Medicare Rules, Process and Basic Concepts in care – Provided through Butler County Mental Health and Addiction Recovery Services Board

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Goals of this Program

- To understand the differences between Medicare A, B, D and D and how these programs impact Mental Health and Addiction coverage
- To understand how these programs work and the responsibility of the providers to enroll with Medicare, to code and bill services correctly and collect appropriate co-payments
- To understand the “incident” to process when delivering services “under a credentialed provider” provided by a non credentialed provider
- Questions

The realities of BH/SUD Redesign

- When BH/SUD redesign the payment structure changes to match how all other providers in health care code, bill and are compensated for the care they provider. The reality of these changes was that the level of payment would not be the same as before.
- This change also meant that how care and services were provided would need to change including issues of:
  - Contracting with managed care plans
  - Modifying staff roles and process
  - Understanding the reimbursement rules (co-pay, deductibles, prior authorization, scope of practice and related rules).

The role of the "Board"

- The role of the "Boards" varies throughout the state based on the specific county where services are provided
- Funding varies by county based on specific levies, grants and other sources of revenue for BH/SUD services
- Not all boards pay or cover services in the same way
- Boards are to be the payment of last resort for non covered clients and specific types of services not covered
- The Board process was not meant to subsidize agencies to the prior level of reimbursement by the Medicaid programs – but to support services needed by clients and provided by agencies

Issues to consider…

- All agencies do need to rethink….

  - How services they provide can be delivered and managed based on client need, at the highest method of correct coding and reimbursement
  - Staffing review of productivity and client care needs
  - Re-thinking how the care is provided – and think outside the box to identify other opportunities in the care model for both outcomes and reimbursement
  - Review each position within the agencies to identify the process for financial coverage of their role or is it a non compensated role (and why)

The Board as "Payer of last Resort"

- The Board is the payer of last resort and as all Boards adapt to help agencies provide client care and service, the Board needs to know how you provide care, what "lapses" in reimbursement are "out there" and how the agency is attempting to manage this process

- The prior methods for Board support may not be the future methods

Medicare…

- Medicare is the federal program that covers patients/clients who are retired or disabled.
- Medicare has a number of options that cover specific parts of the client/patients health care
- Medicare patients pay a premium for Part B/C and D either directly or it is deducted from their Social Security check
- Medicare providers each patient, every year, a review of the rules of being covered by Medicare – including identifying non covered services, the importance of co-payments and deductibles as well as the responsibility to provider Medicare cards and identification.

Part A

- The part A portion covers the inpatient care and some services in a skilled nursing facility, dialysis center and other "building" locations. There is a deductible of $1408 in 2020 (this changes every year)

- A patient cannot "opt out" of Part A – but they may or may not have an insurance plan to cover co-pays, deductibles and non covered services for facility care.

Part B

- Part B is the traditional coverage for outpatient and professional services, that includes physicians, nurse practitioners, physician assistants, LISW and clinical psychologists
- The lowest premium for this coverage in 2020 is $144.60
- The annual deductible is $198.00
- As of 2020 non of the traditional Medigap plans are allowed to cover the full 100% of the patient's co-pay and deductible if they become Medicare eligible in 2020.
- There are a number of rules Part B has in place to cover care and services

Part B rules

- All providers must be enrolled with Medicare Part B (per CMS and Ohio BH/SUD redesign) no matter what
- The providers who are eligible for enrollment include: physicians(MD, DO); mid level providers (APN, NP, CNP, PA), and licensed clinical social workers(LISW), licensed Psychologists (clinical)
- Services must be coded and billed using standard CPT and ICD 10 codes that are as specific as possible to reflect the service as provided and to support medical necessity
- The documentation of care must follow the standards within the CPT code language, governmental rules and publications as well as in accordance with state law.

More Part B rules…

- Patients with Medicare know they have a co-pay and deductible and with the exception of a Medicaid co-insurance, they are required by law to pay their share of care with this co-pay and deductible.

- Waiving of the copay must be based on individual status of the patient as indigent that is documented within the financial record of the patient

- Not collecting co-payments is a major compliance issue

Medicare Part B billing requirement

- Medicare requires that all covered services be coded, billed and submitted to the Medicare Part B intermediary within on year of delivery of care.
- If a services (CPST or non covered providers) is statutorily not covered based on the H code process, this can be submitted to the secondary plan or Medicaid.
- There is a new Medicare Opioid program for 2020 that will be reviewed later in February that allows for a wider range of providers than the traditional process.

Medicare Part B Collaborative Care model

- There is also a Psychiatric Collaborative Care Management coding process (CPT codes 99492-99493 and 99494) that can be coded by a CMHC if they have this model in place with the patient's primary care – this is coded on a monthly basis. This can be provided by CPST and other levels of staff with a physician/MLP

- 2020 Rates:
  - 99492 (initial set up) – first 70 minutes $ 148.90
  - 99493 (follow up month) first 60 minutes $120.26
  - 99493 (each additional 30 minutes) $60.97

Part C

- Part C is Medicare which a patient selects that covers the Part B services but is administered through a commercial insurance program – managed care. The patient must be enrolled with Part B to select a Part C managed care plan.
- These services may have additional premiums or not. They may have additional services that they cover (eye, dental, transportation, meals, housing modification, etc.) The specific items covered are based on the specific plan the patient selects

Part C rules and process

- As patients sign up for a Medicare Part C plan they are notified of the "providers available to them" and the process for specialty care, including "co-payments" (often higher in Part C plans)
- Providers need to be specifically contracted with the Part C Medicare Advantage plan – if they are not then they are considered to be "out of network" and the patient is fully responsible for the payment for services

Part C rules continued

- Some Part C programs enroll additional levels of BH and SUD providers based on their mental health and addiction coverage process – so each program in this category may cover
- The copayment cannot be waived and is required at each visit
- The managed care plan may cover the collaborative care plan codes (traditional Medicare)

Part C rules…

- Like commercial insurance plans, the Medicare Part C process requires referrals (from a PCP or other identified provider) and often prior authorization to cover services – and there may be time limits, need for additional authorization and provision of supporting documentation to support the care provided
- ISP, initial assessments and progress notes are often reviewed as part of this process

Part D

- The Medicare part D coverage is either through a commercial plan or through Medicaid. This is the specific plan that covers medications
- This part of Medicare has some limits based on the plan and may require authorization of certain medications.
- For certain medications, the Part D plan may require the patient to be enrolled in a “90 day” mail in program.
- There may be co-payments and deductibles for some medications based on the specific medication (non generic) and plan the patient has as a secondary

Eligible provider enrollment

- All providers who are eligible for Medicare must enroll for Part B and for Part C programs (even pediatric practices)
- This enrollment should be verified every year as Medicare does a “review” and revalidation on a regular basis
- The agency should also monitor the CAQH for insurance contracting, licensure issues and activity

Collection of amounts identified as "Patient Responsibility…"

- All patients/clients who visit each and every agency need to have their status verified with insurance, Medicare and Medicaid
- When the agency identifies the specific patient/client status this should result in education about their responsibility for payment of identified services and the necessary paperwork for services that the agency wants to be considered for Board coverage (in Butler County)
- If a patient slips through the cracks – the process needs to be refined..

What is "incident to"

- This is the Medicare concept of allowing practices to code and bill some services under a directly supervising provider for pay at that providers level.

- Incident to can never be used for a "new patient", "new problem" or when the supervising (billing provider) is not in the office

Mid Level provider and BH CMS rules …

- Chapter 15 of the CMS Provider Manual
  - Identifies supervision needs
  - Incident to
  - Skilled Nursing prohibition on shared visits
  - Admission to facility issues

- Chapter 12 addressed
  - Incident to
  - NPP rules
- BH addressed in chapters 2,6 and 15 and https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Mental-Health-Services-Booklet-ICN903195.pdf

Incident to and the role of the Physician, LISW, or NP

- CMS rule and process that applies to Medicare and Medicaid – and some other federally funded coverage programs
- May or may not be used by commercial plans with respect to non physician services (such as testing, nurse visits and NPP care)
- Physician must personally render and document the initial visit. Develop a treatment plan.
  - Provide subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment.
  - Provide Direct Personal Supervision for "incident to" services. The physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services.

Medicare has an LCD C34539

- "Incident to" a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. (CMS Pub 100-02, Chapter 15, Section 60.1) The "incident to" provision may also apply to coverage for psychological services furnished "incident to" the professional services of certain non-physician practitioners including clinical psychologists, clinical social workers, nurse practitioners, and clinical nurse specialists (CMS Pub 100-02, Chapter 15, Section 60.2). Section 1862(a)(1)(A) of the Social Security Act governs payment for the provision of medical care to Medicare beneficiaries.

- The training requirements and state licensure or authorization of individuals who perform psychological services are intended to ensure an adequate level of expertise in the cognitive skills required for the performance of diagnostic and therapeutic psychological services. Therefore, only the types of individuals listed later in this policy are considered qualified to perform medically necessary psychological services addressed in this policy. Delegation of diagnostic and therapeutic psychological services to personnel not performing within the scope of practice as authorized by state law, under the "incident to" provision, would bypass the safeguards afforded by professional credentialing and state licensure requirements. Such delegated services under the "incident to" provision would be inappropriate, unreasonable, and medically unnecessary, and therefore not covered by Medicare

- For psychology services rendered under the "incident to" provision, the billing provider must first evaluate the patient personally and then initiate the course of treatment. The appropriately trained therapists may then render psychological services to the patient under the billing provider's direct supervision.

- Only the types of practitioners listed below, when they are performing within their scope of clinical practice as authorized under state law, are qualified to perform the indicated diagnostic and/or therapeutic psychological services under the "incident to" provision. (Next page)

These individuals can be coded and billed incident to Medicare and governmental programs

- These are the individuals who services can be coded "incident to"
  - Masters level or higher Clinical Psychologist
  - Masters level (or higher) clinical social worker (LISW – Ohio)
  - Clinical Nurse Specialist
  - Nurse Practitioners

The rule says..

- Individuals who are not licensed or otherwise authorized by state law to provide psychological services may not provide psychological services under the "incident to" provision. This level of professional credentialing is necessary to furnish appropriate medically necessary services under the "incident to" provision.

A clarification…

- Psychological services furnished to Medicare beneficiaries under the "incident to" provision by individuals other than those listed above are not covered. (Note: the standards for professional credentialing are higher for these services billed to Medicare Part B than for similar services performed by other mental health professionals not under the "incident to" provision and billed to Medicare Part A. Under the "incident to" provision, services are performed in the place of the billing provider. In order for services performed and billed under the "incident to" provision to be commensurate with the services performed by the billing provider, and therefore medically necessary, this higher standard of professional credentialing is necessary.)

A WORD ABOUT MARRIAGE AND FAMILY THERAPY

- The practice of "marriage and family therapy" includes the identification and treatment of cognitive, affective and behavioral conditions related to marital and family dysfunctions that involve the professional application of psychotherapeutic and systems theories and techniques in the delivery of services to individuals, couples, and families. Local laws regulating their professional practice do not authorize any licensed marriage and family therapist or marriage and family therapy associate to administer or interpret psychological tests. Please refer to applicable state laws.

A FEW MORE WORDS…

- Coverage of services and supplies "incident to" the professional services of a physician in private practice is limited to situations in which there is direct physician supervision of auxiliary personnel. (CMS Pub 100-02, Chapter 15, Section 60.2). This also applies to the services of certain non - physician practitioners who are being licensed by the states under various programs to assist or act in the place of the physician, including nurses, clinical psychologists, clinical social workers and other therapists. Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services (CMS Pub 100-02, Chapter 15, Section 60.1 - Section 60.3). Services and supplies incident to a physician's service in a physician directed clinic or group association are generally the same as those described for the office setting (CMS Pub 100-02, Chapter 15, Section 60.3).

The ideal process…

- Practices should identify the services and bill them correctly based on who provides them

- For Medicare – the counseling and assessment should be performed by the LISW – not other identified providers with the exception of the new Opioid treatment program

What about $$$

- Remember your fee schedule should not be based on the Medicaid fee schedule as some third parties and some specific Medicare fees (and Part C) may be higher – after the Medicaid rate changes 8/1/19 most fees are compatible between Medicare and Medicaid (a few higher a few lower)

- Example:
  - 99205 Medicaid $236.92 Medicare $203.34 ($233-$246)
  - 99211 Medicaid $22.31 Medicare $22.01 ($25-$31)
  - 90832 Medicaid $ 69.73 Medicare $ 69.51 ($68-$81)
  - 90846 Medicaid $86.94 Medicare $ 101.88 ($99-$119)
  - 90791 Medicaid$111.11 Medicare $125.77 ($125-$160)

Remember

- Services need to be coded and billed as provided
- Fee schedules should be based on a % of Medicare fee schedule to cover the amounts paid by non Medicare and Medicaid programs (which are often 10-20% higher)
- All employees need to be appropriately enrolled
- All documentation needs to be clear, concise and accurate!

Upcoming Web Meeting on Medicare OPIOID Treatment Program 2/12/2020

Buter County Menta; Health Addiction - Medicare OPT Program

- Wed, Feb 12, 2020 9:30 AM - 11:00 AM (EST)

- Please join my meeting from your computer, tablet or smartphone. https://global.gotomeeting.com/join/117079973

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Understanding the Crystal Ball

The process of coding is a step by step

Patient focused

Always a challenge

Adaptable!