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On the topic:
HCPCS Reimbursement Impacts the Bottom Line

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HCPCS – Reimbursement That Impacts Your Bottom Line!

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Objectives

- HCPCS background
- What is reported with HCPCS
- PDAC
- DME
- What’s missing?
- How to’s
  - Drugs
  - Supplies
  - DME
- Examples
- Conclusion
Healthcare Common Procedure Coding System (HCPCS)

Often referred to as Level II codes!!
- Allow use of uniform reporting on items or services that are medical in nature
- Report costs and services not included in CPT® codes
  - Transportation, including ambulance services
  - Durable medical equipment, Orthotics and Prosthetics
  - Drugs (other than oral)
  - Procedures/ Professional Services (G, S codes)
- Typically not costs that get passed through a physician’s office (Watch for change)
  - Medicare and Medicaid may require use of these codes to report services that other insurance companies would report with traditional CPT® codes
- Important to capture services for practice to be profitable

Background

- Use began in 1980’s
- Each year over 5 billion claims for payment are processed by Medicare and other health insurance carriers
- October 2003 HHS authorized CMS to maintain and distribute HCPCS level II codes
  - Prior to this state Medicaid agencies, Medicare contractors, and other insurers developed HCPCS for local jurisdiction or programs.
- HIPAA required CMS to adopt HCPCS as standard code set (responsible agent)
  - Eliminated Level III codes
- Currently codes represent over 4,000 categories of like services or items from different manufacturers
- Code descriptors do not identify specific products or brand/trade names
- Payment determination is based on each payer’s coverage and policies

Common HCPCS Modifiers

- **AI** - Principal physician of record
- **GA** - Waiver of liability statement issued as required by payer policy, individual case
- **GW** - Service not related to the hospice patient’s terminal condition
- **GZ** - Item or service expected to be denied as not reasonable and necessary
- **AT** - Acute treatment (use with 98940, 98941, 98942)

EPSU Modifiers

- Effective January 1, 2015, CMS defined four new HCPCS modifiers; these modifiers DO NOT replace modifier 59. However, CMS may request that 59 not be used when a more descriptive modifier is available. CPT instructs us to use 59 as a last resort.

- **XE** - Separate encounter
- **XS** - Separate structure
- **XP** - Separate practitioner
- **XU** - Unusual non-overlapping service
Administration Codes

- Medicare has specific administration codes for the administration of some immunizations. Be sure to check your state carrier to see if they are recognizing these codes. Medicare being the “standard”.

- G0008-Administration of influenza vaccine
- G0009-Administration of pneumococcal vaccine
- G0010-Administration of Hepatitis B vaccine

- Audits have revealed that administration codes are commonly left off of the claim form which is considered non-compliance.

Administration Codes

- Another example: J0558-Penicillin injection supply
  96372-Administration of Penicillin

- If patient is seen in the office for separate issue, may bill E/M visit with -25 modifier as appropriate.
- Medicare will pay separately for the administration of a therapeutic or prophylactic injection.
- Administration codes (96365-96379) require direct supervision which includes patient assessment, provision of consent, safety oversight, and intra-service supervision of staff.
Colorectal Cancer Screening

- Effective 01-01-16, Use CPT 81528 when billing for the Colorguard test (your MAC will continue to accept HCPCS code G0464 for claims with dates of service prior to 12-31-15).

- Diagnosis: Z12.11 and Z12.12

Smoking Cessation

- G0436-Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes.

- G0437-Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes.

- 99406, 99407 (CPT codes)

Hepatitis C Virus Screening

- Go472-Hepatitis C antibody screening, for individual at high risk and other covered indication(s).
- Z72.89 and F19.20
- For patients at high risk for HCV infection or who were born between 1945 and 1965

Initial Preventive Physical Examination

- Go402-IPPE
- Go403-EKG for IPPE
- Go404-EKG tracing for IPPE
- Go405-EKG interpret & report for IPPE
Intensive Behavioral Therapy for Obesity

- G0447 - Face to face behavioral counseling for obesity, 15 minutes
- G0473 - Face to face behavioral counseling for obesity, group (2-10), 30 minutes
- Check out the Z68 category ICD-10 codes

Screening Pap Tests

- G0123, G0124, G0141, G0143, G0144, G0145, G0147
- G0148 - Screening cytopathology, cervical or vaginal
- P3000 - Screening Pap smear by technician under physician supervision
- P3001 - Screening Pap smear requiring interpretation by physician
- Q0091 - Screening Pap smear, obtaining, preparing and conveyance to lab

High risk or low risk patient must be stated in the record as appropriate
Trays/Supplies

- A4550 - Surgical trays

- 99070 - Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)

- Compare these codes with the payer!

What is Reported with HCPCS Level II?

- Prosthetics, Orthotics and Supplies
- Drugs, Injectables
- Cast materials
- Bandages, surgical trays – under very specific guidelines
- Transportation (ambulance, portable X-ray equipment, non emergency)

Not Billable

- Things that are incidental and part of the cost of running the business
  - Gauze, cotton balls
  - Ace wraps, band aids
  - Tongue depressors
  - Gloves
  - Paper products
  - Lab supplies, urine cups
Pricing, Data Analysis and Coding – PDAC

- Pricing, Data Analysis and Coding Contractor for all of CMS
- Current PDAC contractor is Noridian
- Determines appropriate HCPCS code for DMEPOS
- Some “DME” items must be approved by PDAC to be covered

CMS DME Center

One stop shop for DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) questions:
- Fee schedules
- Manuals
- Links to DME MAC
- SNF Excluded list
- Enrollment
- Etc.

www.cms.hhs.gov/center/dme.asp
Pre-fabricated Orthoses/ Braces

- January 2014 CMS established 23 HCPCS codes to describe Pre-Fabricated Off-the-Shelf (OTS) Orthoses
  - OTS is defined under Medicare as orthotics that require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling or customizing to fit a beneficiary. Minimal Self-Adjustment is defined as an adjustment that the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and does not require the services of a certified orthotist.
- Revised 29 codes to describe Pre-Fabricated Custom-Fitted Orthoses
  - Suppliers of custom-fit orthoses must be certified orthotist or must possess specialized education, training, and experience in fitting and certification and/or licensing.
  - [Link](https://www.dmepdac.com/resources/articles/2014/01_03_14.html)

Durable Medical Equipment – DME

- Medicare (Part B) covers medically necessary durable medical equipment (DME) that is prescribed by a provider for in-home use
- Items cannot be billed without written order
- Requires signed delivery notice (item number, specific manufacturer or brand name), date received and location
- DME meets these criteria:
  - Durable (long-lasting)
  - Used for a medical reason
  - Not usually useful to someone who isn’t sick or injured
  - Used in the home (private residence, assisted living, apartment, relative’s home, institution other than hospital or SNF)
Checklists

- [https://www.cgsmedicare.com/jc/mr/DocumentationChecklists.html](https://www.cgsmedicare.com/jc/mr/DocumentationChecklists.html)
- [https://www.medicarenhic.com/dme/forms.aspx#form4](https://www.medicarenhic.com/dme/forms.aspx#form4)

Considerations for Your Practice

- Who is responsible to track supplies in practice?
- Who monitors supplies received and verifies the invoice?
- How are supplies labeled?
- Who is responsible for recording supply when used?
- Denials
  - Was item billed the item dispensed?
  - Is it never covered or is it a medical necessity restriction (frequency, diagnosis, etc.)
- Drugs
  - Is the older inventory used first?
  - What about used and wasted?
    - Schedule multiple patients to avoid waste
Caution!

Do your homework when a vendor tells you to use a particular code for payment:
- They are selling a product
- They are not necessarily coders and reimbursement experts
- They will not be affected if you are audited for receiving payment erroneously
- It is your responsibility to make sure you are billing correctly

Selecting a HCPCS Code

- Read medical documentation to identify:
  - Service
  - Supply
  - Equipment
  - Drug

- Table of Drugs
  - Dose
  - Unit
  - Route
Missed Revenue in Orthotic Supplies

- Patient injures ankle and is diagnosed with sprain; an orthotic brace (L4350) is used to immobilize the ankle while patient elevates and ices it.
  - Orthotic brace is constantly confused with a disposable bandage and not submitted for payment due to internal inventory numbers being transposed.

Missed Revenue in Orthotics

- Patient is seen and prescribed wrist brace for carpal tunnel syndrome (L3908 wrist hand orthosis (WHO), wrist extension control cock-up, non-molded, prefabricated, off-the-shelf)
  - Brace is documented on encounter form or in medical record
  - Explanation of Benefits for office visit and brace shows the visit paid and the brace denied because that particular payer does not cover it
  - Biller/coder no longer bills for braces based on one payer
Is this Coded Correctly?

A Medicare patient is given 5mg Methadone SC and it is submitted with HCPCS code **S0109**.

It is denied by Medicare; why?

- This is a temporary national code, but it is not for Medicare.
- **S0109** is for oral administration
- **J1230** reports injection of Methadone up to 10mg by intramuscular or subcutaneous administration
Is this Coded Correctly?

A patient who is having difficulty ambulating and using a walker was prescribed a raised toilet seat (E0244) for ease of use. Medicare denied the charge.

- While E0244 is a correct HCPCS code, there is a notation that the service is not separately priced by Part B.
Is this Coded Correctly?

A male patient is seen for his routine physical examination. During the exam, the provider performs a digital rectal examination as prostate cancer screening (G0102). Medicare denies G0102 and pays the evaluation and management code.

G0102 is not separately payable with an evaluation and management code. CMS considers this to be a very quick and simple examination taking only a few seconds and when furnished on the same day as an E/M, it is appropriate to bundle it into the payment for the covered E/M encounter”

Federal Register, November 2, 1999, Page 59414
Is this Coded Correctly?

Patient is seen and diagnosed with bronchitis and sinusitis. Rocephin, 1000mg is given IM. The claim is submitted as J0696 1 unit.

- The dose for J0696 is per 250 mg
- The amount given was 1000 mg
- Units should have been indicated as 4
- Lost revenue
Conclusion

Goal is to capture all costs of supplies, injection, etc.
- Is there a flow chart or assigned tasks to ensure supplies are received, priced correctly, dispensed and charged?
- Is review of coverage policies and insurance allowables reviewed prior to bringing in supplies to be sure costs are covered and there is a margin of profit?

Who reviews denied services?
- Is the service being reviewed or written off?
- Is this policy followed for all payers?
- Does the documentation clearly define the supply provided?

While some missed services may seem minimal, when the calculation is performed for 6 months or 1 year worth of services, the amount adds up.
- Could be an additional staff member or a new piece of equipment

QUESTIONS?

Thank you for your attendance!

Get your questions answered on PMI’s Discussion Forum: http://www.pmimd.com/pmiForums/rules.asp

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