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Pain Management Coding Alert

Reimbursement: Here's Your Guide to What CMS Wants in Concurrent Care

Follow these 4 steps to help boost your bottom line.

It's not uncommon for a pain management specialist to provide concurrent care that is, to work with other physicians to provide a patient's care. Coding can get dicey if two or more physicians see the patient on the same day, but that doesn't mean your providers shouldn't get their fare share of the payment. Follow this guide to understand what CMS considers to be concurrent care and how to ethically gain reimbursement.

Step 1: Know What Constitutes Concurrent Care

The Medicare Benefit Policy Manual chapter 15 30 E, addresses concurrent care as existing, "where more than one physician renders services more extensive than consultative services during a period of time." In other words, two or more physicians are actively involved in the patient's care, beyond the level of providing a written report of the patient's condition to a "requesting" physician. In addition, no transfer of care from one physician to another occurs. Rather, two or more physicians share responsibility for the patient, co-managing a single condition or (more commonly) tending to distinct, coexisting medical problems.

Providers rendering concurrent care may include physicians, physician assistants, nurse practitioners, clinical nurse specialists, psychologists and others. The services may be inpatient or outpatient, but generally occur in an inpatient (facility) setting.

Step 2: Prove the Necessity of Care

As with any type of care, insurers will not reimburse for unnecessary or redundant services. That means you need solid documentation that demonstrates medical necessity before you should file a claim as concurrent care.

Regulation: According to the Medicare policy, "To determine whether concurrent physicians' services are reasonable and necessary, the carrier must decide (I) whether the patient's condition warrants the services of more than one physician on an attending (rather than consultative) basis, and (2) whether the individual services provided by each physician are reasonable and necessary." The MCM goes on to note, "Correct coverage determinations can be made on a concurrent care case only where the claim is sufficiently documented for the carrier to determine the role each physician played in the patient's care."

To reach a payment decision, the payer will first consider the specialty of each physician to determine if the patient's diagnosis(es) requires (in Medicare's words) "diverse specialized medical or surgical services."

Example: A physician requests that your pain specialist see a patient she suspects has a diagnosis of carpal tunnel (354.0). If your physician confirms the diagnosis, he will issue a report to the requesting physician, who will either initiate care or transfer the patient's care to the neurologist. But you'll need a more complex situation such as a diagnosis like multiple sclerosis (340) or Parkinson's disease (332.0) or two or more coexisting conditions to justify the need for concurrent care.

Take note: Payers usually will not view concurrent care as reasonable and necessary if provided by physicians of the same specialty or by physicians with a similar knowledge base. The exception to this rule, according to Medicare, is if one of the treating physicians "has further limited his/her practice to some unusual aspect of that specialty" and documentation can unequivocally support medical necessity for the unique contribution of that physician.

Here's help: Individual payers often provide additional guidelines to ease concurrent care reporting. For example, NGS and CGS both include information about concurrent care on their websites to help you correctly report cases.

Step 3: Let the Diagnoses Seal the Deal

Physicians providing concurrent care must be careful when assigning ICD-9 codes. Payers often want to see distinct diagnoses from each of the physicians.

"There are no concurrent care modifiers or CPT® codes," notes **Mary Falbo, MBA, CPC**, president of Millennium Healthcare Consulting Inc., a healthcare consulting firm based in Landsdale, Pa. "You must use the standard E/M and procedure codes so the only way to tell the payer that you're providing services separate from another specialist is to use a different primary diagnosis code."

Pitfall: Too often, Falbo says, the physician providing concurrent care uses the reason the patient is in the hospital as the primary diagnosis. "They should use the reason they were called in to treat the patient," she says. "They shouldn't even include the diagnosis describing why the patient is in the hospital unless it directly relates to the condition they are treating."

Example: Your pain management specialist is called in to see a patient with bone metastasis. You should report 338.3 (Neoplasm related pain [acute] [chronic]) as the primary diagnosis on your claim, whereas the oncologist would submit the secondary neoplasm as his primary diagnosis.

Step 4: Coordinate With Other Caregivers

Concurrent care's unique documentation challenges may require that you coordinate your coding and billing with the other caregivers. As noted, diagnosis codes should not overlap whenever possible, and two or more physicians must not report identical services (e.g., routine hospital visits for the same condition) or their claims will face denial.