Proper Coding -- Beyond the Basics: Maximizing Revenue While Playing by the Rules

Brian Whitman
Glenn D. Littenberg, MD, FACP
Richard W. "Dick" Whitten, MD, FACP

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Maximizing Revenue while Playing by the Rules

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Glenn Littenberg MD, FACP
Past Chair, ACP Subcomm. Coding/Reimbursement
Member, CPT Editorial Panel, 1998-2006
CPT Advisor, ASGE; Medicare CAC member
GlennLitt@aol.com

Disclosure of Financial Relationships
• Dr Whitten doesn’t pay me anything
• Brian Whitman doesn’t pay me anything
• Medicare hardly pays me anything
• ACP pays me $75 for this hour
• I owe most of my revenue to colon polyps

• PLEASE download latest version handout; no cost, obligation, no conflict….

No Country for Old Internists
• Medicare: who’s making what rules? (& what are they after?)
• CPT: new codes, no new coverage
• E&M, some key points, reminders
• How to survive, living in the garage of the medical home

THE COMPASSIONATE INTERNISTS DOESN’T CARE IF HE ISN’T PAID
Wisdom

• "It's too late to correct it," said the Red Queen: "when you've once documented a service, that fixes it, and you must take the consequences.'
• 'When I use a CPT code,' Humpty Dumpty said in rather a scornful tone, 'it means just what I choose it to mean—neither more nor less.'

Goal: Teflon® coated claims

• Do what's medically necessary
• Document per guidelines
• Keep up: CPT, ICD9, encounter forms
• Audit
  – Coding versus specialty norms, E/M guidelines
  – Follow the money
    • Look at your denials as a QI project
• CCE continuing coding education

2008 et seq: life in pay-go land

• CF static with latest "one time" fix
  – but...10% fall July 2008, more to come
  SGR cost to fix $300+ billion:
  -→ no will, no $$$
• GPCI "fixes" also cost
• MedPAC stumped also...not good news
• 2006 5 year review large jump in work value for E/M...
  which CMS sleight of hand erased

Good news & bad news

• Fewer E/M services being billed, part B
• Because millions joining part C
• Medicare PFFS (private fee for service plans)
  – Plans paid an extra LARGE bonus
  – You see a patient, you're in
    • Automatic "deemed" contract
  – Supposedly Medicare fee schedule rate
  – You're presumed to know the rules
    ('see our...)
WHO eyes you?

- Contractors: PCA progressive corrective action
  - Through prepayment review & referrals....
- Benefit integrity safeguard contractors (BISC)
- CERT
- RACs
- OIG
- Fraud Taskforces FBI, attorneys general etc
- Russian mafia (they want your billing #'s)
- Eliot Spitzer no longer interested

Medicare program integrity

- Contractors: benefit of the doubt
  - Incentives favor paying the claim
- Progressive corrective action (PCA)
  - Intervention proportional to the sin
    - Focus on education and monitoring
    - End to random audits, most prepay review
    - Extrapolation nearly gone
    - Probe reviews based on carrier data analysis
- Upstream agencies performing PI activity: incentives favor finding fault

However

- Specialty Comparative Billing Reports on E&M services (CBRs)
  - Individual CBR’s...you may be an outlier
    - Request yours if you can
  - Self-audit; fix the problem or justify to carrier!
  - Prepayment 100% review:
    - the sanction that keeps on giving!!
    - No due process to end it
    - Know thy medical director!

Where CERT faults internists

- 10-15% “error rates”
- Consultations
- Subsequent hospital visits
- Initial hospital visits
- New OV

- Mostly 1 level quibbles but still $$$$

OIG: consult coding deficiencies

- 2006 report: upcoding, lack of docu.;
  - cost Medicare $1.1 B (sample: 400)
- 45% miscoded, 20% not consults
- Only 5% level 5 consults correct
- Comprehensive hx: extended HPI;
  - complete ROS; complete PFSH; compre. PE AND high complexity decision making
- Elements of consult:
  - three Rs: request, render & report

Consult clarifications

- One in-patient consult/doctor/admission
  - Even if called back for new problem
- Self-referred 2nd opinion in office:
  - Use 99201-99205 or 99212-99215
- Hot debate: what’s a transfer of care?
  - When called for a problem, not the whole patient
  - We call it a consult for initial evaluation
  - CMS transmittal 788 calls it hospital subsequent care
  - even though new patient to you
- CPT workgroup struck out...
  - but if they aren’t attacking, don’t duck
Consultation: pragmatic advice

- It’s a consultation if 3 R’s met
  - Document it that way
  - Code the correct level
  - 1 per inpatient stay; can be >1 outpatient
  - NOT consult if patient/family self-refers
- Can’t “split/share” with NP, PA

E&M documentation guidelines: carved in stone??

Subsequent hospital care

- 2 of 3 Hx, PE +/- or Med Decis.Making
  - Or counseling exception (>50% of time)
- 99231 15 min “stable, recov’g, improving”
  - HX, PE: problem focused
    - HPI 1-3 elements, no ROS, no PFSH
    - PE e.g. “lungs clear”
    - MDM straightforward/low complexity
- 99232 “responding inadequately or minor complication”

99232 vs 99233

- HX: expanded PF
- PE: expanded PF
- MDM: moderate (DDX, Data, Risks)
- HX: 1-3 elements HPI pertinent ROS
- PE: limited exam of affected…+other symptomatic/related...
- 25 min unit/floor time

- HX: Detailed
- PE: Detailed
- MDM: high complexity
- HX: 4+ elements or 3+ conditions; ROS + 2-9 systems; 1+ element PFSH
- PE extensive exam…+other sympt./related
- 35 min unit/floor time

Moderate vs high complexity MDM Table of Risk simplified

Moderate

- Problem, not catastrophe
- Low risk invasive tests
- Rx meds, IVs
- Little doctor sweat
- Highest element of risk determines level

High complexity

- MAJOR problems
- High risk invasive tests or therapy
- Toxic/complex Rx
- End of life discussions
- Highest element of risk determines level

Mixing 95, 97 E/M guidelines

- Per CMS, use either set guidelines, whichever more favorable or pertains
- Can defend in audits by either guideline
- 95 more leeway to IM; 97 more explicit
  - “status of 3 chronic or inactive problems” supports high level history
- In general can’t combine 95/97 BUT can use “status of problems” HX with 95 PE
- But: need detail of the problems, like an HPI
CPT 2008

- Anticoagulation management
  - HCFA suggested it, CMS declines to cover it
- Non-face-to-face services 2008:
  - New telephone code services
  - On line evaluation services (categ.III → I)

2008 revised telephone codes

- 99441  Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- 99442  11-20 minutes of medical discussion
- 99443  21-30 minutes of medical discussion

Will these be of use?

- Anticoagulation mgt:
  - CMS hasn't reconsidered;
  - commercial carriers;
  - Bookkeeping issues significant
- Can bill a no-show fee, if all "treated" equally
- Telephone:  RUC approx. $2/min value
  ($14, $25, $37 at current CF)
  - CMS: NONCOVERED  not covered /bundled
- On-line evaluation:  NONCOVERED  no RUC $
- Ergo:  Medicare patients (& privates)
  CAN be billed

Rules: telephone, on-line

- Private transaction
- Follow CPT definitions carefully: lesser levels of same service INCLUDED in E/M
- Patients should be informed
- No ABN needed, no G modifier to bill
- Could use NEMB Notice of Exclusion for Medicare Benefits form

Nursing facility codes

- New or established
- Initial   all 3 components of H, P, MDM
  - 99305  25 min typical  H,P: detailed or compre;  MDM: straightforward or low
  - 99306  35 min typical  compre/compre/mod.
  - 99307  45 min typical  compre/compre/high
  - (Parallels hospital admission coding)
  - Nat'l average fees $83, $116, $149

Subsequent nursing facility

- Parallels estab. Patient OV, elements/RVU
  - 99307  10 min typical  $41
  - H,P:  prob focused;  MDM: straightforward
  - Stable, recovering or improving (like 99231)
  - 99308  15 min  $63  EPF,EPF, low complexity
  - Responding inadequately or minor complication
  - 99309  25 min  $85  Det.,Det., moderate
  - Significant complication or new problem
  - 99310  35 min  $124  Comp.,Comp., High
  - Unstable or new problem req'g immed. MD attention
THE TOP TEN

LOST BILLING OPPORTUNITIES

#10    What do you think? Worth $97?

• Welcome to Medicare checkup
  – IPPE Initial Preventive Physical Exam
  – 1st 6 months of enrollment G0344 V70.0 or…
  – Must include EKG G0366 if you do/read
  Lots of history, little PE; lots of documentation
  • Same day E/M as appropriate
  • Glucose, lipid panel
  • In theory could do followup as 99401-99404
  • Provided to 2% new Medicare patients 2005
  • G0344 denied 23% of time, mostly due EKG

#9

• Missed services:
  • Telephone, on-line evaluation BY THE RULES
  • Lab, same-day procedures, FOBT, injections/vaccines, non-office sites of service
  • Poorly designed encounter forms; inattention
  • Not keeping up with CPT
  • Not keeping careful hospital, SNF service
  • Weigh CLIA fees versus lab revenue

#8

• Home health certification
  • HHA cert G0180 $75;
  • recertification G0179 $57

#7

Lost billing opportunities

• Rules:
  • new vs established 3 year rule;
  • Consult vs outpatient office codes
  • ER vs outpatient or observation
  • Same day hospital discharge/SNF admit
  • New SNF codes with typical times
    – Thus, time exception applies; prolonged service…
  • Home visits
  • Mental illness 50% copay 290-316 ICD9 series
  • refer to Supplement info!!

• Screening pelvic/breast exam G0101
  ~$36
  – Can combine with other billable E/M or with non-covered preventive visit 99387, 99397
  – Every 2 years low-risk (V72.3), yearly high risk
  – Plus G0091 obtaining screening pap smear (~$ 38)
    (low risk V76.2)
  – V76.49 post hys low risk; V15.89 high risk
  • Elements of G0101: 6+ of 10 elements: DRE; external genitalia; urethral meatus; urethra; bladder; vagina; cervix; uterus; adnexae; anus/perineum
  • -GA signed waiver Obtain ABN if suspect exam won’t be covered in a given year
Smoke gets in your wallet
#5
• Smoking cessation counseling to patients with diseases caused or exacerbated by tobacco use
• Two quit attempts/year, up to 4 couns. sessions/attempt
• 99406 intermed. (3-10 min) ($12), 99407 intensive (>10 min) ($24)
• ICD9 305.1 tobacco use disorder + disease;
• -25 OK just document sites of service??
• 1 800 QUIT NOW

Lost billing opportunities
#3
• -25 modifier
• Separately identifiable E/M same day as
  – Services with global period 0-10-90
    • e.g., joint injections, zit removals, scopes
  – NOT for EKGs, echos, most noninvasive DX
  – Needed with consult codes if same day as...
    but not with 99201-99205 new patient OV

Lost billing opportunities
#2
• Documentation pitfalls
  • You did level 5 service but your ROS has only 7-9 items
  – Becomes a level 3 (detailed hx)
  – “all other systems negative” is valid IF you did it
  • Except in Trailblazer-Land
  • You miss updating the FH
  – Same effect “no new FH” or “reviewed but non-contrib.”

Lost billing opportunities
#1
• Counseling exception
to E/M coding: using TIME as basis of code
  • Commonly forgotten
  • Commonly not documented
  • If > ½ length of visit time is counseling or coordination of care, can use time as basis of code selection
  • Document time/content of counseling AND time of visit (“ccc 15/25”)
  • Extent documented detail of Hx, PE not signif.

#4
• Billing for Medicare-
  non covered services
  – Preventive medicine codes
    • 99381-99387 new, 99391-99397 established
    • 99401-99412 indiv., group counseling
    • 99429 unlisted
  – Doesn’t need ABN but explain to patients!!
  – Retail price, adjust for same day covered E&M
  – Digital data (99090-91), surcharges (99050 series)

Watch your templates
• “Medical necessity of the service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of service when a lower level is warranted.”
  –Ch12 Sec 30.6.1 Medicare Claims Processing Manual

THUS:
• Use templates as prompts, checklists & convenience
• NOT as an upcoding device;
• Update, don’t regurgitate
• Did you really seek whispering pectoriloquy????
Yearly practice biopsies

- Diagnose, stage, prognose & plan treatment
- Know thy profile (versus your peers)
- Follow the money
  - (> 10 charts/doc, hi volume, hi level, hi risk
  - Note ➔ fee ticket ➔ computer entry ➔ claim ➔
    EOB ➔ patient bills (appeals?)
  - + internal office financial trails
  - Remember Roy Rogers: “happy audit trails to you…”

Feel free to ask

- College resources: web; Practice Mgt Ctr
  - http://www.acponline.org/pmc/index.html?hp
- Local: ask your gov; state chapter
  - acponline.org/chapters newsletter
  - ACP Internist (Brian Whitman)
    - Search:
      http://www.acponline.org/clinical_information/journals_publications/acp_internist/
    - glennlitt@aol.com

SUPPLEMENTAL MATERIALS

Medicare guides (Calif. Source)

- Preventive Services Billing Guide 2/2008
- Preventive Services Reference Sheet 2/2008
- 2008 Medicare Workshop Seminar Guide

OTHER PRAGMATIC ADVICE

- Coding level distinctions for common E/M
  - E/M Services Medicare guide 10/2007
  - California guides but national pertinence
- 2008 CMS musings
Office situations

• New vs established
  • New: no professional services (CPT codes) from the physician or another physician of the same specialty/same group within the past 3 years
  • same day procedures (not imaging) -25 modifier
    – Medicare does edit for this on consultations...when in doubt, apply -25 to E/M code

• Incident-to nursing service visits 99211
  – eg anticoagulation management
  • Level 2 vs 3, 3 vs 4, 4 vs 5

Office visits, levels of care

• 99212 vs 99213 hx, pe: PF vs EPF +/- mdm straightforward vs low complexity
  • 10 vs 15 min typical time
  • (ossen = for counseling time required to report)
  • 99213 requires prob.-pertinent ROS; no PFSH needed
  • EPF exam: "& other symptomatic or related organ systems"
  • MDM: no/min vs limited ddx: data to rev: +/- pt. risk (2 of 3)
  • e.g. 1 self lim problem (99212) vs 2 minor or 1 stable chronic or acute uncomplicated illness; OTC rx (99213)

Office visits, levels of care

• 99213 vs 99214 hx, pe EPF vs detailed; +/- mdm low vs moderate complexity
  • 15 vs 25 min typical time
  • 99214 requires 4+ elements of PI, ROS of affected system & findings of 2-9 others; at least 1 PFSH item (e.g. medication list)
  • "extended exam of affected body area(s) & other sympt. or related organ system(s)" (1995) (2/6/12 rules from 1997, impossible to recall...)
  • MDM: mod ddx, data +/- or risk (2 of 3)
  • e.g. 99214 1+ chr illness with flare or side effect; 2+ stable chr illness; undiagnosed new problem uncertain px; systemic acute

National average Mcre fees ‘08

– 99231: $39  99232: $70  99233: $100
– Versus 99291 (31-74 min) $225

ER situations

• Consultation vs primary care
  – Elements of consult; documentation/report
  – Choices if primary: 9928X vs 9921X

• Multiple services same day
  (OV-->ER-->admit)
  • ER codes vs outpatient codes

– 99214 vs 99215 hx, pe: det vs comp
  +/or mdm mod vs high complexity
  • 25 vs 40 min typical time
  • 99215 requires same PI as 99214 but complete ROS ("all other systems neg") & 2 (not just 1) PFSH items (e.g. med list + stress, habit or FH)
  • PE comp= 8+ systems (1995); 9+ with 2+ elements (1997)
  • MDM: extensive ddx, data +/- or risk (2 of 3)
  • e.g. 99215 severe flare chr illness(es), life-threatening; highest risk tests, interventions; high risk meds; dnr?
National average Mcre fees

- 99214 facility vs 99284 hx,PE det; mdm mod
  - 2 of 3 elements vs 3 of 3 elements
  - $72 vs $121
- 99215 facility vs 99285 hx,PE comp; mdm high
  - $103 vs $180
- 99223 $180
- Don’t forget -25 with same day procedures

Discharge

- Two levels 99238, 99239 <31 min or >
  - Nat’l fee 99238 $70 vs 99232 $70 WASH
  - 99239 $97 if >30 min DOCUMENT
- Same day discharge/observ. discharge and SNF admit:
  - Acceptable without physically visiting SNF
  - 9923X (99217 observ.) + 99305 (new) $116

SNF services

- Considered “facility” if Medicare covered
  - Becomes nonfacility if non Mcre covered skilled or domiciliary/long term care
  - Designated by correct POS indicators

Preop clearance consultations

- 9924X of request/render/report
- 99201-99215 if estab patient returns
- For consult codes:
  - 1st dx V code for type of exam
  - V72.81 preop CV; V72.82 pulm; V72.83 other specified; V72.84 unspec.
  - 2nd dx reason for the clearance e.g. CAD, COPD, diabetes...
  - Other dx: reason for operation, comorbidity pertinent
- Appropriate use EKG, CXR similar coding

Impact of coding shifts

- If 10% of 99201-99215 services could appropriately be billed at one level higher code:
  - At typical service volume, 10% new/90% established
  - About $20,000 more income at a Medicare fee schedule level
    x 120 vis/week, 48 weeks…

Other CMS musings 2008

- Revision PE-RVU method
- Long advocated by College
- PE survey outsourced by CMS
  - replaces AMA SMS (specialty socioeconomic) survey
- May weigh labor, supply, equipment costs differently;
  different assumptions on equipment use
- Impact on E/M……may free up dollars elsewhere
- DO THE SURVEY RIGHT BUT DO IT!!!
CPT category II

- Expect will be method of reporting, replaces some G codes
- See Appendix H to get an overview
- Exclusion Modifiers
  - 1P can’t do for medical reasons
  - 2P can’t do for patient choice reasons
  - 3P can’t do for system reasons
  - 4P can’t do for unspecified reason
  - Apply to some, not all measures!!

More Supplements

- CERT, RAC
- E/M coding trends; IM code distribution
- Levels of Medicare claims review
- ABN modifiers
- Revised surcharge codes
- Remittance advice education
- Paper remittances going away: new software
- Giving part D vaccines
- More info.: welcome to Medicare
- Anticoagulation management
- More billing & coding resources

Comprehensive Error Rate Testing

- 2006: 140,000 claims all providers
- E/M by 95 & 97 guidelines
- Separate contractor collects records
- So far yearly improvement in paid claims error rates…rates of “improper payments”
- Biggest improvement due to getting records!!
- 1-level amnesty in E/M still under advisement

CERT 2007 error rates

- Overall rate 14.2% 1996 → 3.9% beat estimates
- IM 8% = est $ 600 M
  - 22% no documentation, 54% incorrect code, <1% medical necessity question
  - Consultations 12% est total part B $526 M
  - OV established 5.7% $560 M
  - Hosp visit subsequent 11% $566 M
  - Hosp initial 14.5% $167 M / OV new 14.5% $156 M
  - mostly one level E&M quibbles
  - Reports http://www.cms.hhs.gov/CERT/CR/list.asp#TopOfPage

Internists on the RAC?

- Recovery Audit Contractor initiative
- Pilot Calif, Fla, New York 2005-2008→ GOES NATIONAL in 2009-2010!!!
- Contractors review claims 1 to 5 !! years old
  - Bounty of 28-30% of overpayment identified
  - Can refer for suspected fraud & abuse
  - Refer underpayments back to contractors
- Part A & DME, …for now few MDs called
  - Large # duplicate claims…So Cal anomalous
  - Florida urologists re LH antagonists

RAC comes to you 2009

- As of 11/06, approx $290 M overpayments found though <18 M physician (ambulance, lab)
- Gift of year-end budget deals
- ?? Not E/M claims??
- Expect vague accusatory letter for old records
- Appeal unfair decisions
- Tell ACP what’s going on
  - Due process, statistics, transparency…
E/M coding trends 2000-->2004

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<td>99241 -14%</td>
<td>99221 -24%</td>
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<tr>
<td>99242 -23%</td>
<td>99222 + 17%</td>
</tr>
<tr>
<td>99243-99245</td>
<td>99231 -19%</td>
</tr>
<tr>
<td>up 41 to 52%</td>
<td>99232 +22%</td>
</tr>
<tr>
<td>99253-99255</td>
<td>99233 +26%</td>
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<tr>
<td>up 20-33%</td>
<td>--target,CERT,OIG</td>
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Internist OV code use 2000 → 2005

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Internist code use 2000→ 2005

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<td>99215</td>
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**1 99213 is billed every second to CMS by an internist (31 million)**

What’s in a name? confusion… Medicare levels of claims review

- Fixing error="reopening" (claim rejected, not denied) Call cust.svc; can ask for "lead" or "supervisor"; or resubmit fixed
  - Up to one year (4 years with good cause…)
- First level appeal="redetermination" (formerly called review) via written request 120 days; 60 days to respond; expect same result if nothing new to submit!!
  - New form CMS 20027 or “usual info” in your own format

Medicare reviews cont'

- 2nd level = “reconsideration” formerly called carrier fair hearing; now held through “QIC”s qualified independent contractors.
  - 180 days in, 60 days to respond. All issues related to claim; includes peer review of medical necessity. Can consider NCDs, CMS rulings, laws, regs which are binding; local policies or CMS program guidance not binding but given “substantial deference.”
  - Decision NOT of precedent value.
- 3rd level = any other issue

Medicare reviews cont'

- Third level: ALJ admin. law judge; now part of DHS, not soc security. Regionalized. Must be at least $100 at issue. Attorney fees can be requested
- Fourth level: Departmental Appeals Board 3 judges 90 days to submit; at least $1000 at issue; no change in process or name
- Fifth level: Federal district court
- Also (new): bene.can dispute entire LCD to ALJ
  - But standard to overturn will be high
Remember your ABNs

- **Advance Beneficiary Notice**
  - Draft revision looks better simpler
  - But asks for itemized cost estimates
- **For sometimes-covered services**
  - Can’t “routinely” obtain
  - Can’t bill patient if no ABN and service denied and you knew/should have known it would likely be denied
- **Note for never-covered service, can bill**
  -GY if you need denial; but don’t need ABN

ABN modifiers

- **-GA** signed ABN (or witnessed refusal), expected to be denied on med.necessity basis
- **-GY** service never covered; but need claim processed for secondary (or patient insists…)
- **-GZ** (why use at all??!) Patient didn’t sign ABN & service expected to be denied (can’t collect)
  - IF no GA?? Patient EOB “not covered…you’re not responsible” If you have ABN: legal to collect, but…will patient cooperate?

Revised surcharges codes: medicare bundled

- **99050** “other than regularly scheduled office hours” (or weekend, holiday)
- **99051**…regularly scheduled eve,weekend or holiday
- **99053** 10pm-8 am at a 24 hour facility
- **99056** non office site at patient request
- **99058** emerg in ofc., disrupts schedule
- **99060** emerg out of ofc, disrupts schedule

Remittance Advice Advice

- **New resource** Understanding the Remittance Advice: A Guide…
- [www.cms.hhs.gov/MLNProducts/downloads/RA_Full_03-22-06.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/RA_Full_03-22-06.pdf) + print, CD ROM

Paper remittances go away

- Medicare Remit Easy Print (MREP) software for ERA (electronic remittance advice, also known as “the 835”)
- Flexible search criteria
- Print what claims you need (without printing other patients’); store files
- Export reports incl. denied, adjusted, deductible applied/not applied claims
- Regular updates Medlearn SE0611

Giving part D vaccines,2008

- Medicare covers limited vaccines under part B: influenza, pneumococcal, hepatitis
- Bill G codes with vaccine…G0008-G0010
- Part D vaccine eg Zostavax VZV vaccine
  - G code G0377 $19.33 + geog.adjustment
  - +part D pays for drug ??how per plan
- 2008 Law stipulates part D pays administration cost….new method 2008
More info., welcome to Medicare exam

Elements, IPPE
Initial Preventive Physical Exam: welcome to Medicare!!

• Past med., surg history, meds, FH, SH
• Potential for depression: standardized screen
  – (see Observer jan-feb 2005, 4 tools referenced)
• Functional ability, level of safety; hearing, ADLs, risk of falls, home safety
• PE: VS ht, weight, BP, visual acuity
• Education, counseling, referral for covered screening; written checklist
• All for $97.40 + $26.91 = $124.31
  – Observer Jan Feb 2005
  – Fee schedule resources 53: MD minutes, 51 staff minutes

More “welcome”…

• ABN if maybe enrolled >6 months
  – Unclear what happens if someone else “welcomed” patient during eligible period also
• -25 modifier for same day E/M;
  – High volumes of level 4,5 will be questioned
• Usual copay, deductible
• Glucose 2/yr prediabetic; 1/yr “at risk”
  – V77.1 Not magent strip glu (82947 or GTT)
• Lipid panel or components 80061 every 5 years
  – V81.0 screen isch.heart dis. or V81.1 HTN or V81.2 other

Depression screen
(or, reality check on practicing IM today)

• Asking the following two questions may be as effective as using longer screening instruments:
  • Over the past 2 weeks, have you ever felt down, depressed, or hopeless?
  • Over the past 2 weeks, have you felt little interest or pleasure in doing things?
    – If you answer YES to either question, you’re likely depressed, or you’re an internist, or both

Standard screens  your choice

• www.cdc.gov/hrqol/hrqol14_measure.htm
  – 14 item health related quality of life survey
• www.ahcpr.gov/clinic/3rduspstf/depression/depresswh.htm
  – USPSTF depression screen
• HANDY TEMPLATE TO DOCUMENT VISIT: AAFP
  – Please try this link:
  – aafp.org/fpm/20050400/27howt.html

Anticoagulation Management

• 99363 Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)

• 99364 each subsequent 90 days of therapy (must include a minimum of 3 INR measurements)

• Medicare: bundled into existing E/M
PRACTICE MANAGEMENT CENTER RESOURCES
Reimbursement & Documentation

• Medicare changes for 2007
• E/M coding assessment tool
• A Comprehensive Guide to Medicare Covered Preventive Services
• Medicare Medical Review
• Care Plan Oversight
• Medicare regulations...Patients in SNFs
• Medicare regulations...Home Oxygen
• Requirements for Certifying...Home Health Services
• Documentation for Services

Provided by Teaching physicians
• Ordering DME...
• Billing & Coding Adult Immunizations
• Welcome to Medicare Exam

Laminated Coding Sheets
• E&M Service Codes: selecting and documenting appropriate levels of service
• Commonly Used ICD9 codes
• Electronic medical records resources

Sources of E/M guidelines

• http://cms.hhs.gov/medlearn/emdoc.asp
  – pdf files of 95, 97 guidelines
• http://cms.hhs.gov/medlearn/appndix1.pdf
  – side by side comparison 95,97, 2000 draft
• http://www.acr.org/departments/econ/econ_pubs/guide_ems.html
  – word docs 95,97,2000
• http://www.acponline.org/pmc/coding.htm
  – coding cards, icd9 lists

Other references

• USC compliance manual
  – http://www.usc.edu/health/uscp/compliance/tm2.html#2
• E/M docum.guidelines in RTF (opens in Word)
• MD compensation

• AMA CodeManager 2008 includes:
  - RBRVS Relative Value Units (RVUs)
  - 2008 Ambulatory Payment Classifications (APCs)
  - CPT 2008 Professional Edition
  - ICD-9-CM 2008 Volumes 1, 2, and 3
  - HCPCS Level II
  - AMA Exclusive CPT® Clinical Vignettes updated through 2008
  - 2008 Diagnostic Related Groups (DRGs)
  - 2008 Medicare Payment Rules
  - 2008 Ambulatory Surgical Center list (ASC)

• New-England’s Illustrated Medical Dictionary, 30th Edition*
• National Correct Coding Policy Manual Versions for 2 years
• Medicare Fee Calculator National Version ($258 includes:
  - RBRVS relative value units and
  - CPT codes—get the facility and non-facility charges, the
  - Clinical Laboratory for amounts, and the
  - Durable Medical Equipment for
  - National Correct Coding Policy Manual Version for 2 years
  - Medicare Fee Calculator National Version ($258)
  - 800 621 8335 $309 single user single yr

Billing website resources

• ICD9 codes http://www.icd9data.com/
• teaching physicians: Dec 2007 8 pg summary
  http://www.acponline.org/private/pmc/teachphys.pdf
• IPPE Welcome to Medicare
• ABN:
  cms.hhs.gov/BNI/Downloads/CSMR131G.pdf

Other references

• Re: IPPE Documentation Template
  Please try this link:
  http://www.aafp.org/fpm/20050400/27howt.html
  download pdf template form

CMS form 20027 for “redeterminations”
  cms.hhs.gov/forms/CMS20027.pdf
Maximizing Revenue …while Playing by the Rules

Richard W. Whitten, MD, MBA, FACP
Contractor Medical Director for AK, HI & WA
Vice-Chair, AMA/Specialty Society RUC 2000-2006
Member, CPT® Assistant Editorial Panel
(253) 437-5402
dick.whitten@noridian.com

TODAY’S OBJECTIVES
• Pending Legislation
• Contracting Reform & Implications
• Recovery Audit Contractors (RACs)
• 2008 Audits – OIG & Others

Medicare RVS Pending 7/1/08
• -10.6% under current legislation
• Sen. Max Baucus (D, Mont.), Chair, Senate Finance Committee
• Sen. Charles Grassley (R, Iowa) ranking Rep.: “I’m going to keep those cuts from happening”

Medicare Contracting Reform
• Medicare Administrative Contractor = “MAC”
• Single A/B MAC within a jurisdiction
  • Promotes consistency on coverage issues
  • Promotes better coordination of services
  • May result in coverage changes for individual providers
  • May encounter “Scope of Practice” Issues with multistate jurisdictions
  • “Jurisdiction 2” = J2, etc.

Medicare Contracting Reform
• CMS will “fully and openly” compete MAC contracts
  • Fewer MACs
  • Larger jurisdictions
  • Potential outside entrants
• MAC contracts will require compliance with Federal Acquisition Regulations (FAR) and Cost Accounting Standards (CAS)
• CMS will compete all contracts within the initial implementation timeline and then periodically re-compete them at least once every five years
Medicare Contracting Reform

- Where it stands now?
  - A/B MAC Jurisdiction 3 (“J3”) awarded to Noridian in 2006
  - J4 awarded to Trailblazers; J5 awarded to WPS
  - J1 to Palmetto GBA - “Protested”; resolved for Palmetto
  - J12 to Highmark – Protested – resolved for Highmark
  - J13 to United Government Services (UGS)
  - J2 to National Health Insurance Corp (NHIC)
  - J7 bid remains under review in “Cycle One”
  - RFPs for the rest were issued 9/07
  - DME MAC awards were made 2007

www.cms.hhs.gov/medicarereform/contractingreform
Total Improper Payments Collected & Costs (Claim RACs & MSP RACs) – FY 2006

<table>
<thead>
<tr>
<th>Overpayments Collected (in millions)</th>
<th>Underpayments Paid Back (in millions)</th>
<th>In The Queue (in millions)</th>
<th>Total Improper Payments Identified (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$883.8</td>
<td>$2.9</td>
<td>$232.0</td>
<td>$303.5</td>
</tr>
</tbody>
</table>

Costs: $14.5

$64.1 Back to the Trust Funds

In Spring 2006 CMS revised RAC contract to provide financial incentives for identification of underpayments.

Recovery Audit Contractors (RACs)

RAC contract includes the following tasks

1. Identifying Medicare claims that contain non-MSP underpayments for which payment was made under part A or B.
2. Identifying and Recouping claims that contain non-MSP overpayments for which payment was made under part A or B. Includes corresponding with the provider.

RAC Tasks - continued

3. For any RAC-identified overpayment that is appealed by the provider, the RAC shall provide support to CMS throughout the administrative appeals process and, where applicable, a subsequent appeal to the appropriate Federal court.
4. For any RAC-identified vulnerability, support CMS in developing an Improper Payment Prevention Plan to help prevent similar overpayments from occurring in the future.
RAC Tasks - continued
5. Performing the necessary provider outreach to notify provider communities of the RAC’s purpose and direction.

NOTE: The proactive education of providers about Medicare coverage and coding rules is NOT a task under RAC statement of work. CMS has tasked QIOs, FIs, Carriers, and MACs with the task of proactively educating providers about how to avoid submitting a claim containing a request for an improper payment.

RAC Expansion
• To All MAC Areas by 1/01/2010
• Look-Back to be three years
• “Oldest” look-back to be 10/1/2007
• No RAC review of claims previously in appeal or complex review such as by Carrier, MAC, PSC, CERT
• Six month “blackout period” from 3 months before a MAC transition until 3 months after

MAC Limitations
• Post payment medical review proposed to be limited to:
  ... Areas...where a RAC has not been granted the authority to perform postpayment review…

(i.e. “stay outta their way…”)

LCDs by state/contractor
http://www.cms.hhs.gov/mcd/index_lmrp_bystate.asp

LCD Retirements
• Contractors will retire when data show not as important – does not mean LCD is “incorrect”
• Responsibility for correct performance, coding, billing and medical necessity under Medicare, remains with provider offices
• Responsibility for correct claims submission is unchanged whether or not an LCD is in place

Prepay Reviews
Probes
Progressive Corrective Action (PCA)

Postpay Reviews: Audits
Payment Safeguard Contractors (PSC)
Comprehensive Error Rate Testing (CERT)
Recovery Audit Contractors (RAC)

Other Reviews
Office of Inspector General (OIG)
US Attorney’s Office
**Probe Reviews**

- Simple contractor probe review: "educational"
- Probe is a sampling of claims to validate the code(s) billed are supported by the documentation
- Some follow-up probe done routinely/commonly
- Potential for further follow-up based on multiple factors (majors being provider active participation in education process, and a decrease in error rate)
- Probe closed when no errors found (or very few with clear improvement)

**Western Integrity Center (WIC)**

- Program Safeguard Contractor (PSC) for Centers for Medicare & Medicaid Services (CMS), based in Easton, Maryland
- "Program Integrity" operations in 15 states
- DATA driven (not necessarily anything wrong)
- But... REAL TEETH!! Be careful to respond thoroughly and accurately!

**Comprehensive Error Rate Testing – (CERT)**

- CERT Documentation Contractor (CDC) is Livanta
- Purpose: Verify if claims were sent, processed & paid correctly
- If information not returned, funds will be recouped
- Send records to address listed
OIG Work Plan 2008

“This publication describes activities that the Office of Inspector General (OIG) plans to continue or initiate with respect to the programs and operations of the Department of Health and Human Services (HHS).”

http://oig.hhs.gov/publications.html

Medicare Payments for Selected Physician Services

“We will review the appropriateness of Medicare payments for various types of physician services ...including surgery; consultation; and home, office, and institutional calls... to determine whether these services were paid in accordance with Medicare requirements.”  (p. 10)
OIG 2008: Selected Physician Services

“We will examine the Medicare services that selected physicians bill “incident to” their professional services and the qualifications and appropriateness of the staff who perform them... medical necessity, documentation, and quality of care for “incident to” services.”

OIG – Medicare 2008: Others

• appropriateness of payments for polysomnography services.
• whether Medicare providers are adhering to assignment rules...
• arrangements under which magnetic resonance imaging (MRI) is provided
• payments for interventional pain management procedures
• areas with high utilization of ultrasound services

OIG Announced Focus: Consultations

• In 2001 - $3.3 billion
  • Estimated by audit to be $1.1 billion overpaid
  • Many not “consultations”
  • Many “Wrong level”
  • Many “Wrong type” ("Follow-Up In-patient" & “Confirmatory,” now gone)
• 2004 - $4.1 billion
• 2007 – $4.2 billion
http://www.oig.hhs.gov/oei/reports/oei-09-02-00030.pdf

Consultations

• Consultation is provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source
• Physician consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit
• “Evaluate & treat” ≠ “consultation”

Consultations

• The consultation is to be provided by the person of whom it is requested
• Component services of an outpatient consultation may not be provided by another provider incident to
• Component services of the inpatient consultation may not be provided by another provider as a split/shared service
• Incident to and Split/shared rules are different

• A referral for care as opposed to a request for an opinion or advice regarding evaluation and/or management is not a consultation and should be billed using other appropriate E & M codes
• A consultation may not arise from a "standing order" such as might occur on admission to a coronary unit, ICU, SICU, etc.
CONSULTATIONS

- **BE CAREFUL** – Any request to see the patient is **one or the other**!
- A request for advice or opinion back to referring provider who is seeking information to continue him or herself some participation in this aspect of care
- A referral to assume this aspect of care

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IOM 2-104  Chapter 12 - Physician/Practitioner Billing §30.6.10 - Consultation Services

A **transfer of care** occurs when a physician or qualified NPP requests that another physician or qualified NPP takes over the responsibility for managing the patients complete care for the condition and does not expect to continue treating or caring for the patient for that condition.

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Caution: Changing a Record

- *Never* “amend”, “fix”, “clarify”, “improve”…or otherwise change a record **after** an audit request!
- But, may send a currently-dated translation, clarification, explanation or companion note
- **Must** be able to document the **original** record, even when a needed clinical correction made.

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RECOMMENDED !

- Periodic “Practice Audits”
- Charting through billing, coding, reconciliation, reopenings, redeterminations, reconsiderations
- Consider pairing the senior billing/coding person from three like-practices as the “audit team”

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Thank you. Comments/questions welcome:

*Please remember to 1st check both your contractor’s website & provider call center*

Dick Whitten, MD – CMD AK, HI & WA
(253) 437-5402
dick.whitten@noridian.com