Issues with Reimbursement under Medicare

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The following article is for informational purposes and should not be construed as constituting legal advice. A psychologist concerned about reimbursement under Medicare is advised to consult with an attorney familiar with the Medicare rules and regulations.

Dr. John N. Tripper treated Sadie Sadd for 5 years after she was diagnosed with bipolar disorder following the loss of her husband. Dr. Tripper’s practice is entirely self-pay although he provides his clients with the information and forms necessary for them to secure reimbursement from their insurance carrier, in Sadie’s case, Blue Cross/Blue Shield. Sadie’s ongoing treatment has been very productive. However, six months ago Sadie reached her 65th birthday and became eligible for Medicare Part B. When Sadie contacted Blue Cross/Blue Shield about reimbursement for recent services, she was told that she cannot be reimbursed without a Medicare Claims Rejection, since Medicare is now her primary carrier. Sadie then submitted a bill to Medicare. Three weeks later, Dr Tripper received a letter from Medicare demanding that he return the $2,400 paid by his patient for services rendered after her 65th birthday. Dr. Tripper called Medicare and was told that a licensed psychologist cannot provide self-pay services to a Medicare-eligible Part B patient unless the psychologist has “opted out” of his or her provider status in compliance with national Medicare regulations. Dr. Tripper noted that he has never been a Medicare provider; that he does not recall “opting in” and thus he assumed he must be “opted out.” The Medicare representative informed Dr. Tripper that, because he was not a Medicare provider, the patient’s money must be returned and the patient cannot be charged for any future services. Further, the matter would be turned over to the Medicare fraud unit. In addition to Sadie, Dr. Tripper has three other patients who are over 65 years old. They have paid him in excess of $12,000 since their 65th birthdays. What should Dr. Tripper do?

As our population ages, psychologists are increasingly being confronted with patients who are currently or potentially Medicare eligible. Consequently, knowledge of and compliance with the rules governing Medicare eligible patients is crucial for all professional psychologists, whether they are participating providers or not. In addition, because Medicare is a Federal Government program, its definitions of medical necessity and audit processes are likely to be adopted by major private carriers, particularly in view of the legal issues created by the recent passage of Federal parity legislation. Consequently, it will be hard for local regulators to challenge these processes. There is considerable confusion about how the Medicare system operates and the potential
financial and disciplinary risks involved in treating Medicare eligible patients. This article is intended to provide a brief overview of the topic of Medicare billing to assist psychologists when they are treating patients 65 years and older.

The first area of concern deals with the psychologist who has been approached for services by a potential patient who is an eligible Medicare Part B beneficiary and who wants to pay for the services out of pocket. If the psychologist is a Medicare provider, the answer is relatively simple. The psychologist cannot accept private pay and must receive reimbursement through Medicare. In addition, the psychologist must follow the accepted methods for billing and collection. Any other arrangement is a form of balance billing and is considered Medicare fraud.

However, what most psychologists do not know is that they cannot provide any outpatient services to Medicare Part B beneficiaries if they are not Medicare providers even if they have no desire to become Medicare providers. If one wants to provide services to Medicare beneficiaries outside of the Medicare reimbursement system, one must officially “opt out” of the system, and comply with very specific informed consent requirements. Most physicians are aware of this issue, because critics of Medicare have been active in recommending that physicians “opt out” of the Medicare system.

In order to “opt out,” a practitioner must provide the local Medicare fiscal intermediary with a signed affidavit that includes the practitioner’s Medicare number, National Provider Identifier (NPI), or tax identification number and indicate that he or she will only provide services to a Medicare beneficiary if the services are provided under a specific contract signed by the beneficiary. This is further complicated by the fact that the opting out process is handled by the fiscal intermediary, which has some discretion about the opting out process. Some intermediaries have required that providers become Medicare providers first, and then opt out of the process. Individuals should check with the relevant intermediary. You can find out your intermediary at the following website: www.cms.hhs.gov/apps/contacts.

There are a number of other elements that must be included in the affidavit making clear that the practitioner understands all of the terms and conditions of his or her decision not to participate.

Once a psychologist has opted out, he or she must provide each Medicare B beneficiary requesting services with a contract that must:

1. be in writing and in print sufficiently large to ensure that the beneficiary is able to read the contract;
2. clearly state that the practitioner is not a Medicare provider;
3. state that the beneficiary or his or her legal representative (beneficiary) understands that Medicare billing limits do not apply to the practitioner’s charges;

4. state that the beneficiary agrees not to file a claim with Medicare;

5. state that the beneficiary understands that he or she may secure Medicare reimbursed services from another qualified practitioner;

6. state that the beneficiary understands that Medigap and other supplemental plans may elect not to make payments for these services;

7. have the date that the provider’s opt-out expires;

8. and be signed by the beneficiary.

A copy of the signed contract must be given to the beneficiary and a copy must be retained by the provider and submitted to Medicare on request.

The second area of significant risk to psychologists treating Medicare patients deals with billing and audits. In 2007, the Center for Medicare and Medicaid Services (CMS) released a report entitled Medicare Payments for 2003 Part B Mental Health Services: Medical Necessity Documentation and Coding (www.oig.hhs.gov/oei/reports/oei-09-04-00220.pdf) Its most significant findings were that forty seven percent (47%) of claims did not meet Medicare requirements, twenty-six percent (26%) of claims were miscoded and nineteen percent (19%) were insufficiently documented. According to the Inspector General (IG), this resulted in $718 million in improper payments. Needless to say, this number captured people’s attention. In response, CMS initiated a two-pronged attack on the problem, first by launching an educational effort to change provider behavior and, second, a stepped up audit program to prevent fraud and abuse.

The first part of the audit program is the Comprehensive Error Rate Testing program which initiated large numbers of random audits of paid Medicare claims for compliance. If providers were identified as potentially problematic, they were asked to provide additional information to reviewers. If the additional information did not eliminate the perceived problems, providers could be assessed for inappropriate claims. The assessment could be determined by an interpolation process which would estimate the number of inappropriate claims based on the sample audited and the total number of claims submitted. This could, and has, resulted in significant financial recoupment of claims. These decisions can be appealed, but the costs of an appeal are significant and the success rate of such appeals is low.

In a second attack on the problem in 2006, CMS piloted the hiring of Recovery Audit Contractors, a program that is scheduled for extensive expansion. This program hires independent agencies to audit providers and recoup inappropriate claims payment. These audits are targeted, not random. At this point in time, we are unaware of the targeting criteria. In this program, the contractors are incentivized. That is, they receive a
Psychologists caught up in this process can be assessed large amounts for recoupment. During the pilot phase of the program, the number of psychologists that have been audited has been relatively small, but as the program expands, so will the number of psychologists targeted for audits. In addition, this kind of audit has not traditionally been covered by malpractice insurance policies. Fortunately, the Trust-sponsored Professional Liability Program has expanded its policy to provide some coverage for legal representation.

The next area of concern for psychologists providing services to Medicare patients deals with the concept of “medical necessity.” For psychologists who have experience with managed care companies, understanding the Medicare definition of medical necessity should not be difficult. However, all psychologists who have Medicare B eligible patients should reference “Medicare Payments for Part B Mental Health Services” ([www.oig.hhs.gov/oei/reports/oei-09-04-00220.pdf](http://www.oig.hhs.gov/oei/reports/oei-09-04-00220.pdf)), which is the source for what follows.

In order to be medically necessary, the services must be “reasonable and necessary for the diagnosis and treatment of an illness or injury or to improve the functioning [of the patient]…” Providers must document the specific sign, symptom or patient complaint necessitating the service. The patient must have an appropriate ICD-9-CM diagnosis and the provider must document the appropriate procedure code for the service from the CPT Code Book. The services must be aimed at coming to an appropriate diagnosis or be designed to reduce or control the patient’s psychiatric symptoms so as to prevent relapse or hospitalization and improve or maintain level of functioning. In fact, the CMS definition of medical necessity is more liberal than that used by many managed care organizations because “improved functioning” does not require

“restoration of the patient to the level of functioning exhibited prior to the onset of symptoms, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable level of improvement. ‘Improvement’ in this context is measured by comparing the effect of continuing treatment vs. discontinuing it. Where there is a reasonable expectation that a patient’s condition would deteriorate, relapse further, or require hospitalization if treatment were withdrawn, this criterion would be met.”
The problem for most practitioners caught up in the audit system will be the failure of their documentation to adequately demonstrate that the patient meets the diagnostic criteria. Consequently, every patient record must include an evaluation, a diagnosis and a treatment plan that specifically references the problems the patient is presenting, the techniques the provider intends to use, and the goals of the treatment. CPT and ICD-9-CM codes reported on the health insurance claim forms should also be supported by documentation in the medical record. Each session note, in addition to the diagnosis and CPT code, should state the target areas of intervention with reference to the original goals and objectives and the definition of medical necessity. The record should also clearly and behaviorally document patient progress (or lack thereof) between sessions and what needs to be worked on in the future.

An area related to documentation identified by the IG’s Report as a major cause of miscoded individual psychotherapy claims was inadequate documentation to justify the time billed. Medicare takes a very literal view of the amount of time patients spend in treatment and what Medicare will compensate. Conversely, psychologists often tend to take a more dynamic view. For example, if a patient is 10 minutes late for a 45-50 minute session and the actual face time is 35 minutes, the psychologist often bills for a 45-50 minute session. However, to Medicare, this may be determined to be “up-coding”, a prominent source of Medicare fraud and abuse. Further, since a 75-80 minute session requires extra documentation and is subject to increased scrutiny, psychologists may be tempted to bill for a 45-50 minute session. Medicare considers this “down-coding” and it is also considered Medicare fraud and abuse. It is important to remember that Medicare only pays for the actual face time spent with a patient and this must be carefully recorded in the note of each session.

CMS also cites a number of other common errors that are more problematic for psychologists, including billing for phone sessions or cancelled sessions, under-diagnosing in order to avoid embarrassment of or conflict with the patient, billing for note taking after a session, and systematically failing to collect copayments.

These are very complicated issues and, as can be seen, potentially fraught with risks for the psychologist. Those who have questions and are insured with the Trust-sponsored Professional Liability Program can seek consultation with the Trust’s Risk Management Advocate Dr. Eric Harris. To set up a free confidential consultation with the Trust Risk Management Advocate, please call (800) 477-1200. APA members who are not insured through the Trust but are APA special assessment payers should contact the APA Practice Organization for assistance.