Eli's Rehab Report

Avoid OIG Scrutiny in 2003: Correctly Code Rehab Claims,Incident-To Services

Because the U.S. Office of Inspector General (OIG) intends to scrutinize consol idated billing in 2003, PM&R practices must submit technical component claims (modifier -TC) directly to skilled nursing facilities (SNFs) not to Medicare for their SNF patients.

The Balanced Budget Act of 1997 requires SNFs to consolidate billing for Medicare Part A residents, which means that physiatrists who perform in-office procedures such as electromyograms (EMGs, 95860-95872) on SNF patients must bill the technical component of the service directly to the SNF.

Forge Relationships With SNFs

When an SNF calls your practice to schedule a procedure, the receptionist shoul indicate on the patient's fee ticket that he or she resides in an SNF.

"When the fee ticket gets to the coder, they should create another, separate fee ticket," says **Deb Hudson, CCS-P**, coder at the Mason City Clinic, a 30-physician multispecialty practice in Iowa. "The fee ticket for professional services will go to the patient's Medicare Part B carrier, and the other fee ticket, for technical services, is billed to the SNF with modifier -TC (Technical component)." Hudson suggests setting up separate accounts for the various SNFs in your area so coders can send information to the appropriate party at the nursing facility.

Suppose a patient recovering in an SNF after surgery to repair a hip fracture (733.14) presents to her physiatrist for a rehab visit. The practice's radiology technician x-rays two views of the patient's hip (**CPT 73510**). The physiatrist reads the x rays and writes his report, then examines the patient during a level-three E/M service (99213 for outpatient).

The coder should submit the following claim to the patient's Medicare carrier: 73510-26 (Professional component) 99213.

The practice should send a separate claim directly to the SNF listing 73510-TC as the procedure code and 733.14 as the diagnosis.

Remember that you can bill a procedure's technical component only if your practice owns the equipment (x-ray, EMG, etc.) and pays the salaries of the personnel taking the films, because the -TC modifier's fee includes those technical costs.

Consolidated-billing rules also apply to physical, occupational and speech therapy services furnished to SNF residents covered under a Part B stay. These therapies are the only Part B services included in SNF consolidated-billing regulations. Remember that SNF patients' E/M visits **can** still be billed directly to Medicare and should not pose a problem.

Bill Bone Density Testing Carefully

PM&R practices can bill for bone density screening (76075-76078, 76977, 78350-78351) only on patients sufficiently at risk for osteoporosis (733.00-733.09). Although many insurers define "at risk" differently, most carriers require that patients have one of the following five conditions.

1. The patient is estrogen-deficient and at clinical risk for osteoporosis, based on medical history and other clinical findings.

2. The patient has vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia (low bone mass) or vertebral fracture (733.13).

3. The patient receives glucocorticoid (steroid) therapy of 7.5 or more milligrams of prednisone (J7506) per day for more than three months.

4. The patient hasprimaryhyperparathyroidism (252.0).

5. The patient is being monitored to assess the response to any FDA-approved osteoporosis drug therapy.

Your local carrier may have more specific guidelines, so get your insurer's policy in writing before scheduling bone density screenings.

Always maintain documentation demonstrating that the patient has one of these five conditions in case the scan is negative for osteoporosis. If the OIG subsequently audits your practice's bone density scanning claims, you can substantiate that the patient was sufficiently "at risk" for the service.

Streamline Incident-To Billing

Because OIG continues to monitor claims for incident-to services, always follow the Medicare Carriers Manual (MCM) guidelines for billing incident-to services:

1. The physician must be on-site at the time of treatment
2. The physician originally saw the patient during his or her first visit to the office or clinic
3. The physician sees the practice's established patients for any new medical problems.

Sometimes these guidelines aren't clear-cut in the practice setting. For instance, the physiatrist evaluates a new patient (99201-99205), refers her for a wrist x-ray (73100-73110) and asks her to return the next day to receive the results. When she arrives the next day, the physiatrist is detained at the hospital, so the physician assistant (PA) phones the physiatrist and reads him the report. The physiatrist advises the PA to apply a short arm splint. The practice bills the PA's splint application (29125) as incident-to, arguing that the physiatrist supervised the PA and plans to dictate a note later for the patient's chart.

This is not correct incident-to coding, says **Cheryl Gueldenzopf,** practice manager at Northeast Orthopedics in Tawas City, Mich. Not only was the physician off-site (a definite deal-breaker for incident-to claims) but "Medicare also requires that the physician see new patients to identify the plan of care, and that the PA can follow the plan. The PA should charge for the visit with his own Medicare number in this situation."

"Many practices make the mistake of saying, 'Well, we've billed incident-to before when the physician wasn't in the office, and we got paid for it,' " says **Ron Nelson, PA-C,** reimbursement policy analyst, president of Health Services Associates Inc., a family practice in Fremont, Mich., and past president of the American Academy of Physician Assistants. "But just because you got paid for something doesn't mean you did it correctly. The carrier may have paid you, but you are still subject to an audit."