Medicare update 2009

Medicare direction unknown until Obama takes office

By Paula E. Hartman-Stein, Ph.D.

President-elect Obama's naming of former Senator Majority Leader Thomas Daschle as both secretary of Health and Human Services and director of the White House of Health Reform bodes well for improvements, but the exact direction Medicare will take remains unknown.

Jim Georgoulakis, Ph.D., APA's representative to the American Medical Association's (AMA) Relative Update Committee (RUC), said firm decisions can't be made until Daschle is confirmed and officially begins work.

Early indications may come quickly, however. "During the last week of January when the first RUC meeting of the year convenes, we will learn which clinical service codes will be reviewed in 2009 for their work values," Georgoulakis said.

Congress mandates that all codes be reviewed approximately every five years, and, according to Georgoulakis, the APA has been working to place the psychotherapy codes on the agenda this year.

Work values are an important part of the equation that determines the monetary value of clinical services reimbursed by the Medicare system.

According to *The Washington Post*, Daschle, co-author of the new book, *Critical: What We Can Do about the Health-Care Crisis,* has been Obama's central advisor on efforts to expand health care coverage while at the same time lowering costs.

In a recent interview, Georgoulakis provided practical advice based on questions asked of him by psychologists who work within the Medicare system. "It is important to keep up with changes in coding and payment policy both for Medicare/Medicaid and commercial payers. An answer I may have written in the past does not necessarily indicate that the information is still current. We have rules, regulations or policies modified annually that impact payment," he said.

Georgoulakis emphasized that Medicare carriers may have local determination policies (LCDs) that differ from region to region. "Psychologists must remain aware that LCDs take precedence over national policy. Individual commercial payers are not required to follow any payment policy other than their own."

The U.S. Congress, however, can mandate certain regulations. For example, according to Georgoulakis, all payers, both commercial and government, must now use the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) for diagnosis codes.

The cross walk from the Diagnostic and Statistical Manual, 4th Revision (DSM-IV) to the ICD-9-CM is fairly consistent, but is not a straight one-to-one. He advises psychologists to submit claims by utilizing the ICD-9-CM for all diagnoses; e.g., using the mental disorder section codes for psychotherapy and the physical disorders with the Health and Behavior codes. When coding the diagnosis for neuropsychological testing procedures, Georgoulakis suggests using the codes from the nervous system section of the ICD-9-CM.

Psychologists frequently ask him about the necessity of documenting exact start and stop times for clinical procedures. "All providers, regardless of specialty, must document time spent if the service is a time-based code. Clinical services in the behavioral health area are psychotherapy, neuropsychological assessment and the Health and Behavior services. The documentation requirement has nothing to do with the specialty of psychology, as some clinicians may suspect. In fact, more specialties desire their services to be time-based so they can utilize multiple units for billing."

Although the neuropsychological assessment codes reimburse for time spent scoring, interpreting results and writing the report, he explained that for an initial assessment or re-evaluation done under the Health and Behavior codes, only face-to-face time with the patient may be billed.

When rounding time spent to units of time for billing purposes, Georgoulakis recommends checking whether the Medicare carrier for the region has a specific LCD on that issue.

"Psychologists must understand the concept of medical necessity," he said. "It is defined by the payer (commercial and government) in a specific manner. Both the AMA and the Center for Medicare and Medicaid have acceptable definitions."

The CMS website defines medically necessary services as those that "are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care and treatment of your medical condition, meet the standards of good medical practice in the local area and are not mainly for the convenience of you or your doctor."

Georgoulakis also commented upon the Physicians Quality Reporting Initiative (PQRI) in which individual providers and healthcare institutions submit separate G codes indicating documentation of specific measures suggestive of quality reporting.

For such documentation submitted in 2009, providers will receive a 2 percent bonus payment in 2010 that is calculated on claims paid by Medicare. "CMS is really committed to PQRI, he said. If hospitals do not participate in PQRI, their reimbursement rates from Medicare will be reduced. The reporting of quality measures is a trend that is here to stay."

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