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On the topic:
Optimizing Compliance and Maximizing Revenue

Jeffrey Restuccio,
CPC, COC, MBA
Ritecode.com
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Optimizing Compliance and Maximizing Revenue

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

Today’s Presentation

• Often compliance will be at odds with maximizing revenue. In addition before a clinic should embark on a system-wide goal of maximizing revenue, they must ensure that their coding, billing, documentation and reporting is compliant and could withstand an audit from any group.

• The first part of the presentation we will wear our Compliance Director hat. The second part we will remove it and wear our CFO/Billing Director hat. Some of the information will be the similar but we will approach it from the two different perspectives. Whether you are new to coding and billing or a seasoned veteran, it’s a valuable exercise.
Introduction

• Please understand that in all my classes I have a mix of new and experienced coders and billers as well as providers. In my presentation I will address basic and complex topics, administrative concepts and clinical information.

• This is a shortened version of a full, six-hour day program. Therefore we will not define every basic term and concept you should know in detail. Here is my list of 45.

45 Key Coding, Billing Concepts

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Ranking of Guidelines (CPT™ Concepts)

State Regulations
State Boards
Medicaid Guidelines
Medicare Advantage (Part-C)
Private Payor Guidelines
Medicare Guidelines
General CPT™ Concepts – AMA Guidelines

If Medicare Guidelines disagree with AMA CPT Guidelines, who do you go with?
Compliance Obstacles

- Everyone must learn the basics: This includes providers, front-office staff, and management. I recommend everyone be tested for basic coding and billing knowledge.
- 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 2017.
- Have a current HCPCS book.
- Know which procedure codes are unilateral or bilateral.
- Know your global days (zero, 10, 90)
- Know modifier rules.
- Understand ICD-10/CPT linking and Medical Necessity Rules.

Medical Necessity, Billing

- It is the one-to-one linking of a diagnosis to a CPT code to support medical necessity.
- Some CPT codes require two diagnoses.
- Some CPT codes are paid only on a very specific diagnosis.
- The source for medical necessity is the Local Coverage Determination.
- Without medical necessity, the procedure is a screening.
- This is the “catch 22” of healthcare.
- If unsure if paid, have the patient fill out an ABN (Medicare) or a similar private carrier form stating they are responsible if the carrier does not pay.
Medicare Local Coverage Determinations

- LCD’s are published by your local Medicare provider.
- Medicare is not one monolithic agency regarding reimbursement.
- Every Medicare intermediary (jurisdiction) has slightly different rules and guidelines.
- 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.
- The number of CPT codes covered will range from 6 to 18.
- If your carrier does not have an LCD find another one from another Medicare carrier (a different state).

Medical Necessity

- Medicare LCD for **Routine Foot Care**: L34944 (Cahaba)
- Includes general background, CPT codes and ICD-10 codes supporting medical necessity.
- Sometimes Medicare adds to or differs from CPT definitions: Although CPT coding does not exclusively apply CPT codes 11720 and 11721 to mycotic nails or to the feet, Medicare assumes these are the CPT codes usually used to code for services related to debriding mycotic nails.
- Foot care services are covered in the presence of a systemic conditions. (e.g., DM, arteriosclerosis obliterans, Peripheral neuropathies)
Medical Necessity

- Medicare LCD for **Cardiovascular Stress Testing**: L34324 (Noridian)
- Includes general background, CPT codes and ICD-10 codes supporting medical necessity.
- A cardiovascular stress test (93015-93018) is a diagnostic test designed to evaluate a patient for the presence or the severity of coronary artery disease (CAD), exercise-induced arrhythmias or hemodynamic changes, and/or cardiac functional capacity.
- Numerous CPT and ICD-10 code combinations.
- All relevant LCD’s should be reviewed periodically.

Surgical Operative Reports

- Mostly 90-day procedures (ASC and hospital)
- For small procedures, recommend separating the surgical notes from the office visit progress notes.
- Sometimes the actual procedure does not match the Op Report description.
- Always should be spot-audited once a year.
- Watch for cloning.
- Watch for RT and LT consistency.
Small Surgical Procedures

- Foreign body removal, cornea: (65220 or 65222 [slit lamp]) [global period is zero–day of service only]
- Aspirations
- Nasal endoscopies

- 10-day global or zero day global.
- Need adequate documentation.
- Should always be “separately identifiable” if reported with an E & M and MOD-25 [e.g., link E & M to glaucoma or cataract]

Co-Management

- These are common with cataract surgery. Another provider (optometrist) provides the follow-up care (post-op care, co-management) of a 90-day global surgery patient. It can be any number of days (87, 60, 45) your reimbursement will be prorated.
- The surgeon reports with Mod-54.
- The optometrist reports with Mod-55 and RT or LT.
- Your reimbursement is 20% of the Medicare allowable.
- Some Medicare carriers have slightly different reporting rules and guidelines. A few require that units = days. Always confirm with your specific Medicare carrier.
Screenings

• Any procedure performed in the absence of a diagnosis supporting medical necessity.
• Primary Care
• OB/GYN
• Ophthalmology

Always link a preventive/routine exam to Z0-00 or Z0-1.01 if there is no presenting problem.

Medicare Preventive Services

• Medicare has dozens of preventive codes and services:
  – Alcohol Misuse Screening and Counseling
  – Annual Wellness Visit (AWV)
  – Bone Mass Measurements
  – Cardiovascular Disease Screening Tests
  – Colorectal Cancer Screening
  – Counseling to Prevent Tobacco Use
  – Depression Screening | Diabetes Screening
  – Diabetes Self-Management Training (DSMT)
  – Glaucoma Screening
**Medicare Preventive Services**

- Hepatitis B Virus (HBV) Vaccine and Administration
- Hepatitis C Virus (HCV) Screening
- Human Immunodeficiency Virus (HIV) Screening
- Influenza Virus Vaccine and Administration
- Initial Preventive Physical Examination (IPPE)
- Intensive Behavioral Therapy (IBT) for CVD
- Intensive Behavioral Therapy (IBT) for Obesity
- Lung Cancer Screening Counseling and Annual Screening for Lung Cancer With Low Dose Computed Tomography (LDCT)
- Medical Nutrition Therapy (MNT)

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**Medicare Preventive Services**

- Pneumococcal Vaccine and Administration
- Prostate Cancer Screening
- Screening for Cervical Cancer with HPV Tests
- Screening for Sexually Transmitted Infections (STIs) and Behavioral Counseling (HIBC) to Prevent STIs
- Screening Mammography
- Screening Pap Tests
- Screening Pelvic Examinations (includes a clinical breast examination)
- Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)
Long-Term Use of a High-Risk Drug

- In many specialties you will be reimbursed for an office visit, diagnostic tests linked to screening for the long-term use of a high risk drug. The definition of “long-term use” will follow standards of care for your specialty and the specific drug. **These are reimbursed screenings.** There are numerous conditions and drugs that impact other systems. Examples include:
  - Boniva
  - Psychotropic drugs
  - Accutane
  - Steroid use
  - Dozens more…

Professional Component

- All radiological procedures and diagnostics with an image or tracing include a professional and technical component. If you own the equipment, use your own tech, and document the interpretation and report—simply report the procedure without any modifiers.
- MOD-26: Professional Component Only
- This is also called the **Interpretation and Report**
Technical Component

- Report with MOD-TC
- This is the payment for the equipment and the tech’s time for the diagnostic or x-ray equipment.
- Anything with an image or tracing.
- You do not perform the professional component (MOD-26)
- The other doctor performs the interpretation and report.
- If you have the equipment and perform the test, report the procedure with MOD-TC, the other doctor reports with MOD-26.

Legal Issues

- All clinics need to know when an issue is more a legal issue, that must be review with an attorney, versus a coding compliance issue.
- **Contractual issues.** If a specific contract states that you must document a certain way or cannot use “overhead” in determining your costs, then you must abide by that contract.
- Stark laws and self-referral.
- Undercoding
- Self-Pay patients
Summary – Selected Topics

• In all there are at least 45 key coding and billing concepts. We’ve reviewed here just a sample. It is imperative that every manager, provider, coder, and billing at least be aware of them and their significance.

So What?

How does it impact your compliance and risk?
How does it impact revenue?
We will now discuss compliance.
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

Seven Core Elements of a Compliance Plan

1. Adequate compliance standards and procedures
2. Effective compliance oversight
3. Careful delegation and due care in hiring/screening employees
4. Effective training and education for roles and responsibilities
5. Monitoring, auditing, and hot lines
6. Enforcement for violations (what is a plan with teeth?)
7. Corrective action.

Have a plan even if it is one page. Mine is over 40.
Compliance Strategies

• Prepare a Coding Compliance Plan for your clinic.
• Comprehensive Review of Documentation.
• Create a plan then work it every month.
• Don’t worry about red flags
• Instead, Audit-Proof your documentation

What Exactly is a Red Flag?

• Some call them outliers.
• Do you want to be an outlier?
• If it’s justified, you want to be in the top ten percent in your specialty for your area. However, the outlier cannot be arbitrary. It must be justified.
• What is a concise, correct answer for skewing higher?
• More procedures.
• More higher level codes.
• A lot more revenue.
Compliance

- Always remember there is a difference between compliance and getting paid.
- Required documentation must support the service (code) reported to an insurance company.
- Another good question should be, “compliant with whom?”
- Medicare guidelines
- Medicaid
- Private carriers.
- What is an official or valid source? (CPT™, CPT™ Assistant, Medicare, OIG, AHIMA ICD-10 guidelines).

Compliance Issues: Audit Risk

- Specialty Board audit
- Medicare Whistleblower audit.
- Medicaid Audit
- Private carrier audit
- Unhappy customer audit (triggered by complaints)
- Outlier Audit (Excessive reporting of a specific code.)
- Interpretation and Report Audit
- Meeting documentation standards
Types of Audits

- Medicare, Medicaid, private Carrier, Office of Inspector General (OIG) and RAC.
- *Always ask* if what you document and what you perform would be approved by a *jury of your peers*.
- Legal audits – Note that these follow different rules than Medicare/CPT based audits. Example: No Hx or Exam taken per 2 of 3 rule.
- I am not a lawyer and don't give legal advice.

Compliance Implementation

- At least one annual coding and documentation compliance 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.
- There may be pushback from the doctors, finance or billing.
- There will be many obstacles to implementing coding compliance for your clinic.
- Find a champion.
The Mind of an Auditor

Overall Documentation
• Organization
• Legibility
• Consistency
• Evidence of Training
• Accurate use of coding guidelines and scoring rules.
• Cloned notes and phrases
• Use the same verbiage as Medicare
• I tell my audit clients that one of my goals is to teach them how to speak fluent auditor.

The 50% (Auditing) rule

• This is an Ritecode Concept. You won’t hear this anywhere else.
• For many of my audits I prefer a percentage of audit risk versus correct or incorrect.
• Some consultants teach everything is Black and White. I don’t.
• If I believe there is 50% or greater probability that an auditor will rule against you then I will audit it as incorrect.
• That means you can find “Suzie” in Idaho, a certified coder with 20 years experience, and she will not agree with me. I can find 5 and you can find 5. Those are coin flipping odds. Are you willing to assume that risk?
• There is a wide difference in the skill level and clinical experience of documentation auditors
• All auditors are not created equal
• Lots of vague and interpreted rules. (see grey areas).
Specific audit focus examples

1. Level IV codes.
2. Misuse of **modifier-25**
3. Misuse of **2 of 3 rule**.
4. Two psychiatric elements (mood and effect and A+OX3 in *history* and not *exam*). I have seen these more than one time in EMR software.
5. Cloning
6. Right and left cloning of surgical operative notes
7. One time and not two when using counseling to determine the level of the office visit.

Documentation Consistency

- If the patient is on Aricept© (Donepezil) then there should be consistency in the medical record:
- ROS: Psychiatric should note this.
- Exam: A & O X 3 should note this.
- MDM: Relevance should be noted.
- Never check ROS: *All Normal* when the patient is on Lasix, Boniva and Effexor.
- This is not specifically a CPT or Medicare guideline. It helps to avoid the impression of cloning; it shows continuity, and an attention to details. This is my interpretation on ROS—especially with specialties.
- Some auditors may not enforce, require or discuss this.
Documentation Consistency and Cloning

• Notes should be (boringly) consistent but never cloned.
• If an auditor can lay out 10, 20 or 30 notes that all look identical, these can be considered “cloned notes.”
• Your History and Exam elements should change from level to level and be relevant to the presenting problem(s).
• Many EMR vendors will encourage copying notes from a previous visit. (i.e., diseases). This is not considered accurate or compliant documentation. Only report what is relevant and managed today.
• A consistent error across patients, encounters, and providers is an example of a cloning template (and programming error).

Cloned Notes

• This is “copying and pasting” one note to another. With the increased use of Electronic Medical Records, this is now a primary audit target. Do you have a written cloning policy?
• If verbiage is the exact same from visit to visit and patient to patient it can be audited as cloned.
• 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.
• Government audits indicate that a high number of EMR notes are cloned (around 24%).
• Counseling documentation: Always include 3 elements that are unique to this patient on this DOS. Do not clone counseling verbiage.
Office Visit Errors

- **Selecting the level before the encounter.**
  - I have seen some clinics where the code level is selected before the encounter. It appeared to be somewhat arbitrary. This is not recommended. The Medical Decision Making should determine the visit. The documentation should determine the visit.

- **Documenting the time every visit** or selecting E & M codes by time (other than for counseling and coordination of care).

- **Two one progress note forms,** (E & M and a follow-up form)

Chief Complaint

Yes, CPT does state “it is in the patient’s own words.” However, this does not mean that the following are sufficient:

- “My wife told me to come.”
- “Feeling better.”
- “Here for IOP.”
- “Here to review labs.”
- You are at risk, not the patient. Your staff needs to explain to the patient why they are returning. It should always be medical diagnosis, a medical reason, a condition or disease to link the visit.
- Otherwise, it is a **routine “well” exam.**
Does the chief complaint “lock you in?”

This is from a national Medicare Regulations and Guidance Transmittal dated August 8 2014. [original link is on the Ritecode.com website] I’ve been asked, many times over the years, what are the guidelines concerning the chief complaint for an Evaluation and Management office visit. It is an official position on whether the provider can use a confirmed diagnosis when the patient presents with only signs and symptoms. The text is below:

- “For outpatient claims, providers report the full diagnosis code for the diagnosis shown to be chiefly responsible for the outpatient services. For instance, if a patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom is reported. If, during the course of the outpatient evaluation and treatment, a definitive diagnosis is made (e.g., acute bronchitis), the definitive diagnosis is reported.”

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 (99203) 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.
- Remember that MDM always determines the level and can never be the lower of the three (hx, exam and MDM).
- 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 this unless there is a very good reason for it (patient is going to the ER or unconscious).
Counseling and Coordination of Care, Time

- Must include both total time and then either counseling time or a specific percent.
- Must be over 50% of total time.
- Must be unique as a counseling note. Use the phrase “I counseled the patient on…”
- Always something unique to the patient and this individual encounter (Date of Service) in your notes.
- Include specifics on what was discussed, the reason and topic of counseling.
- History and exam should be minimal; do not include counseling with every progress note; do not document comprehensive exam notes with counseling.
- MDM is no longer a factor. State time and counseling was used to determine the level of the visit.
- Use the estimated times in your CPT manual per E & M code.

Upcoding/Downcoding

- I see just as many upcoding instances as downcoding.
- An upcoded note could cause the clinic to pay back the over-charging.
- Any deficiencies in hx or exam can and should be corrected immediately.
- MDM is more difficult and the majority of providers simply have never received training in how it is scored.
- While there are some articles on the impact of downcoding, it is mostly financial—the provider is simply losing revenue, that he/she is entitled.
- Remember, most EMR systems do not score MDM.
Upcoding/Downcoding

- **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: Remember 2 and 10 (comprehensive). Comprehensive Exam requires 13+1 elements.
- 50% rule – auditors
- Suzie said so and so.
- Three key E & M components: History/Exam and MDM.
- **Downcoding** – simply losing money.
- Is it fraudulent or illegal to downcode?

Diagnosis Problem Lists

- There is a very distinct difference between a *problem list* and the final, *differential diagnosis assessment*.
- However copying every diagnosis from previous encounters as the **current presenting problem** is very common with EMR systems. While sold by EMR vendors, this is not considered proper documentation.
- Do not list every diagnosis (i.e., a problem list) in your assessment. This is not compliant and an auditor could challenge whether you could have reviewed, and managed every condition listed during that visit.
- Only report those conditions relevant, managed, and reviewed **today**.
- If you are reporting a level IV E & M encounter always strive to list either a new dx or at least three; otherwise the encounter while most likely not support moderate MDM.
Medical Decision Making (MDM)

- Single most important element in determining the level of an E & M office visit.
- The sicker the patient and the more chronic illnesses, generally, the higher the MDM. Think 3 chronic illnesses = moderate MDM.
- **Time is not a factor** (Except for counseling encounter)
- Three Tables in CPT. 1) Number of diseases 2) Data analyzed 3) Table of Risk. Medicare has more detailed guidelines.
- The MDM scoring system was not developed by Medicare or in the original guidelines but widely used by Medicare intermediaries and auditors.

MDM (really) Simplified

- Chronic cough, Diabetes Type II, hypertension, URI, alone, **established**, stable, will never support moderate MDM or a 99214 level E & M code.
- 90% of the time, Table A and C will support the MDM level. Table B is rare.
- Three stable diagnoses, with at least two chronic will always support moderate MDM.
- Recommend reporting three diagnoses to the insurance carrier with all 99214 level E & M codes when appropriate.
- Be clear if the disease/condition is newly diagnosed; then it is three points (Table A) and could support moderate MDM.
Medicare Guidelines

- Very detailed payment and documentation guidelines.
- About 74% of private carriers follow Medicare guidelines.
- Many guidelines are local and not national.
- Medicare and the OIG will audit you.
- Medicare Concepts:
  - “Incident To” Services
  - Local Coverage Determinations
  - 1997 Exam
- Jurisdictions

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 if the carrier does not reimburse, then the patient is responsible.
- Append modifier GA (MOD-GA) to the code.
- Use on screenings without medical necessity Be sure you have the latest version. Download from the Medicare website.
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.
• MA is not as simple as Part-A or Part-B. Each MA plan can be further divided into different plan types. (HMO, PPO, etc.)
• While most will follow Medicare Part-B guidelines for your state (local vendor) some offer services not covered by Medicare Part-B.

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)
• Compliance Tip: Do not report this code whenever a tech performs a diagnostic test. It is a national NCCI edit violation and highly unlikely the claim will be paid..
• If a patient has an IOP check without seeing the provider then a 99211 could be reported.
Carrier-Specific Rules

- Many consultants don’t teach this concept.
- Main culprits: National conventions. A consultant who works in a particular clinic in the same city for 20 years.
- There are different Medicare jurisdictions and providers.
- There are over 50 different Blue Cross/Blue Shield plans.
- Every state Medicaid is different.
- You need to know the difference between a national rule and a carrier-specific one.
- MOD-50 vs RT/LT; MOD-59; requiring documentation, units for co-management are all examples.
- If the rule is not published you can send a questionnaire.

Modifier 25

- CPT manual states it must be “separate and distinct.”
- However, CPT also states that it may be linked to the “same ICD-10 code!”
- However, I personally recommend two, separate diagnoses to avoid confusion.
- Most often used for small surgical procedures:
  - Knee aspiration
  - ENT diagnostics for deviated septum
  - Removal of a foreign body
- Do not report if the procedure is the only reason the patient is seeing the doctor.
What is a foreign body?

- It is dirt, metal, wood or glass.
- It is not something put into the body such as a stent, wire or suture.
- Not something the eye creates such as conjunctival concretions (lithiasis): 372.54
- Do not report the removal of something put into the body as a foreign body removal.
- This definition does not match the clinical definition found in most medical journals.

Interpretation and Report

- Required as part of the “Professional Component”
- There are three main components.
  1. Clinical Findings
  2. Comparative Data.
- Do not list simply “normal.” Recommend separate from office visit documentation. What is the source of the three requirements above? Is it a Medicare requirement?
- Valid Documentation Sources: Medicare LCD. BCBS Bulletin. AMA: owner of CPT ©
- Next slides provide additional detail. The provider does not need to “write a book”, just address each component.
Compliance Obstacles: Implementation

- Recommend **baseline** training for all new doctors and billers/coders.
- No **buy-in** from Doctors or Managers.
- No **funding** for training and audits.
- The inherent problem that in an organization of 10, 50 or 100 doctors a** certain percentage** will always Overcode (or under-document) and Undercode.
- How strict are you willing to be? Are you actually willing to **fire** a doctor for non-compliance?
- The billing director is paid a bonus on revenue.
- It is always good to have a third-party audit your clinic.

**Top Gray areas in Auditing**

1. Is it a self-limited diagnosis (max. 2 points) or chronic (up to 4)
2. Incident-to services. Can it be a tech or nurse?
3. Chief complaint locked in or not?
4. How do you report a wrong referring diagnosis?
5. Two of Three Rule (Doctor’s argue that Medical Decision Making is the low score and that exam and history are at the same level).
6. Billing a preventive “well” visit plus and E & M on the same DOS.
Top Gray Auditing Areas

7. Cloned notes / Illegible notes
8. Interpretation and Report guidelines for 3 components
9. Aricept in medicine list, a line through ROS (psychiatric) and nothing listed in Alert and Oriented to time, place and person. Is that a contradiction, cloned note or does a person need to have specific active complaint for ROS?
10. Is undercoding illegal or considered fraudulent?
11. Counseling time. Is one time sufficient or are two required?

Top Gray Areas in Auditing

12. What do you do (or use) if there is not an LCD for a procedure from your local Medicare carrier?
13. Accepting a Problem List in the History section as supporting MDM or considered an assessment.
14. A list of diagnoses is not sufficient for the assessment/impression (no status codes: stable, worsening, improving, or “not responding as expected to treatment.”)
15. Why report injury location (home, work) and reason (drill press, bicycle) if not required?
Optimizing Compliance Action Plan

• Don’t try to do everything at once.
• Set out a list of tasks and work them over the next six months.
• Work a different area every month.
  – Office Visits
  – Procedures
  – Top Insurance Carriers
• Work on the progress notes first.
• Be sure to have an LCD for every procedure and review it.
• Be sure to review ICD-10 codes every 3-6 months in 2016.

Optimizing Compliance Summary

• Don’t worry about red flags – audit-proof your practice.
• Know the basics: E & M, procedures, ICD-10 specificity, Medicare guidelines.
• Audit your documentation every six months and discuss the results with all the providers.
• This is not a comprehensive review on this topic.
ICD-10 and October 1 2016

• Medicare carriers will now be allowed to deny claims due to “unspecific codes.”
• What exactly does this mean?
• For some this refers to laterality: right or left.
• Another possibility would be unspecified asthma, bronchitis, heart disease or other common conditions.
• It also could apply to the application of the AHA 2017 ICD-10 Coding Guidelines for sequencing codes and reporting additional codes when instructed. Most EMR systems do not include these instructions.

Hierarchy of ICD-10 Coding Activities

• 100% accurate and compliant coding and billing: audit-proofing your clinic
• Reporting codes at highest specificity: tell a story.
• Supporting medical necessity: reimbursement
• Coding Guidelines: sequencing
• Reporting sequela, adverse effects, poisonings
• Reporting injury, activity, and location.
• Coding Guidelines: Includes/Excludes
• Alternate terms and definitions
• Laterality: eyes, eyelids, no laterality and other categories.
• Bookkeeping: crosswalking ICD-9 to ICD-10
Maximizing Reimbursement
Through Accurate Coding, Billing, and Documentation
1. Updating your fee schedule. Understanding RVU's
2. Learn how to appeal denied claims.
3. Niche markets: psychiatric, neurology, orthopedics, pediatrics
4. Reporting optimal levels (audit-proofing your clinic)
5. Documenting and scoring E & M office visits
6. Know how to score MDM.
7. Understanding medical necessity
8. Medicare Guidelines and Tips
9. Knowing information not in the CPT™ manual (e.g., unilateral vs bilateral codes)
10. Work screenings for high-risk drugs
11. How to document the Interpretation and Report for diagnostic tests

Medicare PFSRVU Database

• Physician Fee Service and Relative Value Unit database. An ASCII/Excel file on the Medicare website. It is free to download. This is information not found in the CPT™ manual! The file is updated every year.
• Includes:
  – RVU data
  – Bilateral surgery modifier
  – Global Days
  – Breakable or not breakable NCCI edit flag.
  – Professional and Technical Component
  – Much more.
National Specialty-Specific Manuals

- Coding Coach™ by AAOE
- Optum™ Coding Companion
- Decision Health Manual
- PMIC Coding Guide
- Where do they get all this information?
- Is there a national repository for medical necessity?
- While it may not appear that way, staff medical professionals are determining medical necessity for each service or procedure.

Relative Value Units (RVU’s)

- All reimbursable procedures/services have an RVU value.
- These are established by Medicare and determine your Fee Schedule.
- E & M codes, surgical procedures, diagnostics, labs, radiology.
- Small procedures have low RVU
- Large procedures have high RVU’s
- Determines your reimbursement.
- Coding specialty manuals
- List CPT™ codes in decreasing RVU value.
- Not in the CPT™ manual.
2017 Medicare Conversion Factor

- 2013: $34.02
- 2014: $35.8228
- 2015: $35.8013
- 2016: $35.8279

- **2017 Conversion Factor 35.89**

More on RVUs

- The Medicare allowable is based on the total RVU *times* the GPCI value. The national average would be 1.0 with some areas higher and some lower.
- The split of RVUs varies by physician service but as a general guideline (on average):
  1. Work RVUs 52.5 percent
  2. Practice Expense (PE) 43.6 percent
  3. Malpractice Insurance RVUs 3.9 percent
- Medicare pays **different fees** in each of 92 localities or **Geographic Practice Cost Indices (GPCIs)** across the U.S.
### Procedure 71010: Chest X-Ray

<table>
<thead>
<tr>
<th></th>
<th>Medicare Facility</th>
<th>Medicare Non Facility</th>
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</thead>
<tbody>
<tr>
<td>Global Allowed</td>
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<td>$23.00</td>
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<tr>
<td>Reimbursement</td>
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<tr>
<td>After Sequest</td>
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<td>$18.03</td>
</tr>
<tr>
<td>RVUw</td>
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<td>0.18</td>
</tr>
<tr>
<td>RVUpe</td>
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<td>0.44</td>
</tr>
<tr>
<td>RVUm</td>
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<tr>
<td>RVU total</td>
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<td>0.64</td>
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</table>

### Procedure 71010 (Atlanta GA)

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<th>NH Facility</th>
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<tr>
<td>26</td>
<td>$9.34</td>
<td>$9.34</td>
<td></td>
</tr>
<tr>
<td>RVUw</td>
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<td>0.18</td>
<td></td>
</tr>
<tr>
<td>RVUpe</td>
<td>0.07</td>
<td>0.07</td>
<td></td>
</tr>
<tr>
<td>RVUm</td>
<td>0.01</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td>RVU total</td>
<td>0.26</td>
<td>0.26</td>
<td></td>
</tr>
<tr>
<td>TC</td>
<td>Allowed</td>
<td>$13.66</td>
<td></td>
</tr>
<tr>
<td>RVUw</td>
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<td>0</td>
<td></td>
</tr>
<tr>
<td>RVUpe</td>
<td>0.37</td>
<td>0.37</td>
<td></td>
</tr>
<tr>
<td>RVUm</td>
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<td>0.01</td>
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<tr>
<td>RVU total</td>
<td>0.38</td>
<td>0.38</td>
<td></td>
</tr>
</tbody>
</table>
Tip$: Setting Fees

• Many clinics charge a percentage of what Medicare pays you.
• The number ranges from 130% to 150% with occasionally a surgical group at 200%.
• The higher your percent, the higher your contractual write-offs will be.
• Another strategy is to use what your top insurer pays as a benchmark. Same issue with write-offs.
• Technically, it's illegal to ask other practices what they charge.

Fees: Office visits as a % of MCR

<table>
<thead>
<tr>
<th>E &amp; M</th>
<th>Total</th>
<th>130%</th>
<th>150%</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>$81.46</td>
<td>$105.90</td>
<td>$122.19</td>
</tr>
<tr>
<td>99203</td>
<td>$117.59</td>
<td>$152.87</td>
<td>$176.39</td>
</tr>
<tr>
<td>99204</td>
<td>$179.36</td>
<td>$233.17</td>
<td>$269.04</td>
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<tr>
<td>99205</td>
<td>$223.03</td>
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<td>$48.07</td>
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<tr>
<td>99213</td>
<td>$79.63</td>
<td>$103.52</td>
<td>$119.45</td>
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<tr>
<td>99214</td>
<td>$117.26</td>
<td>$152.44</td>
<td>$175.89</td>
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<tr>
<td>99215</td>
<td>$156.62</td>
<td>$203.61</td>
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<td>92012</td>
<td>$96.02</td>
<td>$124.83</td>
<td>$144.03</td>
</tr>
<tr>
<td>92014</td>
<td>$138.75</td>
<td>$180.38</td>
<td>$208.13</td>
</tr>
</tbody>
</table>
Global Period

- Also called Global Fee or Global Days
- Applies to surgical procedures.
- Zero days
- 10 days
- 90 days
- Not applicable to diagnostic tests such as fundus photography, visual field exam.
- Co-management (cataracts: 90 day global procedures)

Why do I care?
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Bilateral Surgery Modifier

- 1 = Unilateral
- 2 = Bilateral
- 9 = Concept does not apply (92015 refraction services)
- 3 = 150% rule does not apply (get paid 100% for each eye)
- These flags are in the Medicare PFSRVU database.
- Some diagnostic codes are inherently bilateral such as fundus photography and visual field exams.
- If you perform a unilateral procedure on both eyes on the same DOS, you are reimbursed 150% for both eyes, not 200%.
- This information is Not in the CPT™ manual.

Why do I care?
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Other PFSRVU Surgery Flags

- These flags (0, 1, 2 and 9) indicate whether:
  - Assistant Surgeon
  - Co-Surgeon
  - Team Surgeon
- Are allowed and payable
  - Asst Surg 2 Payment Restriction
  - Co-Surg 1 Permitted, Documentation may be necessary
  - Team Surg 0 Not Permitted

NCCl Edits

- National Correct Coding Initiative
- Not in the CPT manual
- Not in the PFS-RVU database
- Medicare has files you can download (excel, ASCII)
- Long lists of 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.
**TIPS: Special Codes: 99050**

- 99050: Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service. Medicare does not pay on this service.

<table>
<thead>
<tr>
<th>Report both codes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
</tr>
<tr>
<td>99050</td>
</tr>
</tbody>
</table>

**TIPS: Special Codes: 99058**

- 99058: Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service. Not paid by Medicare.
  - Can a carrier request you not bill their patients this code?

<table>
<thead>
<tr>
<th>Report both codes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>99214</td>
</tr>
<tr>
<td>99058</td>
</tr>
</tbody>
</table>
**TIPS: 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 request an e-mail reply.

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**More Tips on Appeals**

- State the facts.
- State your certifications if you have any.
- Know your CPT™, ICD-10 and HCPCS rules and guidelines.
- Always reference medical necessity, modifier rules, NCCI edits, the bilateral surgery modifier and global days number as necessary.
- Be clear that you understand the appeals process. Remember you have the right to appeal.
- The more informed you are (and appear) the more likely you will get paid.

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Tip$: The Ropes To Skip,  
The Ropes To Know

- 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.

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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

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Twelve Appeal Steps

1. Identify a Rejection VS Denial
2. Get organized before you call
3. Identify the Carrier and state / Gather the manual or LCD.
4. Is this a non-covered service?
5. Is pre-authorization always required?
6. ICD-10 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.

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TIPS: “Casino” Health Insurance

- What is it? It’s the best insurance plan in your area.
- Actually, casino’s really do have good insurance.
- Use coding to find these plans. Examples are codes 99050 (non-work hours) and 99058 (disruption of schedule). Only a few carriers in any given city pay on these; those that do are considered “provider friendly” insurance companies.
- Find out which employers use this insurance.
- Market to their employer. Visit the HR director. Conduct an eye-fair once a year. Sell your medical screening services.
Always Report Encounters at Highest Allowed Level

- Most clinics are throwing money away every day because they are unsure of proper coding and documentation guidelines.
- They fear the “red flag!”
- Remember, compliance first and code with confidence.

MACRA/MIPS

- MACRA revolutionizes reimbursement to physicians.
- The focus is now on quality improvement activities and prevention of disease rather than simply on what level of service are billed.
- The goal is to replace the current fee-for-service model. CMS announced a goal of 50% of all Medicare payments would be paid through alternative payment models by the end of 2018.
- As a result there will be changes in how Providers document, code, and bill under the new system.
MACRA/MIPS

MACRA creates the Quality Payment Program:
  • Represents a shift from a fee-for-service model to a fee-for-value model.
  • It repeals the Sustainable Growth Rate (SGR) physician payment formula.
  • Provides incentive payments for participation in Advanced Alternative Payment Models (APM)
  • MIPS will combine and streamline these existing EHR Incentive Program and pay-for-performance program measurements into one program:
    – Physician Quality Reporting System (PQRS)
    – Meaningful Use (MU)
    – Value-based Payment Modifier (VBM).

Analyzing your weighted averages

  • As part of your compliance plan you should review the suite of procedures/services that have the highest exposure for your group.
  • For most clinics the office visit codes 99213/99214 will be in the top ten. Multiple quantity X allowable (or RVU) and the total is the weighted average.
  • This is more useful than just analyzing the top most expensive procedures or the highest quantity. While useful the weighted average is a better determinant of your exposure.
  • In addition a utilization review of each provider for office visits and procedures should be conducted annually.
Medicare Part-B National Summary Data File

- Previously known as BESS
- The most current year available is 2014.
- This only applies to Medicare submissions so it will skew toward conditions common with those over 65.
- The data sets are summarized by CPT code ranges.
- Brief descriptions for the code ranges and modifiers are provided in the readme file.
- The file is updated annually and usually available by September for the previous year.
- This file is free and available on the Medicare Website https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Part-B-National-Summary-Data-File/Overview.html

Maximizing Revenue Summary

- You must optimize compliance before your organization maximizes revenue.
- You must have a compliance plan and work it.
- Training for every one is essential.
- Never leave money on the table.

I would like to end with two of my favorite examples of how extraordinary coding (training, curiosity, and persistence) can lead to maximizing revenue.
Example of Anatomy and Coding (1)

- 65280 Repair of laceration; cornea ... not involving "uveal tissue" (estimated Medicare allowable amount is $757.61 [fully implemented non-fac RVU=19.04]) (relative value unit)
- 65285 Repair of laceration; cornea ... with ... "uveal tissue" (estimated Medicare allowable amount is $1,248.42 [fully implemented non-fac RVU=31.43]).
- 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 $491!
- **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.
Destruction of Lesion Example

- The surgical operative report details:
  - “the hemangioma on the lid was destroyed.”
  - “the port wine stain on the lid 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 3.80 and approximate Medicare allowable in LA CA is $155.95.

- 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 code 17106 is 9.75; approximate allowable in LA CA is $390.80.
- 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.
Questions?

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

Compliance Team Quarterly Meetings
- Coding Compliance Officer
- Medical Director
- Coding Supervisor
- Attorney
- CFO
- Director of Medical Records
- Physician Specialties Team

Reports
- Coding and Compliance Summary
- Audit Summary
- Problem Summary
- Provider Compliance Ranking

FEEDBACK

Clinic Staff
- Departmental Managers
- Providers
- All Coders

FEEDBACK

Corrective Procedures
- Review and Update of Compliance Plan
- Disciplinary Procedures
- Time-Line for Remedy
- Coder Education
- Provider Education
- New Employee Education

FEEDBACK

Compliance Elements
- Outpatient Coding / Services
- Review of Billing Practices
- Medical Necessity
- Claim Rejections
- Coding / Rejections
- Cloned Services
- Medical Supervision / Incident To Services

Source of Coding Guidelines

Coding Resources
- Medicare E & M Guidelines
- Local Medical Review Policy
- Specialty Coding Alerts
- AMA CPT Assistant (CPT)
- AHA Coding Clinic (ICD-9)
- OIG Compliance Plan

Jeffrey Restuccio, CPC, CPC-H
May 2008
901-517-1705

Review of Coding & Documentation (8 - 12 Providers per month)
- Coding/Billing E & M Clinical Services
- Coding/Billing for Hospital Services
- Coding/Billing for Surgery/Procedures

Report Results

Problem Found?

YES

YES

Plan for another audit in twelve months.

Twelve Months Later