Welcome to PMI’s Webinar Presentation

Brought to you by:
Practice Management Institute®
pmiMD.com

Meet the Presenter…

On the topic:
Billing Compliance
versus
Coding Compliance

Jeffery Restuccio
CPC, COC
Ritecode
Welcome to Practice Management Institute’s Webinar and Audio Conference Training. We hope that the information contained herein will give you valuable tips that you can use to improve your skills and performance on the job. Each year, more than 40,000 physicians and office staff are trained by Practice Management Institute. For 30 years, physicians have relied on PMI to provide up-to-date coding, reimbursement, compliance and office management training. Instructor-led classes are presented in 400 of the nation’s leading hospitals, healthcare systems, colleges and medical societies.

PMI provides a number of other training resources for your practice, including national conferences for medical office professionals, self-paced certification preparatory courses, online training, educational audio downloads, and practice reference materials. For more information, visit PMI’s web site at www.pmiMD.com

Please be advised that all information in this program is provided for informational purposes only. While PMI makes all reasonable efforts to verify the credentials of instructors and the information provided, it is not intended to serve as legal advice. The opinions expressed are those of the individual presenter and do not necessarily reflect the viewpoint of Practice Management Institute. The information provided is general in nature. Depending on the particular facts at issue, it may or may not apply to your situation. Participants requiring specific guidance should contact their legal counsel.

CPT® is a registered trademark of the American Medical Association.

Practice Management Institute®
8242 Vicar | San Antonio, Texas 78218-1566
tel: 1-800-259-5562 | fax: (210) 691-8972
info@pmimd.com
Billing Compliance versus Coding Compliance

Jeffrey Restuccio, CPC, COC, MBA
Memphis TN
(901) 517-1705
jeff@Ritecode.com
www.Ritecode.com

Ranking of Guidelines (CPT Concepts)

State Regulations
State Boards
Medicaid Guidelines
Medicare Advantage
Private Payor Guidelines
Medicare Guidelines
General CPT Concepts – AMA Guidelines

If Medicare guidelines disagree with AMA CPT guidelines who do you go with?
Billing Compliance vs Coding Compliance

The question is:

- **Who’s compliance?**
  - Who can audit you?
  - Medicaid
  - Medicare
  - Private carriers
  - OIG/RAC
  - Board (cardiology, orthopedic, ophthalmology)

What is a pure coder?

- Modifier E1, E2, E3, E4 versus RT and LT.
- Modifier 51 (surgical)
- Modifier 25
- Reading surgical Op Reports for additional services.
- Telling the “complete story” of the encounter.
- Reporting medical misadventures.
Know Coding and Billing Basics

- Have a current CPT manual or LCD.
- Have a current ICD-10 manual or access.
- Have a copy of the AHA ICD-10 Guidelines for 2016.
- Have a current HCPCS book.
- Know your bilateral indicator codes.
- Know your global days (zero, 10, 90).
- Know modifier rules.
- Know ICD-10/CPT linking or medical necessity rules.

Coding Compliance Flowchart

Discussing and reviewing this document, alone could take a full hour – with your interdepartmental team.
1. Compliance Team – Quarterly Meetings.
2. Determine the reports you want generated
3. Audit Reviews
4. Corrective Procedures/Training
5. Compliance elements
6. Coding Resources
Specific Coding Compliance Examples

- Misuse of the 2 of 3 rule.
- Misuse of modifier-25
- Upcoding
- Downcoding
- Cloning
- Mixing the right and left side due to cloning of surgical operative notes. (Yes I have seen this during audits.)
Compliance Plan Implementation

- Regardless of whether it's for coding or billing, every clinic should conduct at least one compliance plan meeting.
- Bi-annual, quarterly, and monthly meetings as needed.
- Everyone on the team should have action items, targets and due dates.
- This is a marathon, not a race – it's easy to get discouraged.
- Also get ready for pushback from the doctors, finance, coders or billing.
- There will be many obstacles to implementing both coding and billing compliance.

Components of Billing Compliance

- RVU's and the Medicare allowable amount
- Refunds
- Submitting claims within the allowable period.
- Financial policy and Advance beneficiary notices (ABN)
- ABN goes in the medical record.
- ABN is signed by patient; -GA modifier is appended to the code.
- Utilization review.
- New technology and equipment purchase.
- Provider education; niche markets.
Some suggestions

- Have the coding manager and the billing create separate compliance or issue documents.
- Make a specific list of areas where they could or are in conflict.
- Create a policy and guidelines for resolving conflicts between billing and coding.
- Get buy-in from the most supportive provider and use that provider to help convince the others.

Unique conflicts (true stories)

- One of the founding five partners had almost zero percent accuracy and compliance in the audit. The documentation was virtually non-existent. Technically, based on a coding compliance plan, this provider should have been first verbally reprimanded, then reprimanded in written format, not allowed to bill, and potentially fired. Of course that would never happen. How do you handle this situation?

- Working with a large multi-specialty group I needed the support of the clinic medical director. After reviewing his records and talking with him, I realized that he was the least qualified of his doctors in terms of documentation and compliance.
More Stories

- New technology, service, or HCPC code (supply) is marketed to the clinic as a “potential to increase revenue.”
- Billing, coding and the clinical director must be involved.
- Is there a CPT or HCPC code for this product/service?
- Is it accepted by any carrier and is it documented?
- Don’t take the sales representative’s word for it.
- You may find conflicting information on reporting it.
- If you are not sure, simply ask the carrier.
- Although rare, it is possible to get an unlisted code paid.
- Also more rare but have seen a category III code paid.

Data Entry “busy work”

- Coders creating extra work for billing/data entry.
- Billers not understanding why a claim is denied.
- A pure coder not understanding carrier-specific rules.
- Additional ICD-10 codes that tell the story but don’t impact reimbursement.
- Modifiers that may be no longer necessary or required by many carriers (MOD-51, MOD-52, MOD-32).
- Just because a coder is certified it does not mean they can audit or know anything about the real world.
Documentation and Billing

- Before you can maximize revenue you must ensure optimal compliance and therefore accurate and complete documentation.
- This is very important because often they are not conducted simultaneously.
- If you are compliant you can always code at the highest documented and accurate level.
- The billing department should instigate documentation audits because without accurate and complete documentation you will owe money if your audit does not meet guidelines.

Documentation Audits

- History
- Exam elements
- Medical Decision Making
- Interpretation and Report
- Surgical Operative Reports
- Specialty reviews of all Local Coverage Determinations

- What about Weighted Average Reviews? Is it a coding or billing request? In one clinic all utilization statistics were created from the finance department, not the coding department.
Billing Compliance and Revenue

- With our new service/coder/CEO we are getting paid for everything and revenue is up. Everyone is getting a bonus.
- Someone in your organization should be concerned if revenue increases suddenly.
- New procedures are being billed.
- Are there coding compliance policies in place?
- Utilization review?
- Coding Compliance plan
- Billing Compliance plan?

Carrier Tips and Tricks

- When calling your carrier always get the person’s name and email address if possible.
- Chat them up and compliment them on how hard they work. Be nice even if you are frustrated with them.
- When you ask them what modifier to use they will say, “we cannot tell you how to code.”
- Always work to get a carrier representative for your top carriers (Medicare, Medicaid, Blue Cross).
- Always get any unique instructions in writing. Ask for their E-mail address and send them an overview of the discussion and have them reply.
Have you read your contract lately?

- Occasionally there will be surprises there:
  - A Blue Cross Blue shield contract not allowing you to bill the patient if you do not meet timely filing.
  - A BC/BS policy not allowing the clinic to bill other patients a lower fee (like Medicare).

- If you are a large clinic you may be able to negotiate either higher reimbursement or reimbursement for unlisted codes or even category III T codes. (Not easy but it has been done.)

Medicare Guidelines

- Well over 1400 pages.
- Very detailed payment and documentation guidelines.
- Over 74% of private carriers follow Medicare guidelines.
- Many guidelines are local and not national.
- Medicare and the OIG will audit you.
- Never pays for refraction or glasses.
- Medicare Concepts:
  - “Incident To” Services
  - Local Coverage Determinations
  - 1997 Exam Guidelines
Medicare Jurisdictions

- Medicare is not one monolithic agency.
- There are multiple contracts and jurisdictions.
- Each Medicare contractor can have slightly different rules. I call these carrier-specific rules.
- Most are very similar—but the exceptions are what will trip you up.
- Many of you have had your Medicare carrier change over the last ten years.

Medicare is moving from 16 to 10 jurisdictions (Medicare Providers)

- J  Cahaba
- N  First Coast
- 6  NGS
- K  NGS
- E  Noridian
- F  Noridian
- H  Novitas Solutions
- L  Novitas Solutions
- M  Palmetto GBA (J11)
- 15  CGS
- 5  WPS
- 8  WPS
Medicare Jurisdictions

For some procedures there are national coverage determinations. (NCD)

LCD’s are published by your local Medicare provider.

Go to the Medicare website; find Provider information, find LCD’s or publications; review the long list of LCD’s and find all that pertain to your specialty.

If your carrier does not have an LCD find another one from another Medicare carrier (a different state).

There are Active, Retired, and Draft LCD’s.
What is Medicare Advantage (MA)?

- MA (aka Medicare Part-C) is required to offer at least the same amount of coverage as Medicare Part-B, but can include other benefits, like **routine vision, dental, and hearing coverage**.
- Some Medicare Advantage plans include full coverage for routine vision exams, vision correction products, and other vision care. This will be by plan and vendor.

What is Medicare Advantage (MA)?

- MA is not as simple as Part-A or Part-B.
  1. Each MA plan can be further divided into different **plan types** [next slide]
  2. While most will follow Medicare Part-B guidelines for your state (local vendor) some offer services not covered by Medicare Part-B.
  3. While most MA plans will defer to the local Medicare Part-B carrier some MA plans have their own Coverage Policy Bulletins.

- **Is everyone with me?**
Medicare Advantage Plan Types

- MA plans provide the patient with all their Part A and Part B benefits. Medicare Advantage Plans include:
  1. Health Maintenance Organizations (HMO).
  2. Preferred Provider Organizations (PPO).
  3. Private Fee-for-Service Plans (PFFS)
  4. Special Needs Plans (SNP)
  5. Medicare Medical Savings Account Plans (MSA).
  6. HMO Point of Service (HMOPOS) Plans (rare): An HMO Plan that may allow you to get some services out-of-network for a higher cost.

Advance Beneficiary Notice (ABN)

- Required by Medicare if you want to bill the patient for a non-covered service (does not meet medical necessity).
- Have the patient fill out the form. Explain that you may be paid, but if not they are responsible.
- Append modifier GA to the code.
- Use on screenings without medical necessity
- Be sure you have the latest version. Download from the Medicare website.
Medicare PFSRVU database

- Physician Fee Service and Relative Value Unit database. An ASCII/excel file on the Medicare website. It is free to download.
- Includes:
  - Bilateral surgery indicator (modifier)
  - Global Days
  - Breakable or not breakable NCCI edit flag.
  - Professional and Technical Component
  - RVU data
  - Much more.

Bilateral surgery indicator

- 1 = Unilateral
- 2 = Bilateral
- 9 = Concept does not apply
- 3 = 150% rule does not apply
- These flags are in the Medicare PFSRVU database. Some call them the bilateral surgery modifier.
- Some diagnostic codes are inherently bilateral such as fundus photography and visual field exams.
- **Not** in the CPT manual.
Global Period

- Also called Global Fee or Global Days. This applies to surgical procedures.
- Zero days; 10 days; 90 days; YYYY (contractor-priced); ZZZZ (add-on codes)
- Not applicable to diagnostic specialty tests (audiology, eyecare, psychological).
- Co-management
- The change to the global period codes is now on hold (Jan 2016).


Small surgical procedures

- Foreign body removal
- Biopsies
- Ear lavage
- Epilation (removal of an ingrown eyelash): 67820 (forceps) modifiers E1-E4, or RT or LT.
- 10-day global or zero day.
- How would not understanding global days impact reimbursement?
- Need adequate documentation.
- Should always be “separately identifiable” if reported with an E &M
National Correct Coding Initiative (NCCI) Edits

- Not in the CPT manual and not in the PFSRVU database. This information is separate.
- Medicare has files you can download (excel, ASCII)
- Long lists of CPT codes that cannot be reported on the same DOS.
- Breakable edits
- Unbreakable edits
- Use Mod-59 to break an edit. This is for two procedures on the same DOS. 2nd procedure must be separately identifiable.
- Usually included in edit software and specialty manuals.

Specialty Coding Manuals

- Optum
- Decision Health
- PMIC
- Coding Institute
- Understand that they split the difference between local coverage determinations and national. In other words, they cannot accommodate carrier-specific rules. It is an inherent problem with national coding advice.
Relative Value Units (RVU’s)

- Relative Value Unit
- All reimbursable procedures/services have an RVU value.
- E & M codes, surgical procedures, diagnostics, labs, radiology.
- Small procedures have low RVU
- Large procedures have high RVU’s
- Determines your reimbursement.
- Ritecode Coding Advisor has RVU’s
- Coding specialty manuals
- List CPT codes in decreasing RVU value.
- Not in the CPT manual.

Interpreting RVUs

- CY 2016 Physician Fee Schedule database.
- Medicare pays different fees in each of 92 localities or Geographic Practice Cost Indices (GPCIs) across the U.S.
- The split of RVUs varies by physician service but as a general guideline (on average):
  - Work RVUs 52.5 percent
  - Practice Expense (PE) 43.6 percent
  - Malpractice Insurance RVUs 3.9 percent
### RVU Examples

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
<th>Calculated RVU (W<em>PE</em>MP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>66984</td>
<td>Cataract surg w/iol 1 stage</td>
<td>22.35</td>
</tr>
<tr>
<td>31235</td>
<td>Nasal/sinus endoscopy dx</td>
<td>9.03</td>
</tr>
<tr>
<td>99214</td>
<td>Office/outpatient visit est</td>
<td>3.06</td>
</tr>
<tr>
<td>11200</td>
<td>Removal of skin tags</td>
<td>2.53</td>
</tr>
<tr>
<td>20610</td>
<td>Drain/injection joint/bursa</td>
<td>2.05</td>
</tr>
<tr>
<td>69210</td>
<td>Remove impacted ear wax</td>
<td>1.51</td>
</tr>
</tbody>
</table>

### Geographic Practice Cost Indices (GPCIs)

- The Geographic Practice Cost Indices (GPCIs) reflect the relative costs associated with physician work, practice, and professional liability insurance in a Medicare locality compared to the national average relative costs. There are three, individual GPCS values:
  - Cost of Living GPCI: Applied to physician work relative values
  - Practice Cost GPCI: Applied to practice expense relative values
  - Professional Liability Insurance Cost GPCI: Applied to professional liability insurance relative values.
GPCI Examples

<table>
<thead>
<tr>
<th>Locality</th>
<th>2016 GPCI Index</th>
<th>Work</th>
<th>PE</th>
<th>PMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles, CA</td>
<td>1.036</td>
<td>1.154</td>
<td>0.642</td>
<td></td>
</tr>
<tr>
<td>Northern NJ</td>
<td>1.044</td>
<td>1.186</td>
<td>1.045</td>
<td></td>
</tr>
<tr>
<td>West Virginia</td>
<td>0.963</td>
<td>0.828</td>
<td>1.229</td>
<td></td>
</tr>
<tr>
<td>Tennessee</td>
<td>0.972</td>
<td>0.898</td>
<td>0.523</td>
<td></td>
</tr>
<tr>
<td>Houston, TX</td>
<td>1.009</td>
<td>1.002</td>
<td>0.923</td>
<td></td>
</tr>
</tbody>
</table>

Setting Fees for Services

- Physician compensation level for a particular service (think CPT® code) is composed of three components:
  1. A Relative Value Unit (RVU) assigned to it. (Total of Work, PE and PLI).
  2. A geographical adjustment (GPCI) for your state or city is applied to each of the three RVU components.
  3. Multiply by the current year Medicare conversion factor (CF).
Fee Considerations

- Some Clinics set their fees at 130% or 150% or even 200% of the Medicare allowable.
- Higher fees will mean higher contractual write-offs per your private carrier contracts.
- Many private carriers will have a fee schedule.
- High fees could be an issue if you have a lot of Self-Pay patients.
- Always review your top 25 carriers payments every year on your top 25 services (do a search in your practice management system for your top 25 CPT codes).

Fee Setting Strategies

- Be consistent – do not have two fee schedules or different price structures.
- No carrier will pay more than what you charge even if their fee schedule is higher. Some carriers reimburse higher on services than others. Do you know who they are?
- Remember that patients get a copy of the EOB and can compare what you charge versus what the Plan pays.
Fees – Other Considerations

- Some Plans/Carrier pay a percentage of your billable charges. This can happen when a patient is “Out of Network.” Therefore higher charges are best in this scenario.
- Specialties tend to bill higher charges, as a percent of Medicare – but again there is no one formula.
- Do not charge any non-Medicare patients less than what you charge Medicare patients.
- Always read your contracts for “fine print” concerning billing.

Medicare Conversion Factor

- Total RVU’s are multiplied by the conversion factor to provide the Medicare allowable amount.

MPFS (Medicare Physician Fee Schedule)
- 2013: $34.02
- 2014: $35.8228
- 2015: $35.8013
- 2016: $35.8043
Other RVU Facts

- The RBRVS is **not used** to pay for anesthesia services. Medicare uses a separate conversion factor for anesthesia.
- What is the **Medicare Limiting Charge**? This applies to a non-participating health care provider. There is a limit (15% more than the amount Medicare allowable) on how much the provider can charge for a service covered by Medicare.

E & M Utilization

- Your specialty may be available from the medical association (orthopedics, cardiology)
- National utilization data.
- This should be performed for each provider and compared internally and to the national statistics.
- The bottom line is to answer the question: Why are your values different? Is that provider or your clinic seeing the sickest patients? Are you a sub-specialty? Don’t be alarmed if your skew higher, just be able to explain it. Don’t ever accept *time* as an explanation.
Upcoding

- **Upcoding**: reporting a higher level than documented or warranted based on documentation.
- MDM is the main culprit
- 2 of 3 rule (applies to E & M codes)
- ROS must be 10 or more for 99204 and 99215. Comprehensive Exam requirements vary by specialty
- 50% rule – auditors
- Suzie in Cleveland said she thinks the coding is just fine.
- History/Exam and MDM. What about time and counseling?

Downcoding

- More common than you might realize, it becomes quite clear to an auditor after several encounters are downcoded even though the medical decision making (MDM) clearly supports a higher level visit.
- Is it a legal issue?
- Is it a coding issue?
- Is it a billing issue?
E & M: 2 of 3 rule; 3 of 3 rule

- For a **new patient**, to report a given level, all three key components: hx, exam, and MDM must be at the highest level. Missing 10 ROS on a comprehensive encounter (99204) is fatal.
- For an **existing patient**, either hx, or the exam, may be at a lower level, and the level is determined by MDM and the other key component. This is the 2 of 3 rule.
- Remember that MDM always determines the level and can never the lower of the three.
- I have seen some clinics either skip or document a minimal hx or exam for a level IV or V visit. While I must audit these as "correct" I do not recommend it unless there is a very good reason for it (patient is going to the ER or unconscious).

Cloned Notes

- This is “copying and pasting” one note to another. With the increased use of Electronic Medical Records, this is the number one audit element.
- If verbiage is the exact same from visit to visit and patient to patient it can be audited as cloned. Ask if the information provides any specific information for this DOS or patient.
- If the number of ROS and exam elements do not change based on the presenting problem(s).
- If there is inconsistency in the medical record.
- Recent RAC Audits indicated that approximately 24% of EMR notes were cloned.
- Always include 3 statements that are unique to this patient on this DOS. Do not clone counseling verbiage.
Reporting Dx Procedures with an Office Visit

Why am I being Denied?

Confirm if there is a national Edit (NCCI) not allowing your diagnostic service and an Office Visit. This is common in Eyecare and ENT. **Many Carriers will deny these and state that the diagnostic service is included in the office visit.**

Always ask if it is a part of their plan benefits and where is this stated in the manual.

Explain that this is not a valid NCCI edit (except 99211) and they are completely separate. Be sure to send a one-page Overview of the Office Visit Elements and a Description of the diagnostic procedure.

---

Incident-To Services (E & M Code 99211)

- A minimal Provider E & M visit should be a 99212, not a 99211.
- 99211 does not require the presence of a Provider. Sometimes referred to as an “incident-to” Service (Medicare Concept)
- Do not report this code whenever a tech performs a diagnostic test. It is highly unlikely the claim will be paid. That is a national NCCI edit violation.
- To qualify as “incident to,” services must be part of your patient’s normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment.
“Incident to” Services

- Are services supervised by certain non-physician practitioners such as **physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, or clinical psychologists**.
- These services are subject to the same requirements as physician-supervised services.
- Remember that “incident services” supervised by non-physician practitioners are reimbursed at 85 percent of the physician fee schedule. For clarity’s sake, this article will refer to “physician” services as inclusive of non-physician practitioners.


What is a Utilization Review?

- This analysis is often conducted by the finance department and not the coding department. They analyze either office visits or common procedural codes and compare them to national averages. These should be performed by provider every year and they should receive a copy of the report. Deviations either higher or lower than the national average need to be explained.
- Arbitrary differences between providers should be corrected. This is an indication of either upcoding (non-compliant and at risk for pay-backs) or undercoding (lost revenue).
Sources of Comparative Data

- MGMA
- Specialty associations
- Medicare reimbursement database

Top Eyecare Surgical Codes – MCR 2014

<table>
<thead>
<tr>
<th>Code</th>
<th>(By)</th>
<th>QTY</th>
<th>Paid</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>66984</td>
<td></td>
<td>3146453</td>
<td>$1,691,656,285.2</td>
<td>7</td>
</tr>
<tr>
<td>67028</td>
<td></td>
<td>2625485</td>
<td>$211,863,175.25</td>
<td>2</td>
</tr>
<tr>
<td>66821</td>
<td></td>
<td>907809</td>
<td>$201,610,420.90</td>
<td>3</td>
</tr>
<tr>
<td>68761</td>
<td></td>
<td>344776</td>
<td>$36,806,357.86</td>
<td>4</td>
</tr>
<tr>
<td>66982</td>
<td></td>
<td>293643</td>
<td>$186,390,670.52</td>
<td>5</td>
</tr>
<tr>
<td>67820</td>
<td></td>
<td>251833</td>
<td>$9,659,182.75</td>
<td>6</td>
</tr>
<tr>
<td>65855</td>
<td></td>
<td>181079</td>
<td>$43,883,418.66</td>
<td>7</td>
</tr>
<tr>
<td>66761</td>
<td></td>
<td>96905</td>
<td>$20,173,191.41</td>
<td>8</td>
</tr>
<tr>
<td>67210</td>
<td></td>
<td>84454</td>
<td>$33,767,832.63</td>
<td>9</td>
</tr>
<tr>
<td>67228</td>
<td></td>
<td>82027</td>
<td>$63,001,349.82</td>
<td>10</td>
</tr>
<tr>
<td>67904</td>
<td></td>
<td>61330</td>
<td>$34,498,651.40</td>
<td>11</td>
</tr>
</tbody>
</table>
**Just because you can report it does not mean it’s reimbursed**

- 99050 and 99058
- Telephone calls
- S codes (HCPCS); other supply codes
- 92015 (refraction services) for Medicare Part-B patients
- Hearing aids
- Prolonged service codes
- Surgical Tray (A4550) [Medicare considers it bundled; AAPC forum indicates may be paid if *multiple trays* are used]
- Is reporting the codes above a “red flag?”
  

---

**Carrier-Specific Rules**

- **Medicare** carriers often list **documentation requirements** for common procedures in their Local Coverage Documentation.
- Medicaid often make up their own rules, guidelines and interpretations.
- Some carriers may want a report for modifiers 25, 59, or 22. Others may not.
Carrier Specific Rules

- What if the carrier requires “incorrect reporting” to be paid?
- This actually happens and most often with a local Medicaid.
- Billing needs to inform the coding staff of the issue. Typically the coder will state “well, that is incorrect.” You reply, “I know but we won’t get paid if we do it otherwise.”
- Two options
  - Comply and include in your carrier-specific manual.
  - Contact the carrier and perform “carrier education.” Many of my students have done this and sometimes the carrier will change their policy.
- Some carrier reps are not well trained.

Medical Necessity

- There is always a one to one linking of the ICD-10 code to the CPT procedure code or E & M code.
- If two codes are required, link both in Box 24E.
- Sometimes, sequencing of the ICD-10 codes will impact reimbursement. For example, for a screening of long term use of the drug Plaquenil (hydroxychloroquine) instead of linking the Z79.899 code first, link rheumatoid arthritis code first.
- The best source of linking information is your Medicare carrier’s Local Coverage Determination. If you cannot find one for your carrier, then we recommend any LCD is better than no LCD.
Remember it’s one-to-one linking

- **Never** link all four diagnoses (1,2,3,4) to a single CPT code on your claim form.
- 87809 Adenovirus assay w/optic
- B30.1: Other adenoviral conjunctivitis
- With some CPT codes you may link two ICD-10 codes (code additional)
- **Adenovirus infections** most commonly cause illness of the respiratory system; however, depending on the infecting serotype, they may also cause various other illnesses, such as gastroenteritis, conjunctivitis, cystitis, and rash illness.
- The common cold, croup, and bronchitis are all caused by an adenovirus. Contrast to **enteroviruses**.

Self-Pay Patients

Two strategies are:

- Using S codes for some services/procedures.
- Offering a percent discount for “Services paid in full at the time of service.”
- There are really no national guidelines on using S codes for self-pay patients. Some clinics use these to charge lower fees than on their fee ticket. Some societies and many consultants warn against this practice. Always check with your **legal counsel** if you are discounting for self-pay or “full payment at time of service.”
Read…

- Your Carrier manual
- Your contract. It may include specific language concerning what is paid and what is not.
- On an annual “To do” list you should:
  - Review every carrier contract.
  - Confirm someone has read every one of them.
  - Download an LCD or bulletin on every procedure you perform.
  - Review your current fee ticket.
  - Review your documentation.

Red flags?

- What exactly is a red flag?
- Personally there are no red flags, only codes and modifiers reported incorrectly or without sufficient documentation.
- If your clinic is in the top 5 percent you may have more procedures and higher level office visits than anyone in your area.
- Someone has to be in the number one slot!
- Why are you there? What does it mean? How do you protect yourself?
Do you want to be an Outlier?

- If it's justified, you want to be an outlier.
- More diagnostic procedures
- More higher level codes
- A lot more revenue.
- What do you need to make all this happen?
- What is a concise, correct answer for skewing higher?

Top Ten Medicare Part-B Denials (all specialties)

1. Duplicate Claims
2. Medical Necessity
3. Medicare Advantage Plans
4. Provider Eligibility
5. NCCI Edits
6. Screening/Routine
7. Non-Covered Service
8. Patient Supplies
9. Non-Covered Charge
10. Timely Filing
Twelve Appeal Steps

1. Identify a Rejection VS Denial
2. Get Organized before you call
3. Identify the Carrier / Gather the manual or LCD.
4. Is this a non-covered service?
5. Is pre-authorization always required?
6. ICD-9 Linking
7. NCCI Edit?
8. Correct Modifier?
9. What other codes were reported (office visits) on the same DOS?
10. Is this a Carrier-Specific Rule?
11. Is this worth appealing? Can you win?
12. Appeal as many times (levels) as necessary to get paid.

Appeals Process (Medicare)

- Once an initial claim determination is made, beneficiaries, providers, and suppliers have the right to appeal Medicare coverage and payment decisions.
- There are five levels in the Medicare Part A and Part B appeals process:
  1. First Level of Appeal: Redetermination by a Medicare carrier, fiscal intermediary (FI), or Medicare Administrative Contractor (MAC).
  2. Second Level of Appeal: Reconsideration by a Qualified Independent Contractor (QIC)
  3. Third Level of Appeal: Hearing by an Administrative Law Judge (ALJ) in the Office of Medicare Hearings and Appeals
  4. Fourth Level of Appeal: Review by the Medicare Appeals Council
  5. Fifth Level of Appeal: Judicial Review in Federal District Court
ICD-10 and Oct. 1 2016

- Carriers will be allowed to deny claims due to “unspecific codes.”
- What exactly does that mean?
- How will the rules change impact coding and billing?
- Training of the doctors to document more specific and accurate codes.
- Data-entry and computer-system issues.
- Will adding specificity to the disease improve reimbursement?
- Examples: acute conjunctivitis, asthma, headaches.

ICD-10 and Billing Compliance

- Why do I have to report six codes if one will get me paid?
- It’s the right thing to do. It is considered accurate and compliant coding and reporting.
- It helps worldwide research. Do you want to help improve worldwide healthcare?
- Yes, technically many codes are considered optional. Location and accident codes are not required by Medicare.
ICD-10: If one code works, why report two?

- Research
- Right thing to do.
- If you ever said that you wanted to be a doctor because you wanted to help people, here is your chance.
- It may not matter to you, or even how you treat the patient, but it could matter to someone (at a research facility somewhere).
- If you received notes from another doctor you would appreciate the additional detail.
- You will need to sell the doctors; you will need to sell the data entry department.

Billing Compliance (1 of 2)

- Concerned primarily with reimbursement.
- Entering additional codes, that do not impact reimbursement, requires more data entry and may be resisted by the billing department.
- Carrier-specific, not CPT manual specific.
- A carrier-specific manual is a valuable tool.
- Medicare, Medicaid and private carrier plan guidelines are typically outside the coding manuals.
- A billing manager and biller is often not concerned if the documentation matches as long as they are getting paid. This can be a problem.
Billing Compliance (2 of 2)

- This is a valuable exercise for every clinic.
- Create a list where billing compliance may not be in sync with coding compliance.
- RVU’s; Timely Filing; ABN
- Self-pay patients (what code do you submit?)
- MOD-25 usage (coding tells you to stop appending it to get paid).
- Medical necessity
- Appeals; is this a coding responsibility or coding?
- Cross-training of the billing and coding department should be an ongoing task.

Summary

- Billers will benefit from knowing more about coding.
- But sometimes there will be disagreements between what a biller needs and accurate and compliant coding.
- Sometimes a carrier will require that the claim be coded incorrectly (not following generally accepting coding guidelines).
- There are numerous billing areas (covered in more depth in the next presentation on Saturday) that coders do not learn and are not part of a coding certification exam.
ADDITIONAL INFORMATION

Story of excessive 99215 Encounters

- Roughly one percent of your visits could be a level 5. Therefore if your group saw 300 patients per week that would be 3 per week or 150 for 50 weeks per year.
- What about too many 99215’s?
- Medicaid auditor said they were no problem
- Years later there was another audit.
- It was revealed during the appeal that it was the Medicaid auditors first audit—ever!
- And remember, auditing specific office visit encounters per Medicare guidelines is not on a coding certification exam.
- The clinic lost their appeal.
Bad Advice (aka Free Advice)

- Here is a statement from a generic coding website:
  - “Again, most re-evals should be billed with a 99213. 99214 should be rarely used, and 99215 should almost never be used.”

- I have seen some providers use a “follow-up” form. There is no specific code for a follow-up.

- Never use time to determine a visit. It is irrelevant except for a visit based on consulting.

- A 99214 is supported based on medical decision making. Three diagnoses will support it.

- A 99215 is roughly one percent of all visits but should be reported when there is an imminent threat to life or organ system.

Destruction of Lesion Example

- The surgical operative report details:
  - “the hemangioma on the patient’s face was destroyed.”
  - “the port wine stain was ablated.”
  - “the strawberry birthmark was removed via laser.”

- The coder/biller asks the provider if these are malignant or benign. He responds, “they are benign.” She codes them as:

  - 11440: Excision…benign lesion…eyelids….5 cm or less.

  - The RVU is 2.93 and approximate Medicare allowable in LA CA is $150.38.
Destruction of Lesion Example

- However, after some research, the coder discovers that these are considered "cutaneous vascular proliferative lesions."
- The destruction codes are 17106 to 17111 and the RVU for 17106 is 7.72; approximate allowable in LA CA is $370.10.
- That’s over twice as much as the benign lesion code!
- If the coder never asks and the surgeon never documents the specific term "cutaneous vascular proliferative lesion" then these procedures will never be reported correctly and the clinic will lose money every time the procedure is performed.

ICD-10: Two codes instead of One

- If the ICD-10 manual includes instructions to:
  - Code first
  - Code also
  - Code additional
  - Code the underlying cause

It is considered accurate and compliant coding to document and report the second condition. Will you be denied if you do not report it?

The best answer: it depends on how strict the insurance company edits for errors. If you create a good habit of always reporting the second code when required, you should always be paid. However, not reporting the second code is flipping a coin hoping that the insurance company will not deny you.
Example of Anatomy and Coding

- 65280 Repair of laceration; cornea ... not involving "uveal tissue" (estimated Medicare allowable amount is $772 [fully implemented non-fac RVU=20.1])
- 65285 Repair of laceration; cornea ... with ... "uveal tissue" (estimated Medicare allowable amount is $1,179 [fully implemented non-fac RVU=32.92]).
- If the coder never asks and the surgeon never documents that "uveal tissue" was involved, then this procedure will never be reported correctly. The difference is $407!
- Where and what exactly is the uvea?

The uvea is the: iris, ciliary body and the choroid. These are all contiguous structures of the eye.

QUESTIONS?