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All Medicare fees are par, office, national unless otherwise noted.

Benchmark of the week

Target 6 core strategies to overcome TCM code denials, secure payment

A look at 2013 Medicare claims data reveals high denial rates for the new transitional care management (TCM) codes, but you can secure your reimbursement by billing on the correct day, ensuring you're the only provider submitting a TCM claim and other key strategies.

Recently released claims data from CMS show a 36.3% denial rate in 2013 for code **99495** and a 38.5% denial rate for **99496** — the more complex of the two TCM codes.

*(see **TCM codes**, p. 5)*

Billing

On flu shots, check patient eligibility, bill correctly, appeal low payments

Now that it's flu shot season, here are seven tips to not only bill vaccinations correctly, but also get clarity with payers to avoid denials and underpayments.

- **Choose codes based on vaccine and method of administration.** For example, the type of vaccine and how the patient receives it determines whether to bill **90654** (Influenza virus vaccine, split virus, preservative free, for intradermal use) or **90662** (Influenza virus vaccine, split virus, preservative free,

*(see **Flu shots**, p. 7)*

Compliance

Configure deals to ensure physicians avoid inducements, legal trouble

Help your doctors avoid deals that could snare them in an enforcement net.

After accusations by the U.S. Department of Justice of illegal kickbacks, DaVita Healthcare Partners has agreed to pay a $350 million settlement. While the feds haven't so far gone after the physicians involved in the case historically, "the government has said that it is going after those who receive kickbacks as well as those who pay them," says Mark Pastin, president of the non-profit Health Ethics Trust in Alexandria, Va.

DaVita Healthcare Partners, which runs DaVita Kidney Care, settled with the Justice Department over joint ventures the kidney care provider had contracted with an unknown number of medical providers. DaVita targeted physicians who were "young and in debt" as well as "significant patient populations suffering renal disease" and lured them into joint ventures on kidney clinics with the expectation that the physicians would be motivated to refer patients to DaVita clinics, the Justice Department claimed in an Oct. 22 announcement.

DaVita did not just count on ordinary self-interest to motivate these referrals, the Justice Department further claimed; they would also "manipulate the financial models used to value the transaction" to make the physicians more likely to sign and required them to also enter secondary non-compete and non-disparagement agreements that made them still more likely to refer to DaVita.

DaVita denied wrongdoing but will pay $350 million "to resolve claims that it violated the False Claims Act by paying kickbacks to induce the referral of patients to its dialysis clinics," the Justice Department said. DaVita will also sign a corporate integrity agreement and accept an independent monitor to oversee future joint ventures.

Keep volume, value of referrals out of deal

Part of the "smell test" for a partnership is whether the value or volume referrals are instrumental to the deal, says W. Brenda Tso, an associate with the Khouri Law Firm in Dallas. "If a provider is making money off the [business] arrangement and referrals benefit the arrangement, then the situation is probably a violation," she says. The Justice Department clearly thought this was the case here, with U.S. Attorney John Walsh calling it "a sophisticated scheme to compensate doctors illegally for referring patients."

In those cases, both sides in an arrangement that violates the anti-kickback statute "face potential prosecution and civil monetary penalties," says Rick Hindmand, an attorney with McDonald Hopkins in Chicago.

Find a safe harbor

The current regulatory "safe harbors" allow some ways to generate income for providers — as, for instance,

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with certain in-office ancillary services that are exempt from Stark law, Tso mentions (*PBN 10/27/14*). She notes the case of 21st Century Oncology in Florida, which is being investigated by HHS' Office of Inspector General (OIG) for its providers' tendency to recommend the expensive fluorescence in situ hybridization (FISH) test, administered in its own offices.

21st Century Oncology has an arguable case for claiming safe harbor via the in-office ancillary services exception, though they "may still get into trouble because the medical necessity of the service comes into question," Tso says. DaVita, on the other hand, violates several safe harbor requirements right off the bat by rigging its financial models, according to the Justice Department.

How not to get stung

If you're going to enter into deals that involve patient referrals, here are two things to keep in mind:

- **No inducements, even faux inducements.** "You should accept nothing in terms of an exchange in value that could be construed, even incorrectly, as an inducement for referrals," says Mark Pastin, president of the non-profit Health Ethics Trust in Alexandria, Va. "There are cases working their way through the legal system right now where the alleged inducement is no more or less than food and team jackets. No matter how innocent something may seem, nothing you are likely to receive is worth the risk of getting involved in an enforcement net."
- **Keep it at fair market value.** Even without the secondary agreements, DaVita made itself a target by fiddling with the market valuation of its properties to make them more attractive to the physician, says Tso. The concept of fair market value is key to Stark law and other similar regulations, so overpayment for services — or undervaluation of assets, as the Justice Department says DaVita did with its own properties to slip discounts to providers — is a tip-off to investigators of an inducement.

So if, for example, a physician is offered a medical directorship as part of such an arrangement, make sure you can defend the remuneration as something the physician would have received regardless of investment status. — *Roy Edroso (redroso@decisionhealth.com)*

Practice management

Improve employee productivity with proper tracking, growth opportunities

Set relevant employee goals — but also encourage achievements that go beyond the expected — to create employee performance tracking processes that not only measure but can actually improve productivity of non-clinical staff.

Employee performance and productivity is vital to the success of your practice, says Jill Schwieters, president of Cielo, formerly Pinstripe Healthcare, a talent management solutions company in Brookfield, Wis. "You invest in talent," she says. "You spend a lot of time sourcing, interviewing and finding them — it's just good ROI to cultivate that."

Before tracking performance, the practice and employee need to have clear goals and expectations.

Start with an employment policy vetted by an attorney specializing in labor law. The terms of such policies are in most regards cut and dried — for example, about to whom the employee reports — and often are worded to explain what the practice does *not* promise the employee. One practice's policy obtained by *Part B News* says: "A satisfactory performance review does not guarantee continued employment. Performance reviews and salary reviews do not necessarily correspond in time."

Next, devise a way of tracking employee performance. This typically includes an annual evaluation with a form that has clear performance measures and a section that provides opportunities for the employer and the employee to give feedback, says Schwieters.

On what basis do you judge the employee? On clear goals and expectations that both parties agree on and which are included in the employee's file, says Schwieters. These goals and expectations should relate to the practice's needs and be adjustable year to year to drive improved performance. Depending on the practice's own business performance, you may expect employees to exceed their previous year's performance — or, in the case of new employees, the practice's per-capita average in their department — or set more modest goals if general performance is lagging due to non-productivity factors, such as a business downturn.

Examples of job rating metrics

Compliance officers. "Very clear clinical and regulatory guidelines" determine success or failure, and their completion would obviously be part of their performance rating, says Schwieters. But you can't just say that the officer has met expectations if the practice managed not to get sued or fined. Conversely, the office may be doing a great job even if the practice has been charged with fraud through no fault of his or her own.

So you can develop metrics that reflect the relationship of the officer's performance to the practice, says Schwieters — for example:

- **Efficiency.** How efficiently did the officer achieve compliance compared with the previous year? Were more or fewer staff hours or budget outlays required to achieve this than in the previous year?
- **Involvement.** Did he or she improve participation and awareness rates? Measure that metric by surveying employees.

Front desk personnel. Remember than this is a customer service job and devise performance tracking accordingly. "They're your public face," says Schwieters. So track metrics relating to that:

- **First-call resolution.** "Are they getting callers what they need?" says Schwieters. "Or are they just passing them along?" Your phone service provider or an "interactions management" company can help with measurement of this; you also may choose to have employees gather data themselves by asking callers at the end of the encounter whether their issue was resolved and noting it on a call sheet created for the purpose.
- **Average patient wait time.** Your phone service provider can help with this.
- **Patient-satisfaction ratings.** These can be done by patient survey.
- **Number/percentage of copays collected.** This is easy to track, although you should be collecting copays at every encounter (*PBN 5/19/14*).

Have clear goals but be flexible

While it's good to have clear job descriptions, don't leave employees to stagnate in those roles. If you don't give them opportunities to take on new or altered responsibilities, they'll be bored and less productive.

Employees rise to challenges more readily than you'd think, even when the challenge is outside their job descriptions, says Charlene Mooney, practice consultant for Halley Consulting Group, a physician practice management and consulting firm in Westerville, Ohio.

"When I ask employees, 'What do you want to work on?' a lot of times they're interested in other things in the office — and if they're interested, they might do a better job," says Mooney.

For example, when one of Mooney's cardiology practice clients was having trouble getting referrals, they told one of their front desk staffers, "we're giving you a research project." She was asked to contact local referring physicians and to get input on how the office is doing in their estimation. "She got great info and presented it as a spreadsheet," says Mooney. That was reflected positively in her performance review and salary adjustment.

So when extra work has to be done, whenever possible make it into a personal project for an employee with the time and skills to handle it, she says. Give these projects a time frame, says Mooney, and look in part-way through to see how they're doing.

Add other feedback to evaluation

To flesh out the performance picture, collect all performance-related data and add it to the employee's file — not just incident reports and attendance records but also positive and negative comments from patients, fellow staff and physicians whenever they come to the manager's attention, Mooney recommends.

That gives a sense of how the employee performs throughout the year, not just at crunch time. "When you appraise someone's performance, most people can only remember the past few months," Mooney explains.

Use ongoing coaching to motivate staff

Don't discount the role of simple encouragement in getting workers to perform better. "People like feeling valued," says Mooney. "It keeps them motivated. Recognition and rewards are not always money — a pat on the back, a call-out in a staff meeting can help." It helps to get physicians to do the thanking too, notes Mooney.

Managers also should meet frequently with employees to check progress, address concerns and make adjustments as needed.

"Evaluation is a once-a-year, have-to-do thing," says Schwieters. "But good leaders constantly coach their people to keep their development going." — *Roy Edroso (redroso@decisionhealth.com)*

TCM codes

(continued from p. 1)

General practice physicians bore the highest denial rates for both codes: a 49% denial rate for 99495 and a 46% denial rate for 99496. (*See denial rates for specialties that billed TCM codes the most in the benchmark, below.*)

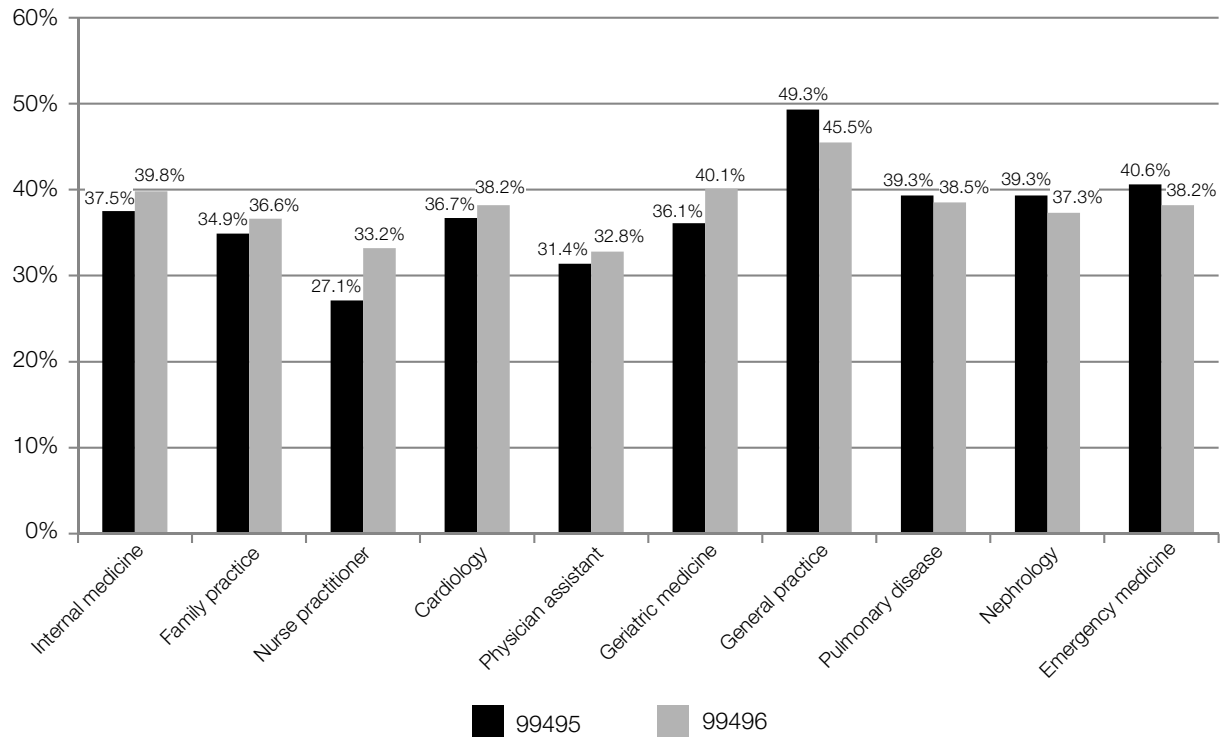
You're losing out on a good chunk of reimbursement dollars if your TCM claim is denied and you're left with an E/M claim. Nationally, 99495 pays $164.07 per claim, and 99496 pays $231.77. For established patients — whom you would most likely see following a hospital discharge — the net gain for billing the TCM code in place of the E/M claim is $56.24 for 99495. The difference jumps to $87.40 for the more complex 99496.

Pay attention to avoid common problems

"There are a lot of reasons that [Medicare] can deny TCM without looking at the claim," says Betsy Nicoletti, president, Medical Practice Consulting, Springfield, Vt. First, understand the details surrounding documentation and use correct filing procedures, including:

- **Heed the 30-day date range** and bill on the 30th day after discharge. Experts cited the date-range issue as one of the leading culprits of deniability. The TCM codes follow a 30-day period, with day one being the day of discharge. The period runs for 29 days after that. For a patient who is discharged from the hospital Dec. 1, the filing date must occur on Dec. 30. "It has to be dated on day 30 or it won't pay," says Nicoletti.
- **Make sure you are billing exclusively** to guarantee that your claim is the one paid out. "Different practices and specialties are crossing over themselves and not communicating with each other on who's to use the code and who's not," says Valerie Rock, CHC, CPC, ACS-EM, manager, Pershing Yoakley & Associates, Atlanta. Only one physician can bill and be reimbursed for the TCM codes. Medicare will reimburse the first-reviewed claim and deny others that may come in, so be sure you are taking control of the transitional care service — and letting other providers as well as the patient know that.
- **Don't bill a TCM code if the patient dies within the 30-day period.** In the event a patient passes away in the midst of the transitional care service period, your

TCM code denial rates for 10 specialties that bill 99495-99496 most often



Source: Part B News analysis of 2013 Medicare claims data

claim will not be paid if you bill a TCM code. If this happens, "you have to go back and bill them as E/M visits," advises Amy Dunatov, MPH, FACMPE, CCS-P, ICDCT-CM, director of coding services, MSOC Health.

Provide the correct services, track transitions

Other factors also can lead to TCM denials, experts told *Part B News*. Adhere to the service requirements of the respective TCM codes, which each encompass three main components:

TCM code	Services required
99495	▶ Communication with the patient and/or caregiver within two business days of discharge. ▶ Medical decision-making that is at least moderate complexity. ▶ A face-to-face visit within 14 calendar days of discharge.
99496	▶ Communication with the patient and/or caregiver within two business days of discharge. ▶ Medical decision-making that is considered high complexity. ▶ A face-to-face visit within seven calendar days.

For both codes, the first point of contact with the patient and/or caregiver can take place in person, via telephone or electronically.

- **Do not bill the TCM code if the patient doesn't transition to his home.** If a patient goes from one facility to another, such as inpatient to skilled nursing, then do not bill the TCM code. Also, the TCM codes do not cover a discharge from the emergency room, which is a common misconception, says Nicoletti. The TCM codes are suitable for patient transitions between the acute care setting and the patient's home. The TCM codes cover inpatient admission to home, observation services to home and skilled nursing facility to home.

- **Use your judgment to bill a TCM code if a readmission occurs.** If a patient is readmitted to the hospital during the 30-day time period, you have two options: Bill for the 30-day TCM service based on the initial discharge date or wait for the new discharge date to begin the 30-day period. You are not allowed to file two TCM claims if a hospital readmission occurs during the 30-day window.

- **Bill an E/M claim for any office visit that your patient makes beyond the one requisite visit associated with TCM services.** Because the TCM service covers one office visit, "any other encounters within that 30-day period can be billed separately as E/M visits," advises Dunatov. If a patient visits the office three times within 30 days of discharge, for example, you can bill for the TCM services plus two additional E/M visits.

— Richard Scott (rscott@decisionhealth.com)

Coding

Modifier 91: Find solution to denials triggered by lab service modifier

A sharp increase in utilization, revenue and denials for claims associated with the modifier for repeat lab tests could combine to expose anesthesia and pain management practices to scrutiny, overpayment demands and fraud allegations.

Modifier **91** (Repeat clinical laboratory diagnostic tests) should be used only in certain, limited instances. However, a *Part B News* analysis of Medicare's utilization data suggests that doctors need to proceed with caution when they use the modifier — claims billed with it have a 22% denial rate.

To curb denials and reduce your audit exposure, remind staff of the rules for modifier 91. "There are times when it is necessary to perform the same test during the same calendar day," says Joan Gilhooly, MBA, CPC, CPCO, president, Medical Business Resources, LLC, Cincinnati. For example:

- A patient who is severely anemic needs a transfusion. The doctor orders a complete blood count or CBC (**85025**) at the beginning of the treatment. Some number of hours later, the doctor orders a second CBC to see whether the transfusion has helped. The coder would append modifier 91 to the second CBC.
- A patient receives a basic metabolic panel (**80047**) in the morning and all of his levels are normal. In the afternoon, he has symptoms of hypoglycemia and the doctor orders a glucose test (**82947**). Because blood glucose is part of the basic panel, the coder has to append modifier 91 to the glucose test.

You're repeating the test or some component of the test because you need to see how the patient is doing, Gilhooly says. You append modifier 91 to tell the payer the subsequent tests are necessary to treat the patient.

Guidance from the CPT manual, Medicare and private payers all emphasize you should not use modifier 91 for the following circumstances:

- To rerun a laboratory test to confirm results.
- When there were testing problems for the specimen.
- When there were testing problems with the equipment.
- When another procedure code describes a series of tests.
- When the procedure code describes a series of tests.
- For any reason when a normal, one-time result is required.

For example, utilization data show doctors enrolled as anesthesia, interventional pain management and pain management specialists reported modifier 91 with codes such as quantitative drug screen **80154** (Benzodiazepines), quantitative chemistry test **82542** (Chemical analysis using chromatography technique) and chemistry test **83925** (Opiate[s], drug and metabolites, each procedure). Repeat testing of these codes would rarely fit the requirement for modifier 91.

Guidance from carriers may be one reason for the uptick in the use modifier 91. CPT Assistant, September 2013, warns that carrier instructions to use modifier 91 on every lab code that is reported more than once on the same day are not correct, so even if you received payment in the past, you may have noticed an increase in denials at the end of last year.

Gilhooly believes that confusion over when to use modifier 91 and when to use modifier **59** (Distinct procedural service) is another contributing factor. For example, a provider who tests three different analytes that don't have their own codes may report a code with modifier 91. That would not be correct. They should report 82542 once and 82542-59 twice, Gilhooly says.

Modifier 91 indicates you did the same test on the same analyte more than once per day. Modifier 59 indicates you did a completely different service but are using the same code, Gilhooly says. — *Julia Kyles (jkyles@decisionhealth.com)*

Flu shots

(continued from p. 1)

enhanced immunogenicity via increased antigen content, for intramuscular use).

This season's appropriate codes for Medicare billing are listed at *www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html*. Other carriers regularly update theirs.

Also, don't miss that these codes change every year, warns Maxine Lewis, CPC, owner, Medical Coding & Reimbursement, Cincinnati. "I had one practice a couple of years ago lose their entire reimbursement for flu shots because the codes had changed that year, and it was not financially feasible to resubmit all of them again," she says.

• **Remember to bill the administration code in addition to the vaccine code.** For Medicare, it's **G0008** (Administration of influenza virus vaccine). Some private payers instead use **90471** (Immunization administration [includes percutaneous, intradermal, subcutaneous, or intramuscular injections]; 1 vaccine [single or combination vaccine/toxoid]), says Lewis.

• **Use diagnosis code V04.81 on the claim.** V04.81 (Need for prophylactic inoculation and immunization again certain viral disease Influenza) is appropriate for when patients receive the flu shot only. Bill **V06.6** (Pneumococcus and influenza) if you're adding the pneumonia vaccine for at-risk patients.

• **Document allergy status** if you've prescribed an albumen-free or antibiotic-free vaccine for a patient. Note the allergy that informed your choice in the documentation; it goes to medical necessity and may head off a denial, Lewis says.

• **Ensure patient birth dates match the requirements of the codes.** A lot of immunization codes are age-specific, warns Sue (Sunni) Patterson, co-founder of revenue cycle management consultants RMK Holdings in Chicago. For example, **90685** specifies children ages 6 months to 35 months of age. Don't try billing the code for a 10 year old, says Patterson. Your coders may miss it, but your payer won't. Also watch administration forms, such as intranasal and intramuscular, and dosages.

• **Watch the payment.** This is not just for vaccines with listed prices — though payers will sometimes underpay on those too, says Patterson. In some cases, vaccine prices are left up to the carrier. You'll notice this year CMS lists pricing for **Q2039** (Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use, not otherwise specified) as "payment allowance is to be determined by the local claims processing contractor."

You can get a pretty good idea of what these prices should be by looking at your historical pricing for these drugs, Patterson says. If current reimbursement is significantly less, you may want to appeal, she says. She adds that payers do sometimes adjust these claims under appeal.

• **Manage patient expectations.** Flu shots are one of those things patients expect to get for free — even if their insurance policies have changed so that they won't. Make sure they know about that before they get the shot to avoid problems collecting the patients' payments, says Patterson. — *Roy Edroso (redroso@decisionhealth.com)*

Editor's note: *Lock in full reimbursement for pneumonia, influenza and hepatitis B vaccinations as well as other common injections with tips from the Nov. 6 webinar* ***Proven coding strategies to ensure full payment for common injections.*** *Learn more at* www.decisionhealth.com/conferences/A2547.

Part B News briefs

• **Justice Department steps up use of the False Claims Act to prosecute health care fraud.** The department implemented a new procedure so that all new whistleblower cases accusing providers of violating the False Claims Act, which are filed with the department's civil division, now will be shared with its criminal division as soon as the cases are filed to determine whether a parallel criminal investigation should be opened. Previously, the Justice Department had the option to review False Claims Act cases filed by whistleblowers for both civil and criminal liability, also called dual review, but often did not do so. While the department can impose civil monetary penalties under the civil provisions of the FCA, the department's criminal division can impose prison time and freeze a provider's assets, which would significantly increase the consequences of such an investigation. The department also noted in its speech announcing this procedural change that it is committing more resources to False Claims Act investigations, that it was not going after just "low-hanging fruit" and that physicians were not immune from investigation. Learn more at *www.justice.gov/criminal/pr/speeches/2014/crm-speech-140917.html*.

• **Recovery auditors collected $3.65 billion in overpayments in fiscal year 2013** and $102 million in underpayments, according to CMS' latest report. Part B claims made up 30% of the claims reviewed. The recovery auditors collected more than $56 million from physicians and returned about $1.2 million in underpayments to them. Of claims undergoing prepayment review, 58% were found to be improperly billed. For more information, visit *www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2013-Report-To-Congress.pdf*.

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