

The Benevolent Clinician/Biller

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Therapists are often concerned with appropriately charging patients for the services they performed. The Federal government and commercial payors, alike, have been scrutinizing “over-billing” practices by providers. But has anyone shown concern for those that practice the “under-billing” of services? The OIG and the Federal Government are starting to take notice and so are the organizations and facilities for which you work. First, for the purpose of this discussion, let’s define “under-billing”.

“Under-billing” is the conscious process of not billing for all of the services provided on a given date of service. For example, you are treating an ankle patient with commercial insurance, who in the course of the treatment receives 30 minutes of therapeutic exercise, 15 minutes of gait training activities, joint mobilization, and ice at the conclusion of the treatment. When it comes time to charge for the treatment, you charge two therapeutic exercise charges, 1 gait charge, and one hot/cold pack charge. Based on the number of modalities that occurred in the treatment you opt not to charge for the joint mobilization (manual therapy, 15 min) charge.

The most likely reason for not billing for all services performed is the notion that the charges for those services are too high and therefore extremely expensive to the patient. Under-billing for services has the potential to affect many of your facility’s internal operations and can lead to investigations into your billing practices by outside agencies. This article will examine five effects, both internal and external, of under-billing.

Effect # 1: Reimbursement

Under-billing of services affects reimbursement in several ways. First, billing for services rendered ultimately generates reimbursement to your facility. Should you elect not to charge for all of the services performed, you are leaving potential reimbursement money “on the table”. Your facility loses the potential reimbursement for those services not billed. Second, in the instance where services are reimbursed on a “per visit”, case rate, or capitated rate, services not billed still affect reimbursement. While the services billed may not be billed in units to the payor under these payment mechanisms, the units of care generated are utilized when negotiating per visit rates, case rates, and capitation

rates. If the units of care are lower than they should be, the facility is not able to demonstrate an accurate level of clinical activity. When a facility engages in contract negotiations with an insurance company, the facility needs to understand the cost of operations as it relates to charge activity. Simply put, they like to know what the cost of operations is for each charge rendered (e.g. it costs the facility \$8 for every procedure or modality charge). This ratio of costs to charges can then be extrapolated into an average cost per visit charge for patient care services. Armed with this information, the facility can then begin to properly negotiate reimbursement that is in their best interest.

Third, if reimbursement dollars are affected by “under-billing”, so then is the use of that lost money in operations of the facility. If the reimbursed dollars are less than expected or budgeted, current and future operations are effected. Operations may be affected in terms of facilities planning and improvement, equipment and supply purchasing and budgeting, and staffing and benefits budgeting. Healthcare facilities are already faced with streamlining and cutting operational expenses due to declining reimbursement. Under-billing of services only compounds the problem of lost dollars to the facility.

Effect #2 – Collection of Co-payments

Many commercial insurers base the calculation of copayments on either a percentage of charges or a percentage of a fee schedule. For instance, Medicare requires that copayments for outpatients be calculated based on 20% of the Medicare Fee Schedule. Collected copayments are a direct source of cash to the organization unless otherwise specified contractually. If the charges are under billed then the copayment is under calculated as well. The resulting effect is less cash for the organization. This is likely to affect operations.

Effect #3: Productivity and Staffing

Many current staff productivity measurement tools are based on recording the number of units generated by each clinician treating patients. Each individual clinician may have an established productivity goal they must meet. Similarly, management bases staffing decisions on the total productivity of the department or facility. If therapists are appearing under productive, then the need for additional staffing may not be recognized. If you are a clinician in these types of productivity systems, under-billing services directly has an effect on you, your productivity, and potentially your

peers as it pertains to department staffing.

In large facilities that use labor distribution type systems, the number of productive full time equivalent (FTE) employees may be measured and monitored based on unit production. Under-billing will affect the interpretation of these measures as well. Typically the finance department utilizes these systems to track and forecast staffing. Under this scenario, future budgeting of staff dollars will be affected by under-billing. If a department appears under productive and a reduction in staffing related dollars appears warranted, the department may be hard pressed to request that no change in budgeted staff dollars be made.

Effect #4 – The \$1500 Cap

Under-billing of services may also produce what may seem to be a positive effect related to the Medicare Part B \$1500 therapy cap. If under billing occurs, it will take a patient longer to reach the cap. Providers are required to bill for the services provided to a patient unless outlined in Medicare guidelines. For example, hot/cold packs when “given prior to but as an integral part of a skilled physical therapy procedure, [they] would be considered part of the physical therapy service” (Hospital

Manual, Coverage of Services, Section 210.8). Per Medicare Local Medical Review Policy, “the payment for hot or cold packs is bundled into the payment for other services” (LMRP (Florida); Physical Medicine and Rehabilitation, 1/7/99). Additionally, Medicare guidelines require that patients are charged appropriately and “charges are equally imposed on all patients (Medicare Hospital Manual, COVERAGE OF SERVICES, Section 210.9). It is clear that a patient must be charged for all services rendered unless Medicare or other payor guidelines dictate otherwise.

The fact that a patient, if under billed for the services they receive, may take longer to reach the \$1500 cap may be enticing to you and your Medicare clientele. However, this practice could be deemed as an inducement to provide services to Medicare beneficiaries. In effect, it is a discounting or waiving of the billing of services, with the potential effect of increasing Medicare business. Medicare requires that Medicare patients, when receiving the same service as those patients of other payors are charged a comparable charge for a comparable service (Carriers Manual, Part 3, Chapter II, Section 5026). Therefore, you cannot elect to bill Medicare patients for less services while still charging patients from other payors

for the full complement of services received.

Effect #5 – Attracting the Attention of Regulatory Agencies

Billing inappropriately for services raises concern from regulatory and governmental agencies. In the Compliance Program Guidelines for Hospitals the Office of the Inspector General (OIG) addresses fraudulent acts with regard to the submission of claims (bills) for payment. Claims must be complete and accurate. A claim that does not contain all charges that should have been billed for a date of service (under-billing) is therefore an incomplete and inaccurate claim. Similarly, a claim submitted with charges for services not rendered (excessive units of a charge, charges for services not rendered) is likewise an inaccurate and incomplete claim.

The Department of Health and Human Services, including the OIG, through various statutes and regulations addresses inducements (Showalter 1999, pp 256-260). An inducement may be categorized as remuneration to a party in exchange for referrals or a reduction of services performed so as to limit operational costs (in the case of saving operational expenses to increase the net revenue received as part of a

DRG payment). An inducement can be thought of as the practice of buying business. Is it not possible that if multiple patients are billed for reduced services by physical therapy, thereby staying off the \$1500 cap for one or possibly two more visits that this too could be considered an inducement? Be careful!

How do you identify under-billing?

Recognition of under billing, fortunately, is the easy part. Use the “connect the dots” theory. Whenever a clinician performs treatment, they must do two other things. They must document that treatment occurred and they must bill for that treatment. Your task is to gather these two pieces of documentation and audit them. Use a suitably sized sample of patients for each clinician each month and gather the treatment notes or complete medical record and a corresponding sample of the bills for each patient for the dates of service that you are reviewing (St. Anthony’s Medicare Billing Compliance Guide. August 1999. Section 7-45,46). Now, “connect the dots”. If the note says 30 minutes of therapeutic exercise on a given, the bill should have 2 units of therapeutic exercise (2 units of CPT code 97110) for the same date of service. Continue this same procedure for all of the dates that you have chosen

to review. Keep an audit worksheet for every clinician and every patient documentation you review (see Figure 1). It is highly recommended that you attach a copy of the treatment notes and bills reviewed. This establishes a viable set of working papers that supports your efforts, and it provides a quick and easy way of creating a set of documents that may be used as a feedback and corrective action plan document for each staff member reviewed.

most departments carry out some form of "peer review" or quality assurance mechanisms on a monthly basis. When this is true, the only pieces missing are the bill review and the audit tool to match the documentation to the bills and summarize your findings. This documentation and billing audit may be performed at the peer level, but to address the sensitive nature of this information, it is recommended that management reviews the results and work papers and give feedback to the staff member.

Before you create an entirely new review process, consider the fact that

Figure 1:

Therapist Reviewed: <u>Jane Doe</u>			
Medical Record # Reviewed <u>AB12345</u>			
Date of Treatment	Service Documented	Service Amount Charged	Variance (Yes/No)
1/1/99	30 minutes of ther ex	2 ther ex	No
	Soft tissue mobs, should joint mobs	1 manual therapy	No
	Ultrasound, 6 minutes	no charge entered	Yes
and so on.....			
Percent Error (charge errors/total documented services): <u>25%</u> <i>1 charge error in 4 charges documented</i>			
Feedback given on: _____			

	Date
Feedback given by:	_____
	Name
Corrective Action Plan:	_____

Signature of Therapist:	_____

The Positive Results

If reviewed, addressed, and monitored by department or facility management, the results will be positive for all involved. These results include:

- ?? Reduced the risk of governmental scrutiny.
- ?? Reduce reimbursement lost
- ?? Greater co-payments accuracy.
- ?? Improved cash flow.
- ?? Improved accuracy of data for negotiating contracts with payors.
- ?? Improved accuracy of data for forecasting and budgeting internal operations.
- ?? Better data for staffing decisions.
- ?? Improved staff productivity measurement.
- ?? Improved reimbursement.

Simply put: “If you do it [the service], document that you did it, and if you document it, bill for it; connect the dots.”

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