a Credit Card On File program to charge the patient’s credit card at time of service, or when the EOB (Explanation of Benefits) arrives in 15 days.

Other important Medicare numbers for 2013

**Part A: Hospital Insurance Premium for 2013**— $441.00 per month. Most 65+ patients get Part A for free if they already receive retirement benefits from Social Security or Railroad Retirement due to taxes paid during working years. Part A includes coverage for:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care – skilled nursing care, physical therapy, occupational therapy, speech therapy, medical social services, dietary and home health aides (100% covered with no co-pay) for homebound patients after a 3-day hospital stay

**Part B: Medical Insurance Premium for 2013**— $104.90 per month for most, but not all patients. Some patients automatically get Part B, others may have to pay more based on their IRS tax return from 2011. Part B includes coverage for:
- Services from doctors and other health care providers
- Outpatient care (includes emergency room and observation services for physician charges)
- Home health care – services provided to a homebound patient when the patient has not been hospitalized for 3 days prior to need
- Durable medical equipment
- Some preventive services

Part C: Medicare Advantage Plans – also called a Medicare Replacement Plan because it replaces traditional or original Medicare with a plan offered by a Medicare-approved private insurance company (BCBS, UHC, etc.) Premiums vary with individual Medicare Advantage Plans. Medicare Advantage Plans:

- Include all benefits and services covered under Part A and Part B
- Usually include Medicare prescription drug coverage (Part D) as part of the plan
- May include extra benefits and services for an extra cost
- Cannot be used in combination with a Medigap policy

Part D: Medicare Drug Coverage for 2013 – monthly premiums will vary based on income, and whether or not Part D is included if the patient opts for Part C coverage. Some plans have deductibles and some do not. Most drug plans have a coverage gap referred to as the “donut hole”, which means coverage is temporarily limited after the patient and drug plan have spent a certain amount for covered drugs. In 2013, once the patient reaches the donut hole, they pay 47.5% of the plan’s cost for covered name-brand drugs and 79% of the plan’s cost for covered generic drugs until the end of the donut hole is reached. In every successive year after 2013, the donut
hole will shrink until 2020 when the donut hole will cease to exist.

Medicare Supplement Insurance (also called Medigap) – Policies are sold by private insurance companies and help pay some of the health care costs that Medicare doesn’t cover. Patients have a one-time 6-month Medigap Open Enrollment Period which starts the first month they are 65 and enrolled in Part B. This period gives patients a guaranteed right to buy any Medigap policy sold in their state regardless of their health status.

Click here to receive a free copy of a financial policy and a patient handout explaining deductibles.

CLICK HERE to Download the Financial Policy and Deductible Handout!

Medicare Audit Guidelines for Provider Signatures

Medicare Signature Requirements

The purpose of a rendering/treating/ordering practitioner’s signature in patients’ medical records, operative reports, orders, test findings, etc., is to demonstrate the services have been accurately and fully documented, reviewed and authenticated. It confirms the provider has certified the
medical necessity and reasonableness for the service(s) submitted to the Medicare program for payment consideration. For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author.

Let’s define some terms first.

**Handwritten Signature** – a handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance or obligation and of the document.

**Digitized Signature** – a digitized signature is an electronic image of an individual’s handwritten signature reproduced in its identical form using a pen tablet.

**Signature Log** – A signature log is a typed listing of the provider(s) identifying their name with a corresponding handwritten signature. This may be an individual log or a group log. A signature log may be used to establish signature identity as needed throughout the medical record documentation. On behalf of a health care provider, the practice manager may create a signature log at any time, and Medicare Contractors will accept all submitted signature logs regardless of the date on which they were created.

**Signature Attestation** – A signature attestation is a statement that must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. SAMPLE verbiage:

*I, [print full name of the physician/practitioner], hereby attest that the*
medical record entry for ____[date of service]___ accurately reflects signatures/notations that I made in my capacity as ____[insert provider credentials, e.g., M.D.]___ when I treated/diagnosed the above listed Medicare beneficiary. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability.

Electronic Signature – Electronic signatures usually contain date and timestamps and include printed statements, e.g., “electronically signed by,” or “verified/reviewed by,” followed by the practitioner’s name and preferably a professional designation. Note: The responsibility and authorship related to the signature should be clearly defined in the record. Example of an acceptable electronic signature: “Electronically Signed By: John Doe, M.D. 08/01/2008 @ 06:26 A

Digital Signature – a digital signature differs from an electronic signature in that it is an electronic method of a written signature that is typically generated by special encrypted software that allows for sole usage.

NOTE: Be aware that electronic and digital signatures are not the same as “auto-authentication” or “auto-signature” systems, some of which do not mandate or permit the provider to review an entry before signing. Indications that a document has been “signed but not read” are not acceptable as part of the medical record.

Signature stamp – a signature stamp is a likeness of a handwritten signature used by administrative staff on medical records. Signature stamps on medical records are NO longer recognized as valid authentication for Medicare signature purposes and may result in payment denials by Medicare.
Rules Medicare Auditors Use for Signatures

- If the signature is illegible or missing from the medical documentation (other than an order), the review contractor shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

- If the signature is missing from an order, the review contractor shall disregard the order during the review of the claim (i.e., the reviewer will proceed as if the order was not received). Signature attestations are not allowable for orders.

- For a signature to be valid, the following criteria must be met:
  
  - Services that are provided or ordered must be authenticated by the ordering practitioner.
  - Signatures are handwritten or electronic. **Stamped signatures are not acceptable.**
  - Signatures are legible.

- Medicare does not accept retroactive orders. If the practitioner’s signature is missing from the medical record, the practice should submit an attestation statement from the author of the medical record.

- Your contractor may offer specific guidance regarding addenda to medical records. If the order is unsigned, you may submit progress notes showing intent to order the tests. The progress notes must specify what tests you ordered. A note stating “Ordering Lab” is not sufficient. If the orders and the progress notes are unsigned, your facility or practice will be assessed an error, which may involve recoupment of an overpayment.
You may submit a signature log or attestation statement to support the identity of the illegible signature. If the original record contains a printed signature below the illegible signature, this may be accepted.

Documentation must contain enough information to determine the date on which the service was performed or ordered. If the entry immediately above or below the entry is dated, medical review may reasonably assume the date of the entry in question.

Reports or any records that are dictated and/or transcribed, but do not include valid signatures “finalizing and approving” the documents are not acceptable for reimbursement purposes. Corresponding claims for these services will be denied.

Acceptable signature phrasing is
- ‘Electronically signed by’ with provider’s name
- ‘Verified by’ with provider’s name ‘Reviewed by’ with provider’s name
- ‘Released by’ with provider’s name
- ‘Signed by’ with provider’s name
- ‘Signed before import by’ with provider’s name
- ‘Signed: John Smith, M.D.’ with provider’s name
- Digitalized signature: Handwritten and scanned into the compute.
- ‘This is an electronically verified report by John Smith, M.D.’
- ‘Authenticated by John Smith, M.D.’
- ‘Authorized by: John Smith, M.D.’
- ‘Digital Signature: John Smith, M.D.’
- ‘Confirmed by’ with provider’s name
- ‘Closed by’ with provider’s name
- ‘Finalized by’ with provider’s name
- ‘Electronically approved by’ with provider’s name
Unique Signature Situations

Incident-to Services – a physician’s professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness. Only the Past, Family, and Social History (PFSH) and Review of Systems (ROS) may be documented by ancillary personnel incident to and incorporated into the E/M documentation, which must be reviewed and signed by the billing provider.

Services of non-physician practitioners (NPPs) – ordinarily performed by the physician such as minor surgery, setting casts or simple fractures, reading x-rays, and other activities that involve evaluation or treatment of a patient’s condition are also covered as services incident to a physician’s professional services. If the NPP performs an entire service incident to the physician (office/clinic/home settings only), the medical record may be signed by the NPP or the physician.

Split/shared services –

- Office setting: When an E/M service in an office setting is a shared/split encounter between a physician and a non-physician practitioner (NP, PA, CNS or CNM), the service is considered to have been performed “incident to” if the requirements for “incident to” are met and the patient is an established patient. The service is reported using the physician’s billing number. The physician must sign. If “incident to” requirements are not met for the shared/split E/M service, the service must be billed under the NPP’s billing number, and payment will be made at the appropriate physician fee schedule payment. The billing NPP provider must sign. Hospital-based setting: When a hospital
inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician’s or the NPP’s number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient’s medical record) then the service may only be billed under the NPP’s number. Payment will be made at the appropriate physician fee schedule rate based on the billing number entered on the claim. The billing provider (physician or NPP) as determined above must sign.

**Assistant at surgery** – It is not required that a surgical assistant also sign the operative report in addition to the responsible surgeon when reference is made in the note that identifies the assistant, provided that the report contains an acceptable signature by the responsible surgeon.

**Physician was present at the visit, but was unable to sign the record due to death or relocation** – If the provider is in a group practice, another provider within the group may sign on his/her behalf; however the following information must be provided:

The submitting provider, John W. Smith, M.D., is unable to sign this medical record because he expired on 10/08/08.  

or  

John W. Smith, M.D. relocated to Colorado on 10/08/08 and was unable to sign this medical record.

**Dictated Notes and Use of Initials**

The physician must review the transcribed note to correct any errors and affirm the note’s contents for it to be considered
the final documentation of the service.

- It is not sufficient that the provider is designated as dictating the note or his/her name is present in the record.
- If an illegible handwritten signature is present and the record contains no other identification of the author (i.e., printed name below, or letterhead with name) a signature log or attestation statement must be included with a response to the auditor documentation request.
- If the record is missing a signature, an attestation statement must be included in the response to the auditor’s documentation request.
- A legible signature that includes the provider’s full name and credentials is always the best practice.
- Initials are acceptable if signed over a typed or printed name.
- Without a typed name to identify the author, a signature log or attestation statement must be submitted or services may be denied.

Medicare News This Week: The 27.5% Cut, Meaningful Use Stage 2 Specifications, and Upcoming Webinars
This Week’s Medicare News for Medical Practice Managers

- Vice Chair Gingrey (R-GA) “Confident” of SGR Fix Passing in Lame Duck Congress Session (jump to story)

- CMS Releases Stage 2 Meaningful Use Specification Sheets with Details on Each Measure (jump to story)

- Information on Upcoming Webinars (jump to story)

Gingrey “Confident” Lame Duck Congress Will Pass SGR Fix.

*Modern Healthcare* (11/15, Subscription Publication) reports that Representative Phil Gingrey (R-GA), vice chair of the House Doctors Caucus said Wednesday that he is “pretty confident” Congress will “approve a one-year freeze in Medicare physician pay rates” during the lame duck session. This so-called “SGR patch” would put off a slated 27.5% cut to Medicare reimbursement rates. He said he believed “Congress would find the $18 billion needed to offset the cost of a one-
year payment freeze,” adding that “his caucus plans to focus next year on finding a replacement t the SGR and a way to pay the $300 billion cost of permanently replacing it.”

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CMS Releases Stage 2 Meaningful Use Specification Sheets with Details on Each Measure

CMS has added Stage 2 meaningful use specification sheets for both eligible professionals (EPs) and for eligible hospitals and critical access hospitals (CAHs) to help them participate in Stage 2 of meaningful use in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.

The new specification sheets can be found on the Stage 2 page of the EHR website. Each specification sheet includes the objective, measure, and exclusion for each core and menu objective, as well as a definition of terms, attestation requirements, additional information, and the corresponding standards and certification criteria.

You can view the specification sheets in two ways:

- **Use the Stage 2 Specification Sheet Table of Contents** – The Table of Contents lists all the core and menu objectives, with direct links to each individual measure specification sheet. The page contains a Table of Contents for both EPs and for eligible hospitals and CAHs.

- **Download ALL Stage 2 Specification Sheets** – Zip files containing PDFs of all of the core and menu objectives for EPs and for eligible hospitals and CAHs are available for download on the page.

*Reminder: The earliest that the Stage 2 criteria will be*
effective is in fiscal year 2014 for eligible hospitals and CAHs or calendar year 2014 for EPs. All providers must achieve meaningful use under the Stage 1 criteria before moving to Stage 2.

Want more information about the EHR Incentive Programs? Make sure to visit the Medicare and Medicaid EHR Incentive Programs website for the latest news and updates on the EHR Incentive Programs. (Back to Top)

Information on Two Upcoming Webinars from CMS

National Medicare Training Program Update Webinar on Tuesday, November 20.

Attendees will hear information on:

- Flu Vaccine
- Plan Finder
- Innovations Center
- Enrollment Opportunities for People Affected by Hurricane Sandy
- Pharmacy & Provider Access During Federal Disasters and Other Public Health Emergencies

When: Tuesday, November 20, 2012

Time: 2:30-3:30 p.m., ET

Call-In Number: 877-251-0301

Conference ID: 90024799
Webinar ID: https://webinar.cms.hhs.gov/nmtpnov12/

Make Your Community a Source of Health and Wellness – Establishing a Health Ministry in Your Community Webinar on Thursday, November 29.

Sue Heitmuller, Health Ministry Coordinator for Adventist HealthCare, will speak in-depth on how to lead communities through the process of faithfully establishing health ministries.

The presentation will be followed by a Question & Answer session.

When: Thursday, November 29, 2012

Time: 2:00-3:00 p.m., ET

Guest Consultant Cindy Dunn: Medical Practices Need to Start Now to Plan for a Happy New Year in 2013

Changes in health-care policy, new regulations, financial incentives and penalties have a direct effect on all healthcare organizations. As we round the corner towards
2013, take a few minutes to create an agenda of Medicare Incentive Programs and a few management initiatives to review with your physicians and leadership team.

**Electronic Health Record (EHR)**

Most practices have an EHR but often times it is not fully implemented:

- Are all of your physicians using the EHR?
- Do you have the latest version?
- Are all of your employees and providers trained properly?
- Are you utilizing all of the available functionality?

**Meaningful Use (MU)**

Strive to meet the Meaningful Use criteria. Even if you are unable to implement and attest to Medicare by the end of 2012 to receive the maximum $44,000 over 5 years, by beginning the process and attesting in 2013, you will be eligible for Medicare incentive payments over 5 years totaling $39,000.

If you have physicians receiving 30% of their revenue from Medicaid, they can attest beginning at any time through 2016 and receive $63,750 over the subsequent 6 years.

**e-Prescribing (eRX)**

If you did not successfully report your eRX efforts in 2011 you are already subject to a Medicare penalty in 2012. In order to prevent the 2013 penalty, each physician needs to report their eRX work on 25 individual patient claims (not 25 e-prescriptions) by December 31, 2012.

If you are unable to eRX because you are in an area with few participating pharmacies, or in a rural area with limited
high-speed Internet access, apply for an exemption by January 31, 2013, to avert penalties that begin in 2013.

**Physician Quality Reporting System (PQRS)**

PQRS is currently a voluntary program. In the claim based reporting option, in order to receive your 2012 financial incentive, each provider should select and report on at least three applicable quality measures. Reporting is for the entire 2012 year and each provider must report on a minimum of 50% of applicable Medicare Part B patients. Many physicians select their measures but they are not always submitted or properly documented.

The final 2012 Medicare Physician Fee Schedule contained a provision that 2015 program penalties will be based on 2013 performance. Physicians who elect not to participate or are found unsuccessful during the 2013 program year, will receive a 1.5% payment penalty in 2015 and 2% annually in the following years.

**Medicare Fee Schedule**

What is the impact of the 2013 proposed Medicare Fee Schedule on your patients, staff, and practice? We are all accustomed to Congress “coming to the rescue” but what if the unthinkable occurs? The proposed conversion factor reflects a 27.4% cut that will take effect on January 1, 2013 and CMS estimates the 2013 MPFS conversion factor will be set at approximately $24.7124 (currently $34.04). Have you reviewed your payer mix, analyzed the receipts and determined the financial impact on your practice? What changes could you make if necessary?
Physician Compare (Website here)

Mandated by the Affordable Care Act, the Physician Compare website was created to allow consumers to compare physicians based on quality of care. Currently it is a directory of ~932,000 doctors and other health care providers who accept Medicare patients. It’s searchable by zip code, city, state, and medical specialty.

Patients will eventually be able to see and compare how other patients rate their experience with physicians as well as how physicians perform on a dashboard of clinical and outcome measures. The Affordable Care Act states that beginning no later than January 2013, CMS is to “implement a plan for making publicly available, through Physician Compare … information on physician performance that provides comparable information for the public on quality and patient experience measures.”

Have you gone to the website – is your practice and physician information correct? If there are errors you should contact the CMS QualityNet Help Desk at (866) 288-8912 and ask for assistance.

Optimize Operational Management Strategies

You find several things in common in the better performing groups: flexible staffing for support staff; cross-training staff for increased utilization; a patient focused schedule that includes open access for same-day appointments; meticulous tracking of accounts receivable (including aggressive day-of-service collections of estimated co-pays, deductibles & co-insurance); and prompt follow-up with payers and patients owing balances on their bills. Does this sound like your practice? If not what are you doing to make
changes?

Measure, measure, measure and share, share, share!

Develop a plan, set goals and share the results with your staff. Staffing ratios, productivity, denials, wait times, patient (customer) satisfaction, quality outcomes and market share are just a few metrics you should monitor.

Resources:

EHR and Meaningful Use Incentive Programs

e-Prescribing

PQRS

Cindy Dunn, RN, FACMPE is the Vice President of Professional Services for Trellis Healthcare

Trellis Healthcare introduces InfoDive®, a web-based business intelligence solution which allows medical practices to
quickly and easily analyze internal data and benchmark their practice to others. This enhanced understanding improves the quality and efficiency of business processes and physician performance and answer questions such as: Are your providers as productive as they should be? Are your payers reimbursing you at the negotiated contract rate? Who’s your best payer? Are you at risk for a RAC audit? What services are being denied? Where are your referrals coming from? Should you open or close an office?

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**Power Wheelchairs: What the Physician Must Do to Ensure Medicare Coverage**

CMS Finds High Incidence of Improper Payments for Power Wheelchair Claims

Based on the findings of the Comprehensive Error Rate Testing (CERT) program reviews of power wheelchair claims, the Centers for Medicare & Medicaid Services (CMS) conducted a special study of power wheelchair claims.

The power wheelchair categories studied
include:

- Group 1: Standard, portable, sling/solid seat/back, capacity up to 300 lbs. (K0813)
- Group 2: Standard, portable, captain’s chair, capacity up to 300 lbs. (K0821)
- Group 2: Standard, sling/solid seat/back, capacity up to 300 lbs. (K0822)
- Group 2: Standard, captain’s chair, capacity up to 300 lbs. (K0823)
- Group 2: Heavy duty, sling/solid seat/back, capacity 301 to 450 lbs. (K0824)
- Group 2: Heavy duty, captain’s chair, capacity 301 to 450 lbs. (K0825)
- Group 3: Heavy duty, sling/solid seat back, capacity 301 to 450 lbs. (K0850)
- Group 3: Very heavy duty, single power option, sling/solid seat/ back, capacity 301 to 450 lbs. (K0861)

What Power Wheelchair Claim Problems Were Found in the Study?

Insufficient Documentation

The majority of power wheelchair errors were due to insufficient documentation errors. Insufficient documentation errors occur when the medical documentation submitted is inadequate to support payment for the services billed. In other words, the medical reviewers could not conclude that some of the allowed services were actually provided, were provided at the level billed, and/or were medically necessary. Claims are also placed into this category when a specific documentation element that is required as a condition of payment is missing. This may include a physician signature on an order, or a form that is required to be completed in its entirety. **EXAMPLE:** Mrs. Smith’s medical record showed that she...
had a physical condition that led to leg weakness and falls at home. However, the face-to-face examination did not address why her mobility limitations could not be sufficiently and safely resolved by the use of an appropriately fitted cane or walker. This claim was scored as an improper payment due to an insufficient documentation error.

Medical Necessity

A small proportion of claims in this special study were categorized as medical necessity errors. Medical necessity errors occur when the medical reviewers receive adequate documentation from the medical records submitted to make an informed decision that the services billed were not medically necessary based upon Medicare coverage policies. A common reason for medical necessity errors was that the face-to-face examination did not support that the beneficiary’s condition required the use of a power wheelchair, such as when they were able to safely ambulate with the use of a walker. **EXAMPLE:** Mr. Jones’ medical record showed that he had a physical condition that led to leg weakness and falls at home. However, the face-to-face examination mentioned that she was safely ambulating around the house with the use of an appropriately fitted walker, but that she wanted the power wheelchair so that she could travel around the neighborhood. This claim was scored as a medical necessity error.

There is currently a prior authorization pilot underway in seven states where CMS will review the patient’s medical record before a device is shipped to ensure they need a wheelchair. The pilot, which started September 1, 2012, is ongoing in California, Illinois, Michigan, New York, North Carolina, Florida, and Texas.

Federal health officials noted that nearly 80 percent of the power wheelchair claims submitted to Medicare don’t meet program requirements. Note that this may mean that the protocol was not followed, as opposed to the patient not being
eligible based on medical necessity. That error rate represents more than $492 million in improper payments annually. The cost for the devices ranges from $1,500 for scooters to $3,600 for more complex power wheelchairs over the course of the rental period. Medicare payment can only be made on a rental basis for standard power wheelchairs furnished on or after January 1, 2011.

What are the Requirements for Medicare Coverage for Power Wheelchairs?

Medicare provides coverage for wheelchairs and scooters under its Part B Durable Medical Equipment (DME) benefit. Here are the requirements for Medicare payment:

- The physician or treating practitioner must conduct a face-to-face history and physical examination (the in-person visit and mobility evaluation together are often referred to as the “face-to-face examination”) of the beneficiary and write a prescription for the item. The prescription must include the following seven items:
  1. Beneficiary’s name
  2. Description of the item that is ordered. This may be general – e.g., “power operated vehicle”, “power wheelchair”, or “power mobility device” – or may be more specific.
  3. Date of completion of the face-to-face examination
  4. Pertinent diagnoses/conditions that relate to the need for the POV or power wheelchair
  5. Length of need
  6. Physician’s signature
  7. Date of physician signature
- The beneficiary must show the provider why they cannot use a cane, walker or manually operated wheelchair to effectively perform Mobility-Related Activities of Daily Living (MRADLs) in the home. MRADLs include feeding, dressing, grooming, bathing, and toileting.
- The beneficiary must be able to safely and effectively use the power wheelchair in the home.
- The prescription and medical records documenting the in-person visit and evaluation must be sent to the equipment supplier within 45 days after the completion of the evaluation.
- After the supplier receives the provider’s order and the face-to-face information, they will prepare a detailed product description that describes the item(s) being provided including all options and accessories. The provider should review it and, if in agreement with what is being provided, sign, date and return it to the supplier. If not in agreement, the provider should contact the supplier to clarify what you want the beneficiary to receive.

Suppliers must meet all documentation requirements included in the power wheelchair Local Coverage Determinations (LCD) issued by the DME Medicare Administrative Contractors (MACs) in order to receive Medicare payment for a power wheelchair. The LCD requires that suppliers maintain a variety of documents that support the beneficiary’s need for, and the appropriateness of, the provided power wheelchair.

**Documentation of the Visit for Your Medical Record (Paper or Electronic) for PWCs**

The face-to-face examination must be relevant to the patient’s mobility needs and include the following elements:

- History of present condition and relevant past medical history, including symptoms that limit ambulation,
- Diagnoses that are responsible for symptoms,
- Medications or other treatment for symptoms,
- Progression of ambulation difficulty over time,
Other diagnoses that may relate to ambulatory problems,
Distance patient can walk without stopping,
Pace of ambulation,
Ambulatory assistance currently used,
Change in condition that now requires a PMD
Description of home setting and ability to perform MRADLs in the home.
Physical examination relevant to mobility needs, including height and weight,
Trunk stability (sitting/standing),
Cardiopulmonary examination,
Arm and leg strength and range of motion; and
Neurological examination, including gait, balance and coordination.

Examples of vague or subjective descriptions of the patient’s mobility limitations include:

- upper extremity weakness” “poor endurance”
- “gait instability”
- “weakness”
- “abnormality of gait”
- “difficulty walking”
- “SOB on exertion”
- “pain”
- “fatigue”
- “deconditioned”

Acronyms for power wheelchairs:

PWC – power wheelchairs
POV – power-operated vehicle (scooter)
PMD – power mobility device (includes PWCs and POVs)
MAE – mobility assistive equipment (includes the continuum of technology from canes to power wheelchairs)

How to Bill for Examination & Mobility Evaluation for a Power Wheelchair

- In the outpatient setting, bill the appropriate level of service from the codes 99201 – 99205 for new patients and from the codes 99211 – 99215 for established patients.
- Bill the G0327 for service required to establish and document the need for a power mobility device (the national payment amount for this code is $9.81)
- The diagnosis for the E/M code and the G0327 should be what condition creates medical necessity for the power wheelchair.