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PAYMENT OPPORTUNITIES YOU MAY HAVE OVERLOOKED

THE FIRST STEP TO IMPROVING YOUR BOTTOM LINE IS TO MAKE SURE YOU BILL FOR THE SERVICES YOU ARE ALREADY PROVIDING.

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This is a corrected version of the article that appeared in print.

Letting reimbursable services go unbilled is something few family physicians can afford, yet we all do it. In some cases we decide that documenting and coding for a particular service is more trouble than it's worth, or we may simply misunderstand the billing requirements. But as our profit margins grow ever narrower, it's especially foolish to leave money on the table.

Determination and disciplined coding and documentation can make a noticeable difference in your revenue. This article focuses on six types of services you may already be providing but not getting paid for. Here's what you need to know to start getting paid more today.

1. Tobacco cessation counseling

Medicare Part B has covered smoking and tobacco cessation counseling for more than three years, but some physicians have yet to catch on to this billing opportunity. Medicare provides coverage for patients who use tobacco and have "a disease or an adverse health effect that has been found by the U.S. Surgeon General to be linked to tobacco use, or patients who are taking a therapeutic agent whose metabolism or dosing is affected by tobacco use."¹ Medicare will pay for two quit attempts per year. Each can include up to four intermediate or intensive sessions.

Three minutes or less of counseling for smoking and tobacco cessation is considered by Medicare to be included in reimbursement for the standard evaluation and management (E/M) office visit. When billing for *more than three minutes* of smoking and tobacco cessation counseling, you may use the following codes:

- 99406: Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes. ►



DETERMINATION AND DISCIPLINED CODING AND DOCUMENTATION CAN MAKE A NOTICEABLE DIFFERENCE IN YOUR REVENUE.

■ You shouldn't let services go unbilled simply because they have complicated documentation requirements or because you don't think you use them often enough to warrant learning the rules.

■ The payments associated with the services described in this article can have a sizable impact on your bottom line.

■ Medicare pays separately for tobacco cessation counseling of more than three minutes when diagnosis codes describe the patient's condition or therapeutic agent affected by tobacco use.

- 99407: Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes.

Medicare's national average payment rate for 99406 is \$12.19; the average rate for 99407 is \$23.99. (See the next page for a summary of payments for these and other services described in this article.)

Medicare claims for smoking and tobacco cessation counseling must be submitted with diagnosis codes that reflect the patient's condition or therapeutic agent affected by the use of tobacco. Medicare will accept the following diagnoses for this purpose:

- Vascular disease, including coronary artery disease, hypertension, myocardial infarction, congestive heart failure, aortic aneurysm, peripheral vascular disease and cerebrovascular accident;
- Lung disease, including chronic obstructive pulmonary disease, chronic bronchitis, upper respiratory infection, asthma and pneumonia;
- Pregnancy complications, including low birth weight, premature birth, abruptio, previa, infertility, premature rupture of membranes and preeclampsia;
- Cancer of the mouth, throat, larynx, lung, esophagus, blood, bone marrow, stomach, pancreas, kidney, bladder or cervix;
- Cataracts;
- Peptic ulcer disease;
- Gum disease and tooth loss;
- Osteoporosis and related hip fractures;
- Conditions such as diabetes, hyperten-

sion, depression and deep vein thrombosis/pulmonary embolism, whose therapeutic agents are affected by tobacco.

Be sure to document the appropriate diagnosis codes in your note for the encounter along with the amount of time spent on tobacco cessation counseling, some details of the counseling and the context in which it was provided.

These services will almost always be provided in the context of a problem-oriented E/M visit on the same day. In addition to including 99406 or 99407, your claim should include the appropriate code in the 99201 to 99215 range with modifier 25 attached to show that the E/M service is significant and separately identifiable from the tobacco cessation counseling.

If tobacco cessation counseling was the main purpose of the visit, you should bill an office visit code based on time, since CPT rules allow for time-based coding when counseling or coordination of care is the predominant focus of the visit.

See "An Update on Tobacco Cessation Reimbursement," *FPM*, May 2006, for more information about payments from private payers; unfortunately, many payers do not allow this service to be separately billed. Also, the January/February issue of *FPM* will feature an overview of Medicare's preventive service policies, along with a tool for keeping track of what's covered.

2. Home health certification

Primary care physicians usually do not get paid for the non-face-to-face care we provide, so we have to make the most of the few billable codes that actually compensate us for this work. HCPCS codes G0180 and G0179, which represent home health certification and recertification, are two such examples. Both are reimbursed by Medicare. (Care plan over-

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sight codes are also in this category and will be discussed later in the article.)

The covered service is reviewing and signing the CMS 485 (formerly HCFA 485) form once every 60 days. Everything else done for the home health patient during this period is covered by the care plan oversight codes. For certification, payment is comparable to what Medicare pays for a level-III visit. For recertification, payment is less, but still more than for a level-II visit.

The certification code, G0180, is reimbursable if the patient has not received Medicare-covered home health services for at least 60 days. The service includes the following:

- Review of initial or subsequent reports of patient status,
- Review of the patient’s responses to the Oasis assessment instrument,

- Contact with the home health agency to ascertain the initial implementation plan of care,

- Documentation in the patient’s record.

The recertification code, G0179, may be submitted when the physician signs a subsequent CMS certification form after a patient has received services for at least 60 days. Code G0179 may be reported only once every 60 days, except in the rare situation when a patient starts a new episode before 60 days elapse and requires a new plan of care.

It takes a systematic effort to make sure you capture the documentation necessary to bill for these codes. In my practice, every time we receive a CMS 485 form in the mail for one of my patients, my nurse prints a charge sheet and attaches it to the form before forwarding it to me. I review and sign the form. If there are no changes in the care plan, I document

When submitting claims to Medicare, use the diagnosis codes that Medicare associates with the service codes.

Medicare pays for home health certification and recertification even though this is not face-to-face care.

These codes pay for reviewing essential information and completing the required form once every 60 days.

A BOOST TO YOUR BOTTOM LINE

Payments for the services described in this article are sizable enough to make it worthwhile to learn the rules and bill for them.

HCPCS or CPT code	Brief code descriptor	Average payment
99406	Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	\$12.19
99407	Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes	\$23.99
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	\$35.04
Q0091	Screening Pap smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory	\$40.37
G0102	Prostate cancer screening; digital rectal exam	\$19.81
G0103	Prostate cancer screening; prostate specific antigen test	\$25.70
G0180	Physician certification for Medicare-covered home health services under a home health plan of care (patient not present)	\$58.27
G0179	Physician recertification for Medicare-covered home health services under a home health plan of care (patient not present)	\$44.56
G0181	Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present)	\$103.98
G0182	Physician supervision of a patient under Medicare-approved hospice (patient not present)	\$107.79
99356	Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service, 30 minutes to one hour (list separately in addition to code for inpatient E/M service)	\$81.51
99357	Each additional 30 minutes of prolonged service (list separately in addition to code for prolonged physician service)	\$81.89

Note: Payments listed are based on 2008 Medicare national average, not adjusted geographically. Private payer policies vary.

using a standard template: “CMS form, care plan and patient’s chart reviewed. Probs, meds and treatments remain accurate. Care plan is approved. Recertify every 60 days as needed.” If there have been significant changes to the care plan, I mention them in the note. In most years, payment resulting from my claims for recertification alone adds up to several thousand dollars in revenue.

For more information about getting paid for home health certification and recertification, see “An Update on Certifying Home Health Care,” *FPM*, May 2001.

3. Home health and hospice care plan oversight

Care plan oversight (CPO) for home health and hospice patients is another non-face-to-face service you can bill and be reimbursed for by Medicare. Physicians often provide this service but do not bill for it because the rules are complicated. However, the payment rates (\$103.98 for G0181, home health CPO, and \$107.79 for G0182, hospice CPO, on average) make it worthwhile to learn the rules, document your time and bill for these services.

Patients are eligible to receive CPO services if they require complex treatment, are being cared for by multidisciplinary teams and are under the care of a Medicare-approved home health agency or hospice. CPO services must be personally furnished by a physician or non-physician practitioner and must total at least 30 minutes in a calendar month.

The following work qualifies as CPO:

- Reviewing charts, reports and treatment plans;
- Reviewing diagnostic studies if the review is not part of an E/M service;
- Talking on the phone with other health care professionals who are not employees of the practice and are involved in the patient’s care;
- Conducting team conferences;
- Discussing drug treatment and interactions (not routine prescription renewals) with a pharmacist;
- Coordinating care if physician or non-physician practitioner time is required;
- Making and implementing changes to the treatment plan.

The following work does *not* count as CPO:

- Telephone calls to the patient or family;

- Time spent phoning in prescriptions;
- Informal consultations with health care professionals;
- Services initiated as part of other E/M services;
- Services to any patients in nursing facilities or skilled nursing facilities;
- Activities related to certification/recertification, i.e., signing the CMS 485 form.

I’ve tried various ways of capturing the time I spend on CPO services. A system that works for many physicians is to maintain a list of the names of patients for whom home health or hospice services are provided each month. (This list reminds the nurse which charts to pull at the end of the month when it’s time to submit claims.) They keep a log in each patient’s chart on which they document the date, a brief description of the CPO services and the minutes spent providing them. At the end of the month, the nurse pulls the charts and adds up the time.

Another system is to keep copies of each lab report, message or other documentation involving CPO services. Note on each the CPO purpose and time spent in the activity, then file them alphabetically. At the end of the month, sort them by name and add up the time.

If the CPO services for an individual patient add up to at least 30 minutes for the calendar month, bill for them using the start and end dates of the month as the service dates and the provider number of the home health agency/hospice as required on the form.

The CPT manual defines CPO using six CPT codes, 99374 through 99380. Check with your private payers to find out whether they pay for these services; many don’t.

For more information about care plan oversight coding, see “How to Document and Bill Care Plan Oversight,” *FPM*, May 2005.

4. Medicare pelvic exams

Although Medicare does not pay for physicals, it does cover one screening pelvic and clinical breast exam for all female beneficiaries every two years. Whether you provide the pelvic exam in the context of treating a patient’s acute problem or along with a comprehensive review of her chronic condition, you should report HCPCS code G0101 for the pelvic exam, Q0091 for the collection of the Pap

■ Home health and hospice care plan oversight are particularly challenging to bill for, but the payment rates for these services are relatively high.

■ Medicare is specific about what qualifies as care plan oversight and what does not.

■ Systematic and careful documentation is the key to getting paid for care plan oversight.



MEDICARE PART B HAS COVERED SMOKING AND TOBACCO CESSATION COUNSELING FOR MORE THAN THREE YEARS, BUT SOME PHYSICIANS HAVE YET TO CATCH ON TO THIS BILLING OPPORTUNITY.

smear specimen, and the appropriate CPT code for the E/M service with modifier 25 attached. The Medicare deductible does not apply to this service.

One of the following diagnosis codes should be linked with the HCPCS codes, as appropriate:

- V72.31, General gynecological exam with or without Pap smear;
- V76.2, Special screening for malignant neoplasms, cervix;
- V76.47, Special screening for malignant neoplasms, vagina;
- V76.49, Special screening for malignant neoplasms, other sites;
- V15.89, Other specified personal history presenting hazards to health (patient who is considered high risk according to Medicare's criteria).

You should also keep in mind that Medicare may pay for a screening pelvic and clinical breast exam annually if the beneficiary falls into one of the following categories:

1. The patient is of childbearing age and has had an exam indicating the presence of cervical or vaginal cancer or other abnormality during any of the preceding three years;
2. The patient is considered to be at high risk for vaginal cancer as evidenced by prenatal exposure to diethylstilbestrol. The patient is considered to be at high risk for cervical cancer based on any of the following:
 - Early onset of sexual activity (under 16 years of age),
 - Multiple sexual partners (five or more in a lifetime),
 - History of a sexually transmitted disease (including HIV),
 - Absence of three negative Pap smears or complete absence of Pap smears within the previous seven years.

5. Prostate cancer screening

Medicare covers an annual prostate cancer screening test for men over age 50. Such tests include digital rectal exams (DREs) and prostate-specific antigen (PSA) blood tests. The code for DREs is G0102, and the code for PSAs is G0103.

Billing and payment for a DRE, however, is bundled into the payment for a covered E/M service when the two services are furnished to a patient on the same day. If the DRE is the only service provided or is provided as part of an otherwise noncovered service, HCPCS code G0102 would be payable separately if the other coverage requirements are met. With an organized effort, your practice could establish periodic prostate screening times and bring Medicare-age men in just for this service. This would be both efficient and covered by Medicare.

Use diagnosis code V76.44 ("Special screening for malignant neoplasms, prostate") when billing Medicare for either service. DREs are subject to the Medicare deductible; no coinsurance or deductible applies to the PSA test.

6. Prolonged services for inpatient care

CPT's prolonged service codes are meant to be reported in addition to E/M codes when the time a physician spends with a patient goes at least 30 minutes beyond the typical CPT-defined time for that service.

I'm occasionally able to bill for prolonged services in the inpatient setting using codes 99356 and 99357, which are for "prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service." Code 99356 is used for the first 30 minutes to an hour of service beyond the time associated with the primary

■ Medicare pays for pelvic exams, even though comprehensive preventive medicine exams are not covered.

■ You can bill separately for a pelvic exam provided as part of a problem-oriented visit.

■ You can be paid for providing annual prostate cancer screening tests for Medicare beneficiaries over age 50.



WE USUALLY DO NOT GET PAID FOR THE NON-FACE-TO-FACE CARE WE PROVIDE, SO WE HAVE TO MAKE THE MOST OF THE FEW BILLABLE CODES THAT ACTUALLY COMPENSATE US FOR THIS WORK.

code, and 99357 is used for each additional 30 minutes. The prolonged service doesn't have to be continuous, but it does have to be face to face. (See "Time requirements for billing prolonged services in the inpatient setting," below.)

For example, let's say you round on a patient in the morning and provide a 99232 subsequent hospital care service. You then return in the evening and have a conference with the patient and her family. Your total time could easily equal 55 minutes – 30 minutes more than the time CPT associates with the level-II subsequent hospital care service you provided. This meets the time threshold for billing prolonged service code 99356 in addition to 99232. If you had provided level-I subsequent hospital care service and your time totaled 45 minutes or more, you could bill 99356 and 99231.

It's important to document the required components of the E/M visit and be specific

about the face-to-face time spent in prolonged service.

As with care plan oversight, you need to be systematic in your efforts to record the time you spend seeing patients at the hospital. I've gotten in the habit of timing my notes, keeping track of the start and end times of my face-to-face contact with each patient as I round.

Get paid

The range of codes described in this article and the detailed rules that underlie them may seem ridiculously complex. We could focus on how crazy the system is, or even on the inadequacy of the payment amounts and the shortsightedness of the coverage limits; these points of view are worth sharing with those in a position to bring about change. But in the daily struggle to ensure the financial viability of our practices, we can't afford to miss these payment opportunities.

If you're providing any of these services but not billing for them, or if you're not sure whether you're getting paid or billing correctly for them, take action today. You'll soon be glad you did. **FPM**

Send comments to fpmedit@aafp.org.

1. Centers for Medicare & Medicaid Services. Decision memo for smoking and tobacco use cessation counseling (CAG-00241N). Available at: <http://www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=130>. Accessed Oct. 10, 2008.

■ Prolonged service codes can be reported in addition to E/M codes.

■ Prolonged service may be most common when rounding on hospitalized patients.

■ Get in the habit of noting the start and end times of your face-to-face contact with patients in the hospital.

TIME REQUIREMENTS FOR BILLING PROLONGED SERVICES IN THE INPATIENT SETTING

Medicare uses these times to determine whether prolonged service code 99356 can be billed with codes for initial and subsequent hospital care.

Inpatient hospital care codes	Typical time for code, per CPT	Threshold time to bill code 99356
Initial hospital care		
99221	30	60
99222	50	80
99223	70	100
Subsequent hospital care		
99231	15	45
99232	25	55
99233	35	65