"Forgotten" Medicare Compliance Issues

IN A NUTSHELL

Loryn Einstein is the Managing Director at Medical Billing Experts.

Loryn Einstein shines a light on the "forgotten" Medicare compliance issues.

Most conversations I have with medical billing clients regarding Medicare compliance centre on item number specific queries that the doctor or practice raises. The focus of this article is the "forgotten" Medicare compliance issues that are just as important as the item numbers themselves.

The compliance and audit activities being run by the Department of Health are focusing as much on these "forgotten" issues as they are on item number usage and proper choice of item numbers to be billed.

COMPLETE MEDICAL SERVICE PRINCIPLE

The Medicare guidelines regarding the 'Complete Medical Service Principle' are the basis of many of the Medicare compliance activities in the last few years. The core principles are:

To bill any MBS item number, you must fulfil all of the service requirements as specified in the item descriptor.

The billing of MBS item 133 is a good example of an item number that has numerous service requirements that need to be fulfilled for billing purposes.

Item 133

Professional attendance of at least 20 minutes duration subsequent to the first attendance in a single course of treatment for a review of a patient with at least two morbidities (this can include complex congenital, developmental and behavioural disorders), where

a) a review is undertaken that covers:

- review of initial presenting problem/s and results of diagnostic investigations
- review of responses to treatment and medication plans initiated at time of initial consultation comprehensive multi or detailed single organ system assessment,
- review of original and differential diagnoses; and

b) a modified consultant physician treatment and management plan is provided to the referring practitioner that involves, where appropriate:

- a revised opinion on the diagnosis and risk assessment
- treatment options and decisions
- revised medication recommendations

The service requirements that must be fulfilled before billing an item 133 include:

- A professional attendance of at least 20 minutes duration; and
- Patient must have at least two morbidities; and
- A review must be undertaken of the items listed in a); and
- A modified consultant physician treatment plan is provided to the referring practitioner including the information listed in b); and

Per Medicare Benefits Schedule Note AN.0.23

- If appropriate, a written copy of the physician treatment and management plan should be provided to the patient; and
- Preparation of the consultant physician treatment and management plan should be in consultation with the patient; and
- If a GP management plan or Team Care Arrangement is in place, the treatment and management plan should augment the GPMP or TCA for that patient; and
- The modified consultant physician treatment and management plan should address the specific questions and issues raised by the referring practitioner and should include:
  - Comprehensive patient history
  - The clinically relevant findings of a full multi-system or detailed single organ system assessment
  - Diagnosis based on information obtained from the history and medical examination of the patient
  - A plan regarding the follow-up of issues and/or conditions, including an outline of the recommended intervention activities and treatment options.
  - Medication Recommendations
  - Social issues and recommendations for addressing them
  - Life style changes including exercise and diet, any rehabilitation recommendations and discussion of any relevant referrals to other health providers.
  - Indications for further review
  - Recommendations for longer term management

In the 2017/2018 financial year, Physicians across Australia billed a total of 750,625 item number 133's. When Medicare audits the use of this item number by Consultant Physicians (and similar item numbers for other practitioners), it is often the lack of either fulfilling or documenting fulfilment of all of the requirements of this item number that leads to the practitioner being ordered to repay the benefit paid for the items billed.

One of the most frequent errors made by doctors billing item 133 is failure to document the elements of the item in clinical notes and/or failing to provide a modified treatment plan to the referring practitioner. Even if the physician did complete all other requirements of the item number, the failure to document the actions taken at the consultation and/or the failure to communicate the required information with the referring practitioner is in itself grounds for Medicare to demand repayment of the benefit paid in relation to the billing of the item.

Where a comprehensive item is performed, separate items should not be claimed for any of the individual serves included in the comprehensive service.

One example of billing a comprehensive item number is when correcting a claw or hammer toe, item 49848 (correction of claw or hammer toe) should be billed. As item 50112 (correction of contracted joint) and item 49809 (foot tenotomy- cutting of the tendon) are an integral part of the operation for correcting claw or hammer toe, these item numbers should not be billed with item 49848.

It is also prohibited to bill individual item numbers where composite item numbers are available.

One example is that if both a right heart catheterisation (item 38200) and a left heart catheterisation (item 38203), the composite item number for right heart catheterisation with left heart catheterisation (item 38206) must be billed as the composite item number.

DOCUMENTATION REQUIREMENTS

Professional Services Review findings against practitioners often focus on the fulfilment of the Medicare requirements for record keeping. The Medicare guidelines require that for any MBS item number that you perform and bill for you must keep adequate, up to date records. In the case of a Medicare audit, clinical records will be reviewed to ensure that they include:

- Clear identification of the patient
- A separate entry for each patient attendance or service
- The date of service
- A clear explanation of the service provided
- Notes that are clear and legible enough that another health professional could take over the patient care based on that record

The notes must be created during or soon after the treatment or service occurred and can be in either paper or electronic form.

COMPLETE MEDICAL SERVICE QUICK CHECK

When you are choosing the most appropriate MBS item number to bill, ask yourself three questions:

1. Does the service rendered comply with all time and content requirements of the MBS item number descriptor;
2. Would a review by the majority of my peer accept that the treatment provided during the service was clinically appropriate for this patient?; and
3. Have I adequately document the service?

LOCUM-TENENS RULES

One of the most frequently forgotten Medicare rules is the locum-tenens rule. Most specialists do not realise that when they are providing weekend cover for their colleagues, that they are actually a locum-tenens and are thus restricted from billing initial consultations for patients seen in these circumstances.

When you provide weekend cover for your colleagues, you meet Medicare's definition of a "locum-tenens". Whilst you are able to bill subsequent attendances when providing weekend/locum-tenens cover of other doctors' patients, Medicare does not allow you to bill initial attendances as per the paragraph below from the MBS.

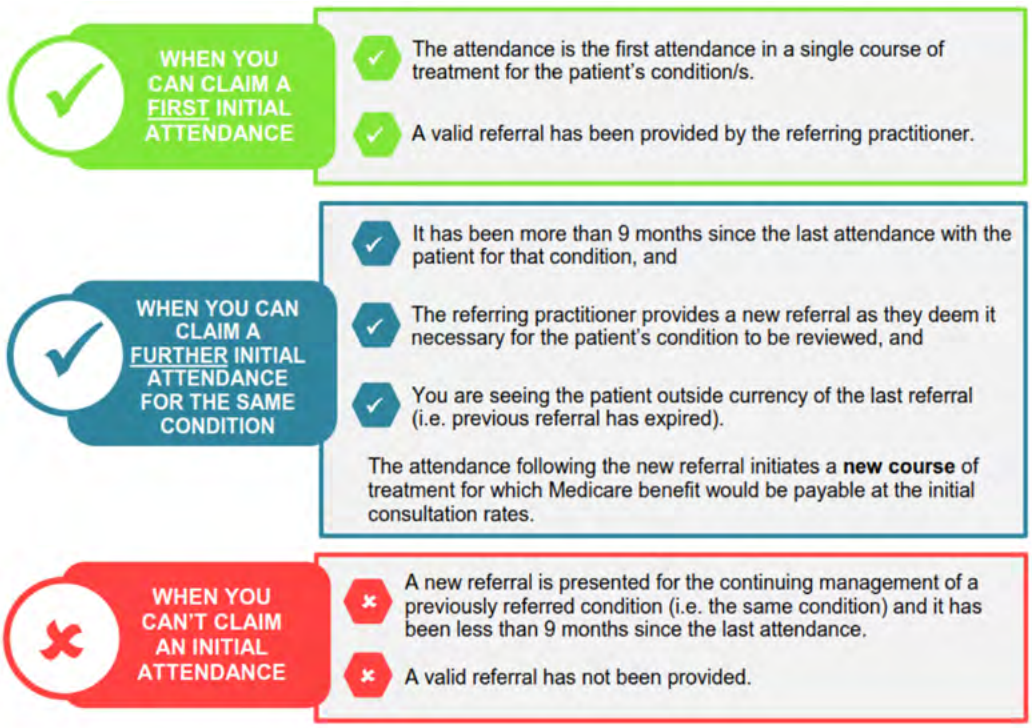
"Fresh referrals are not required for locum-tenens acting according to accepted medical practice for the principal of a practice i.e. referrals to the latter are accepted as applying to the former and benefit is not payable at the initial attendance rate for an attendance by a locum-tenens if the principal has already performed an initial attendance in respect of the particular instrument of referral."

If you are the primary specialist and/or the admitting specialist for the patient AND you comply with the below rules pertaining to initial attendances, you are able to bill an initial attendance.

The Department of Health is able to use electronic records to identify potential locum-tenens activity by electronically tracking multiple initial consultations performed on a singular patient during the course of a hospital admission.

Ultimately, it is up to you to ensure your medical billing is compliant with Medicare – and it isn't just a matter of getting the item numbers right.

Checklist for reviewing initial attendance items 104 and 110



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1300 809 484

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