DIVISION OF MENTAL HEALTH SERVICES

ADMINISTRATIVE BULLETIN 7: 20

EFFECTIVE DATE: August 26, 1997

SUBJECT: Medicare Part B Billing

I. Purpose

Since July 1, 1993, services provided by physicians to Medicare Part B eligible patients have been billed on a fee-for-service basis. A claim for each service provided is initiated by an attending or consulting physician, who provides documentation in progress notes, enters information on billing worksheets or, when applicable, makes direct entry into a computerized billing system (MediTrak). Because dramatic increases in revenue are possible with the increased involvement and commitment of Division executives, Chief Executive Officers and medical staffs, the purpose of this Administrative Bulletin is to establish policy, procedures and responsibility for this billing effort.

II. Policy

In order to maximize revenues for their services, state hospital physicians shall fully document in patient records the services that they provide Medicare Part B patients and potential Part B patients and shall also comply with any requirements that allow the hospital to bill for their services. Responsibility for documenting and claiming shall be extended to consultants and other non-salaried physicians providing services to patients. While there is no set requirement for frequency of billing, physicians who are providing quality patient care are expected to at least record every time they provide a service that is potentially billable.

The Division Director, Assistant Directors, Chief Executive Officers, Medical/Clinical Directors, and Chiefs of Psychiatry and Medicine must provide sufficient leadership to ensure that the documentation and claiming of services are a high priority within the medical staff. These managers must support this activity by providing adequate administrative staff, MIS resources and training. They shall also personally review the status of claiming activity for their organization and take corrective and/or disciplinary action when necessary.

III. Scope

This policy is applicable to those hospitals billing Medicare Part B.

IV. Definitions

Accredited Records Technician means an individual who receives certification through the American Health Information Management Association (AHIMA) in this title, and professionally trained to perform the various functions relating to the Health Information Management field.

Health Care Financing Administration (HCFA) means a Federal agency responsible for administering the Federal Medicare and Medicaid programs.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) means an independent organization which provides health care accreditation and related services.

Medical record is a compilation of documentation on pertinent facts of a patient's life and health history, including past and present illness(es) and treatment(s), written by the health professionals contributing to that patient's care.

Medicare means a Federal health insurance program available to people age 65 and older, for certain disabled people under the age of 65, and for people with End Stage Renal Disease.

Medicare Part B means an optional Medicare program which pays for physician services, outpatient hospital services, laboratory services, and a variety of other health services.

MediTrak means an electronic, computerized billing system used to submit bills for Medicare Part-B billable services to XACT Medicare Services (fiscal intermediary), for reimbursement of physician services rendered.

Performance Assessment Review (PAR) means a State of New Jersey rating system used to rate employee performance.

XACT Medicare Services means an independent fiscal intermediary which processes Medicare Part B claims.

CPT means Physicians' Current Procedural Terminology, published by the American Medical Association, as a coding classification system for procedures and services performed by physicians.

E/M code means the Evaluation and Management Services, which is the major

section of services rendered to patients by physicians.

ICD-9-CM means International Classification of Diseases, 9th Edition, Clinical Modifications, a coding system used for the classification of patient diagnoses and procedures.

V. Procedure

A. Physicians shall be responsible for the accuracy and timely documentation of all billable services that they provide to patients. They shall write legible progress notes that detail services, which at a minimum shall include the following:

1. Date/time
2. All diagnosis and/or symptoms currently being treated (reason patient was seen)
3. Whether face-to-face contact occurred
4. Procedure or course of treatment
5. Type of service (e.g., initial, subsequent or specific procedure referral).

If physicians provide services billable as an E/M code, they must also state the complexity (brief/moderate/high) and/or time spent.

B. Physicians shall be required to initiate reimbursement claims for these services through entry on worksheets or "super bills" or through alternate procedures established at each hospital including direct entry on MediTrak remote terminals.

C. Where available, Accredited Records Technicians (ARTs) or other qualified staff shall assist physicians in identifying billable services, in coding procedures and diagnostics, and in completing transactions and correcting rejections. They shall have the following functions:

1. Visits wards and reviews progress notes to determine if documentation is sufficient to support claims and if all eligible services have been claimed. Initiates corrective action and additional claims.
2. Provides ongoing feedback to physicians on problems found and periodically reports deficiencies to physician supervisors.
3. Codes the diagnoses for each billable service using ICD-9-CM.
4. Reviews billing worksheets and advises physicians of correct CPT procedure coding and alternative coding, or specifics of coding, that would result in greater revenue.
5. Meets with medical staff in small groups to discuss claiming problems and coding changes.

6. Develops and provides summaries and special reports of billing activity for management.
7. Reviews payment denials and takes corrective action.
8. Enters billing data in the MediTrak system.

D. Psychiatrists and specialty physicians are required to give complete, specific and accurate descriptions of diagnoses and procedures, and to respond promptly to all requests from the ART or other qualified staff to provide additional or corrected information.

E. Responsibility for documenting and claiming services shall be included in consultant agreements unless exceptional arrangements have been authorized.

1. When a hospital hires or contracts with a physician for remuneration to provide medical services to patients, the physician should understand that the right to bill third parties has been transferred to the State. He/she is required to complete an "Application for Individual Pennsylvania Blue Shield (XACT) Medicare Provider Identification Number", which will include that physician in the state institutional group practice.

2. The physician consultant is required to comply with procedures for documentation and recording of claim information. This responsibility will be extended to physicians providing services to patients who are being paid from another agency as part of a cooperative agreement.

3. If any physician consultant refuses to abide by these terms he/she shall be either terminated or required to enter into a new arrangement in which the State does not compensate him or her directly, because the physician has assumed responsibility for third party billing.

F. Billing issues shall be regularly discussed with medical staff.

1. Summary information and coding changes shall be routinely reviewed in small group discussions with the medical and psychiatric staff of each hospital.

2. At least quarterly, billing issues and coding changes and clarification shall be discussed at medical staff department meetings.

3. At least quarterly, summary information and problems related to billing shall be discussed as a regular agenda item of the Managing

Physicians meeting at DMHS.

G. Transactions entered by each physician shall be monitored, and claims and medical records shall be audited.

1. Standard monthly MediTrak transaction reports are available from MIS offices and MIS staff can access information for custom reports. Medical Directors and the Chiefs of Psychiatry and Medicine shall review these reports.

2. Claims and medical records shall be audited to determine if codes selected by physicians are appropriate, whether claimed services are adequately documented in the medical record, and whether all procedures documented in progress notes have been claimed.

3. Managing Physicians and Chiefs of Psychiatry and Medicine shall periodically review the above results in order to ensure that physicians are accountable in regard to their billing documentation and response to requests for additional claiming information.

H. In order to evaluate results and take corrective action, hospitals should review their billing systems by generating monthly transaction reports.

1. The brief monthly reports shall describe the total number of valid transactions made during the month and comparison data from prior months, as well as provide an explanation of any issues affecting the interpretation of this information.

2. Monthly reports shall be shared with Assistant Division Directors, including the Office of Fiscal and Management Operations, as well as with hospital staff involved in the billing effort.

I. The Managing Physician at each hospital shall be responsible for including billing duties in the PARs of physicians and for taking corrective actions against physicians who refuse to follow hospital procedures or who fail to respond to requests for billing information (ICD-9-CM or CPT Codes).

Alan G. Kaufman
Director

8/26/97