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Meet the Presenter…

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Faculty
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On the topic:
WHERE IS MY MONEY? Pt. 1:
Increasing Revenue through Accurate Coding and Billing
A practical guide to increasing collections in your practice

PART 1 – Importance of accurate coding and documentation

Presenter: Lisa Maciejewski-West

Where is my Money?

Setting The Stage: COL Reality Check

1982
- Postage stamp $0.20
- Gas/gallon $1.59
- Movie Ticket $3.00
- Bread $0.55
- Milk/gallon $1.30

2014
- Postage stamp $0.49
- Gas/gallon $3.09
- Movie Ticket $9.00
- Bread $2.50
- Milk $3.79

COST OF LIVING DOUBLED……
Doctor’s Office Visit (reimbursement)

- **1982** – on a **$50 charge**, doctor reimbursed **$50**
  (Standard 80/20% plan - $40/insurance, $10 patient)

- **2015** – on a **$100 charge**, doctor reimbursed **$70**
  ($35/insurance, $35 patient, $30 write off)

- In 30+ years, doctor’s reimbursement for standard office visit went up a net of 29% (less than 1%/year). Reimbursements are not even keeping up with inflation.

- Now that we have our heads out of the sand….
  - What can we do to keep our practices solvent?
  - How must things change in order to operate in the black?

Collections, Then…..

- **1982 - SCENARIO**
  - Patient goes to the doctor, pays $10-15 flat cash fee for an office visit if they don’t have any insurance
  - If they have insurance, doctor bills ins company $50
    - If patient has unmet deductible, they just pay cash fee
    - If deductible was met at the hospital or other facility, pt pays coinsurance (usually 10-20%), insurance pays the rest 80-90%
      - $50 X80% = $40, pt pays $10, $5 if it’s 90% coins.
Collections Now….

- NOW 2015 (30+ years later)
  - SCENARIO: Patient goes to the doctor, fee is $100. Patient pays cash fee for an office visit if they don’t have any insurance, based on UCR and Time of Service discount rules
  - If they have insurance, doctor bills ins company $100
    - If Doctor “in-network”, they have to take reduction in billed fee to about $70
    - Patient has average copay of $35-40 or deductible/coins.
    - Because dr is “in network, they HAVE to bill ins. for services. Patient can’t “just go cash, unless they sign a waiver”

- BOTTOM LINE: Doctor CAN’T “just take insurance”. In 1982, they could get $40 from an insurance company on a $50 bill. Now they get $35-40 (after reductions and copay), or about $65-70 if pt has a deductible. Plus cost of living significantly higher now then 1982. And additionally dr has higher administrative costs than in 1982. EVERYTHING THAT CAN BE COLLECTED MUST BE COLLECTED.

Components of Collections

- ACCURATE CODING AND BILLING (Front End Insurance)
- ACCOUNTS RECEIVABLE TRACKING (Back End Patient and Insurance)
- FRONT DESK COLLECTIONS (Front End Patient)
23% of All Commercial Insurance Claims go UNPAID

*Insurer Non-payment.* Physicians received no payment at all from commercial health insurers on nearly 23 percent of claims they submitted. There are many reasons a legitimate claim may go unpaid by an insurer. Claims may be denied, edited or deferred to patients. During Feb. and March of this year, the most common reason insurers didn’t issue a payment was due to deductible requirements that shift payment responsibility to patients until a dollar limit is exceeded. Real-time claims processing would save time and money.


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Insurance Plans Before Managed Care

- Deductible
- Co-Insurance 80/20, etc.
- Out-of-Pocket Maximum
Before Managed Care
How Claims Were Processed

DOCTOR/PROVIDER

OFFICE ASSISTANT (Processes Claims)

Insurance Company Claims Processor
Manual Review of Claims

Insurance Company Pays Claim Issues Check to Provider

Insurance Plans After Managed Care

- Deductible (sometimes)
- Co-Pay (sometimes)
- Deductible with Co-Pay (sometimes)
- Deductible with Co-Pay and Coinsurance (sometimes)
- PreAuthorizations
- Capitations
- Utilization Review
After Managed Care

How Claims are Processed

1. DOCTOR/PROVIDER
2. Office Assistant
3. Preauthorizations
   - Process to Intermediary Clearinghouse (Electronic Submissions)
   - Forward to 3rd Party Payor
   - Utilization Review
   - Requests for Additional Information back to Provider
   - Office Assistant Resubmits
   - Claim Paid (maybe)

Other factors influencing claim payment pre- and post- Managed Care…

- Proper coding
  - Codes were just codes….
- Timely Filing
  - You could submit claims YEARS after the DOS took place
- Appeals processes and rules
  - A letter would suffice
- Third Party Intervention
  - Claims were filed to the carrier, not a TPA
- Patient Responsibility
  - NOOPE was prevalent
Look what happens to $1.00 when you don’t collect it TODAY!

$1.00
$0.90
$0.80
$0.70
$0.60
$0.50
$0.40
$0.30
$0.20
$0.10

31 days
61 days
91 days
181 days
366 days

How Important are Timely Collections?

Source: The Commercial Law League of America
After one year, the uncollected dollar you worked for is only worth 26 cents!

Between 20-40% of Claims are IMPROPERLY paid

“A 20 percent error rate among health insurers represents an intolerable level of inefficiency that wastes an estimated $17 billion annually,” said AMA Board Member Barbara L. McAneny, M.D. “Health insurers must put more effort into paying claims correctly the first time to save precious health care dollars and reduce unnecessary administrative tasks that take time and resources away from patient care.”

Anthem Blue Cross Blue Shield had scored the worst of those measured with an accuracy rating of 61.05 percent.

Getting off to a good start….making sure it’s not OUR FAULT

- Accurate coding and documentation is the first step to successful collections.…
  - Accurate coding allows for seamless billing
  - Accurate coding prevents hang ups in claims processing
  - Accurate coding allows bills/claims to be submitted in a timely and efficient manner
  - Accurate coding AND documentation protects your money (recoupments/audits)

Components of Coding

- Coding is a Language – it’s how we speak to insurance carriers
  - Provides information on the SERVICES and SUPPLIES provided at the time of patient encounter or for the patient
- MODIFIERS:
  - Give further clarity to a patient encounter (attached to CPT and/or HCPCS codes)
- ICD10-CM: International Classification of Diseases
  - Provides vital information on the REASON for encounter
  - Without dx you only have half the story
Leaving Money On the Table – E/M

- Some HCP’s and coders get complacent, use same codes and code levels (E/M) on every patient, even when a higher level may be warranted.
- HCP’s – If you are providing a higher level E/M service than you are billing for, make sure you understand the components of E/M and document the encounter correctly.
- CODERS – Review HCP and Patient documentation to determine correct level of E/M coding. Don’t just “take their word for it”

Do the Math! (use your own figures)

- 99212  *$44.20
- 99213  $73.30  Difference $29.10/visit
- 99214  $108.88 Difference $35.58/visit
- 99215  $146.97  Difference $38.09/visit

*Based on Medicare Fee Schedule, 2015 B National Payment Amount, Par Provider non facility

If you are undercoding 10 visits/week or 2 visits/DAY (99212-99213):
$291/week x 4.2 weeks/month = $1222/month x 12 months = $14,666/yr additional income

If you are undercoding 10 visits/week or 2 visits/DAY (99213-99214):
$356/week x 4.2 weeks/month = $1495/month x 12 months = $17,942/yr additional income
YOU CAN’T CODE WHAT IS NOT DOCUMENTED! DON’T UPCODE JUST BECAUSE IT’S WORTH MORE MONEY. ALL CODING MUST BE ETHICALLY JUSTIFIED THROUGH CLINICAL DOCUMENTATION, OBSERVATION, EXAMINATION AND MEDICAL DECISION MAKING

Leaving Money on the Table-Unbilled Procedures

- Clinical documentation and coding guidelines will dictate additional procedures that can (and should be) billed
- Minor procedures (bill procedure with E/M -25 on E/M code)
- Unreported/Unbilled tests – labs, saliva tests, UA, etc
- Supplies – Example, patient comes in with a neck injury. Office provides cervical collar, but does not document in record, so it’s never billed.
- Consultations 99241-99245
- Prolonged services 99354-99359
- Medical Team conferences 99366-99368
- Timed procedure codes that are not accurately documented and reported (ie: PT codes)
- Telephone/Telemedicine services
And by the way…. modifiers

- Modifiers are the “by the way” part of CPT coding.
  - Modifiers add clarity to an encounter
  - Modifiers add detail to procedures that the code itself may not provide
  - Modifiers may be used to identify circumstances that significantly alter a service or procedure where reimbursement will be affected and/OR
  - Modifiers may be informational only and have no impact on the normal reimbursement
- Common modifier examples (Level 1 CPT)
  - -22 Increased Procedural Services
  - -25 Separate Identifiable E/M on same day as procedure
  - -51 Multiple Procedures
  - -76 Repeat Procedure by Same Physician
  - -77 Repeat Procedure by Different Physician

Coding with Modifiers

- A great coder will recognize opportunities within the clinical documentation to utilize modifiers for enhanced reimbursement
- A great coder will understand the need for modifiers in certain circumstances to prevent claims from being denied or bundled inappropriately
- Correct use/non-use of modifiers can have a significant impact on reimbursements/payments.
Introduction to ICD-10-CM

- On July 31, 2014, the U.S. Department of Health and Human Services (HHS) issued a rule finalizing October 1, 2015 as the new compliance for ICD-10.
- This version is currently being used by most developed countries throughout the world.
- Significant improvement over ICD-9:
  - Expanded injury codes
  - Creation of combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition
  - Addition of sixth and seventh characters
  - Incorporation of common 4th and 5th subclassifications
  - Laterality and greater specificity in code assignment

ICD-10-CM Code Format

- Consist of up to seven digits:
  - The 1st digit is always alpha
  - The 2nd digit is always numeric
  - The remaining five digits can be any combination
Benefits of Adopting ICD-10

- *Greater coding accuracy and specificity*
- Higher quality information for measuring healthcare service quality, safety, and efficiency
- *Improved efficiencies and lower costs*
- *Reduced coding errors*
- Greater achievement of the benefits of an electronic health record
- Recognition of advances in medicine and technology
- Alignment of the US with coding systems worldwide
- Improved ability to track and respond to international public health threats
- Enhanced ability to meet HIPAA electronic transaction/code set requirements

*These will most directly impact reimbursements*

How Does Proper/Improper ICD Coding Affect Payment?

- Correct use, sequencing and dx pointing of codes, to highest level of specificity will reduce the likelihood of claims review/rejections. This saves money in your administrative costs and will allow for claims to be paid “the first time”
- Incorrect dx coding is the number one reason for claims denials for medical necessity.
  - Not coding to highest level of specificity
  - Not coding laterality (new to ICD10)
  - Not coding 7th digit extension properly (ICD10)
  - Not coding in the correct order (sequencing)
  - Improper/inappropriate write offs due to denials for MN that could be appealed, but are just “swept under the rug”
- Improper/insufficient documentation to support coding is number one reason for claims recoupments. “If it’s not documented, it did not happen”
Auditing Is Big Business

- Post payment audits/recoupments are increasing and will continue to do so post ICD10 implementation
- RAC(RECOVERY AUDIT CONTRACTORS) HELP IDENTIFY IMPROPAT MEDICARE PAYMENTS — In the Tax Relief and Health Care Act of 2006, Congress required a permanent and national RAC program to be in place by January 1, 2010. The national RAC program is the outgrowth of a successful demonstration program that used RACs to identify Medicare overpayments and underpayments to health care providers and suppliers in California, Florida, New York, Massachusetts, South Carolina and Arizona. The demonstration resulted in over $900 million in overpayments being returned to the Medicare Trust Fund between 2005 and 2008 and nearly $38 million in underpayments returned to health care providers.


The OIG Work Plan

Work Plan for fiscal year (FY) 2015 summarizes new and ongoing reviews and activities that OIG plans to pursue with respect to HHS programs and operations during the current fiscal year and beyond.

- What do we accomplish? For FY 2014, we reported expected recoveries of over $4.9 billion, consisting of nearly $834.7 million in audit receivables and about $4.1 billion in investigative receivables, which include about $1.1 billion in non-HHS investigative receivables resulting from our work in areas such as the States’ shares of Medicaid restitution.

- SEE EXCERPTS FROM OIG WORK PLAN
Outpatient evaluation and management services billed at the new-patient rate
We will review Medicare outpatient payments made to hospitals for evaluation and management (E/M) services for clinic visits billed at the new-patient rate to determine whether they were appropriate and will recommend recovery of overpayments. Preliminary work identified overpayments that occurred because hospitals used new-patient codes when billing for services to established patients. The rate at which Medicare pays for E/M services requires hospitals to identify patients as either new or established, depending on previous encounters with the hospital. According to Federal regulations, the meaning of “new” and “established” pertains to whether the patient has been seen as a registered inpatient or outpatient of the hospital within the past 3 years. (73 Fed. Reg. 68679 (November 18, 2008).) (OAS; W-00-14-35627; expected issue date: FY 2015)

Ophthalmologists—Inappropriate and questionable billing
We will review Medicare claims data to identify potentially inappropriate and questionable billing for ophthalmology services during 2012. We will also determine the locations and specialties of providers with questionable billing. Medicare payments for Part B physician services, which include ophthalmologists, are authorized by the Social Security Act, § 1832(a)(1), and 42 CFR § 410.20. In 2010, Medicare allowed more than $6.8 billion for services provided by ophthalmologists. (OEI; 04-12-00280; 04-12-00281; expected issue date: FY 2015)

Physicians—Place-of-service coding errors
We will review physicians’ coding on Medicare Part B claims for services performed in ASCs and hospital outpatient departments to determine whether they properly coded the places of service. Prior OIG reviews determined that physicians did not always correctly code nonfacility places of service on Part B claims submitted to and paid by Medicare contractors. Federal regulations provide for different levels of payments to physicians depending on where services are performed. (42 CFR § 414.32.) Medicare pays a physician a higher amount when a service is performed in a nonfacility setting, such as a physician’s office, than it does when the service is performed in a hospital outpatient department or, with certain exceptions, in an ASC. (OAS; W-00-13-35113; W-00-14-35113; various reviews; expected issue date: FY 2015)

Bottom Line

- There is money to be made and money to be lost through correct or incorrect coding practices
- Follow coding rules and guidelines set forth in your manuals
- DOCUMENT your encounters properly to protect your work
- EDUCATE, EDUCATE, EDUCATE!
Next Time….  

- How to ensure payment and protect your money through proper claims filing practices.  
  - Putting a claim together  
  - Scrubbing  
  - Handling Level 1 and Level 2 rejections  
- How to find money in your accounts receivables  
  - Knowing what to look for  
  - Low hanging fruit (claims aged 30-90 days)  
  - When all that’s left is patient money  
  - When is it appropriate to write off old AR  
- Use of collection agencies, billing agencies (pros and cons)  
- Analyzing your collections through statistical data vs. emotions