Billing Audit Deeper Dive: Coding and Documentation
A Close Encounter of the Billing Kind… Are You Ready?

Wednesday, March 14, 2018

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Technical Assistance

- Technical Assistance Telephone Number
  - 732-362-5724
- Question Submission for Q&A Session
  - Type your question into the Questions Box on the control panel on your screen

Please jot down this information

Conventus Practice Resources

For Conventus Members Only:

- 24/7 Practice Advice Hotline
  - Contact the hotline for “Audit Hotspots and Triggers”
- Strategic Partnerships
  - HIPAA, OSHA, Security Risk Analysis, Fraud & Program Integrity Services, CME for MOC, & more!
- Consulting Services
  - Practice Transformation and Quality Improvement Consultation
  - Patient and Staff Engagement Services
    - CARE Program
  - Practice Success Consultation
- Practice Management Resources
  - Pain Management Toolkit, Informed Consent, and more
Presenters

WIKS MOFFAT, CHC
PRINCIPAL-EXECUTIVE VICE PRESIDENT, COMPLIANCE
Wiks is a pioneer in the healthcare compliance industry with over 25 years of experience and expertise. Throughout his career, Wiks has managed compliance project for medical organization of all sizes and specialties.

JIM TUDOR, CPC
DIRECTOR, CODING AND BILLING COMPLIANCE
Jim has over 25 years of experience in the industry and has designed and administered billing compliance audit programs for physician provider organizations and medical offices.

What You Will Learn

- Medical Necessity
- Evaluation and Management (E/M) Basics
  - Time based
  - Key components
  - Consultations
  - Transitional Care (TCM) / Chronic Care (CCM) Management
- Wellness Visits with Problem Component (Modifier 25)
- Unbundling (Modifiers 59 and “X”)
- Assistant Surgeon
- Hierarchical Condition Category (HCC) Risk Adjustment
- Incident To and Shared Visits
- Essentials for Self Auditing
Medical Necessity

The Medicare Definition:
“Health-care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.”

Medicare Local Coverage Determinations (LCD):
www.novitas-solutions.com

- A LCD is a decision by a Medicare Administrative Contractor (MAC) whether to cover a particular service on a MAC-wide, basis. Codes describing what is covered and what is not covered can be part of the LCD.

Medical Policy

Search Tool
By using Print Policy Text tool, those are many very useful tools to quickly and accurately determine medical necessity (LCD).

Medical Policy Parameter

Parameter in action is allowed.

Evidence:
- A/B MACs
- Current CPT/HCPCS
- Practice Guidelines

Medical Necessity:
LCD Policies

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Frequency</th>
<th>N/A</th>
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<td>CPT0123</td>
<td>Injection for Pain Management</td>
<td>N/A</td>
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<tr>
<td>CPT2345</td>
<td>Evaluation and management services provided to a beneficiary</td>
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<tr>
<td>CPT6789</td>
<td>Physical Therapy (Effective Date to be Determined)</td>
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Medical Necessity:
LCD Policies
Medical Necessity: LCD Policies - Other Payers

Horizon Blue Cross Blue Shield of New Jersey
https://www.horizonblue.com/providers

Click on “Policies & Procedures” then “Policies”, then choose from either Medical Policies or Reimbursement Policies & Guidelines

United Healthcare
www.unitedhealthcareonline.com

CIGNA
https://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/

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Medical Necessity

- In context of E/M services, things that compromise medical necessity:
  - Cloned note or conflicting info
  - Excess/superfluous documentation
  - Services performed too frequently
  - No chief complaint (CC) or conflict in CC
  - Note signed well after service rendered

E/M Basics: Time Based

- If over 50% of your face to face time with patient is spent counseling, time is the controlling factor.
- Time spent on unit/floor coordinating care in the hospital inpatient and SNF settings is also eligible
- Document:
  - Total amount of time spent ("I spent 40 minutes with patient face to face……")
  - Delineate as mainly counseling ("…..of which over 50% of the time was spent counseling……")
  - Content of your discussion ("…….regarding lifestyle and dietary modifications, need for compliance with medication regimen")

Pitfalls

- Billing high level codes on the basis of time too often
- Qualifying for a higher level by the key elements
  - Time spent 15 mins (99213, but documentation otherwise supports 99214
- Not describing the counseling
E/M Basics: Key Components

- When not by time, the key components determine code selection:
  - History (CC, HPI, ROS, PFH)
  - Physical Exam
  - Medical Decision Making (MDM)

- Documentation Tips:
  - The MD (or NPP eligible to bill) must document the chief complaint (CC) and history of present illness (HPI)
  - Mention status of three chronic conditions to satisfy extended HPI
  - ROS attestation accepted by CMS:
    - All other systems reviewed and negative (ok to say this if you reviewed at least 10 ROS)
  - If history is unobtainable or partially unobtainable, your note should be clear as to the reason(s) why
  - Decision making data elements:
    - Review and summarization of old records, independent review of images/tracings/specimens, discussion of case with other MD, obtain hx from someone other than patient

Pitfalls

- Disorganized progress note ("alphabet soup" note)
- Family hx noncontributory – the payer will likely not acknowledge this statement.
- Not documenting the full extent of PE
- Volume of documentation is disproportionate to the presenting problem(s)
- Billing only one E/M code 100% of the time (or close to it).

E/M Basics: Consultations

- Medicare stopped paying them in 2010, but they have not gone away
- Includes a request, a reason, and a response (The 3 R's)
  - Best practice phraseology: “Patient is seen in consultation at the request of ______ for evaluation of ______”
- Reimbursement is about 20% higher than the new patient office codes
- You can order diagnostics and initiate treatment and still bill the visit as a consult.
- If the requesting provider can see your note in the chart, an “appropriate entry in the common medical record” will suffice

Pitfalls

- Patient is self referred
- Avoid using the “referred” at all
- Copy of your note is not sent back to the requestor
- If you are being asked to simply treat a problem, it is not a consult
  - There must be some uncertainty as to the definitive diagnosis, or how to treat
E/M Basics: TCM & CCM

- Services intended to incentivize better care of chronic problems
- Both require a fair amount of non-physician clinical staff work
- TCM:
  - Covers the 30 day period following hospital discharge
  - Goal is to see to it that patient receives all required follow up care post hospitalization
- CCM:
  - Time based code billed once per month
  - Clinical staff time associated with implementing, establishing, revising, or monitoring the comprehensive care plan for a patient with two or more chronic conditions expected to last 12 months or longer, or until end of life

Pitfalls

- TCM
  - Pulling together the physician work with the clinical staff work (if audited)
  - Must reach out to patient within 2 business days of discharge
- CCM
  - Not documenting the time spent

Well Visit with Problem Component
Modifier 25 Scenario 1

- Significant portion of the annual preventive medicine service dedicated to acute or chronic problems, billed with an E/M visit code
- Applicable to both Medicare Annual Wellness Visits (AWV) and age based preventative visits
- Chief complaint sets the tone
  - “Here for CPE plus surveillance of chronic conditions”
- You should have a clearly distinguishable problem pertinent HPI / ROS
  - 1. HM here for physical. 2. HTN: BP running high at home lately, on Lisinopril 10 mg. 3. DM: on Lantus, last A1C was 5.5. No frequent urination, vision problems. 3. COPD: doing well, no exac”
- Trivial or insignificant problems should not be reported
- Bill the extra time spent performing counseling related to the problems
  - “I spent an extra 15 min, over 50% counseling, stressing need for compliance with meds and better dietary choices”

Pitfalls

- Documenting the HPI in the Assessment (or vice versa)
- Edit the ROS to reflect positive response
- If you find something significant on exam, add to the history
  - “Breast lump found today, pt does self-exams and had not noticed”
- The patient may have a copayment…but isn’t expecting one!
E/M With Procedure: Modifier 25 Scenario 2

- In general, billing for a visit the same day as a surgical procedure is acceptable when any of the following apply:
  - The procedure was not performed in advance – decision made after the evaluation.
  - A separate problem, completely unrelated to the reason for the procedure, is addressed same day.
  - A considerable amount of extra time is spent counseling (at least 15 min more than the ‘typical’ post op counseling).

Pitfalls

- “Automatically” billing for an E/M visit every time
- The E/M service work really isn’t much different from what’s inherent to the procedure
- Not documenting the extra time right.
  - Should say “I spent an additional ___ min, over 50% counseling regarding *describe*. This is significantly over and above the typical post op counseling for this procedure”
- Don’t use modifier 25 with new patient E/M codes – it is not needed and payer will count it as an ‘error’. Bill the E/M and procedure without mod 25.

Unbundling: Modifier 59 & The X Series

- It is inappropriate to bill in ‘piecemeal’ for multiple surgical procedures inherent to a comprehensive single code
- Certain procedures which contain elements that overlap with the primary procedures can be billed if eligible for modifier 59
- You need to check the National Correct Coding Initiative (NCCI) edits; there is no way around it
- The modifier indicators:
  - 0 = cannot bill separately under any circumstances
  - 1 = can be billed with modifier on the column 2 code.
  - If secondary code is not a column 2 code, you can bill separately without modifier
- Depending on payer (and circumstances) the X modifiers can be used instead of 59:
  - XE: separate encounter
  - XS: separate structure
  - XP: separate practitioner
  - XU: unusual non-overlapping service
Unbundling:
Modifier 59 & The X Series (cont’d)

Example 1
45385 – colonoscopy w/snare polypectomy
45378 – colonoscopy, diagnostic, is modifier indicator 0: cannot bill

Example 2
45385 – colonoscopy w/snare polypectomy
45380 – colonoscopy with biopsy, is modifier indicator 1: can bill with 59 or X modifier

Example 3
45385 – colonoscopy w/snare polypectomy
43239 – EGD w/bx, comes up “not a column 2 code” for 45385. It can be billed separately without a modifier

Pitfalls
- Using a modifier when you don’t need one (see “not a column 2 code”) might be counted as an error!
- Documentation doesn’t support the secondary procedure
- Do not use if the secondary procedure is described by an anatomic modifier (e.g. RT or LT, E1-E4)

Assistant Surgeon
Modifiers 80, 81, 82 or AS

- Assistant typically receives 16% of the surgical allowance
- Increasing scrutiny by the payers
  – Must be medically necessary
- The Medicare Physician Fee Schedule (MPFS) indicators will tell you if a procedure is eligible
- The modifiers:
  – 80: Assistant surgeon (MD)
  – 81: Minimum assistant surgeon (MD)
  – 82: No qualified resident available (teaching institution) (MD)
  – AS: Assistant is a PA, NP, or CNS

Pitfalls
- Not checking the MPFS
- Unclear what the assistant did; narrative should clearly describe
- Billing a different CPT code than the surgeon
- Using the wrong modifier
  – e.g. using 80 when the assistant is a PA
HCC Risk Adjustment
Optimal Documentation to Support Billing

- All conditions that risk adjust should be specifically mentioned in the assessment / plan
- Only those conditions that are Monitored, Evaluated, Assessed, or Treated are eligible (MEAT)
- Chronic conditions must be reported once per year.
- Cannot code from problem lists, encounter forms, or past medical history items.
  - Only those conditions being evaluated that day may be coded
- Code each ICD10 diagnosis to the highest specificity
  - Avoid use of “NOS” or “unspecified” codes

Pitfalls
- Unclear or incomplete documentation of chronic items in the assessment
- Coding problems that have entirely resolved, or are inactive and do not influence care
- Cannot rely on radiological reports
  - Physician has to mention the condition in the assessment.

Incident To & Shared Visits
Billing for Non-Physician Practitioners (NPP) Under the MD

- Whereas the MD does not need to see the patient for an incident to visit, for a shared visit, they must
- Incident To:
  - A follow up visit by mid-level, initially seen for same problem by MD (who created plan of care for that condition)
  - MD should co-sign note
  - Is not allowed in a facility setting
- Shared Visit:
  - Can be for new or known problems
  - MD must do a summary note:
    - "I saw the patient and agree with the NP’s assessment and plan. Briefly…..summarize in a sentence or two"
  - Allowed in most settings

Pitfalls
- Billing ‘all’ visits incident to even though some may not meet criteria
- Shared visit without MD summary note
- Payer variations
Incident To & Shared Visits
Billing for Non-Physician Practitioners (NPP) Under the MD

- All providers must be credentialed by appropriate carrier prior to billing for or rendering services
  - Need to know if carrier requires only credentialed clinicians provide service
  - Can violate contract
  - Can lead to audit recoupment
- Services must be billed under the service rendering provider’s NPI
  - Cannot bill under one provider for the entire practice/group
- Locum Tenens can only practice and bill for 60 days
  - Q6 modifier added to each CPT code

Pitfalls
- Not credentialing providers
  - Not knowing carriers requirements for credentialing
  - Some carriers may not recognize non-physician providers
- Billing under one NPI regardless of who rendered the service

Self Auditing

- A periodic look into the accuracy of your billing involves a meticulous approach:
  - Make your providers aware of what you’re doing
  - Prospective vs retrospective
  - Define the parameters
    - e.g. how many charts, what types of services, how often
  - Utilize Medicare audit tools for E/M services
  - LCDs and other payer policies
  - Consider all the documentation which applies to each code
Self Auditing (cont’d)

- A periodic look into the accuracy of your billing involves a meticulous approach (cont’d):
  - Accuracy of all codes and modifiers
  - Incident to/split shared/teaching institution requirements
  - Check for authentication and timely signatures
  - Look out for cloned or conflicting EMR notes
  - Share the results with your providers, billing staff, office manager, etc.
  - Self-disclose/refund as necessary
  - Supplement in-house efforts with an outside perspective
About Us

75 Years and Counting... That is the collective market experience of the leadership team at HealthCare Compliance Network. It is not bragging when we say, ‘been there, done that.’ We know our depth of knowledge of the regulatory and compliance field is an asset that sets us apart from the competition. But we believe that our commitment to daily in-field learning and passion for remaining abreast of the constantly evolving regulatory environment is just as important.

CONVENTUS

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