The Problem…

- We all have high-cost drug or device billing/documentation horror stories
  - Find one person near you
  - One minute to discuss high-cost drug or device billing/documentation horror stories
    - GO!
- Who heard a good one?
- Tell us what you heard!
The Problem...

- Heightened scrutiny and requirement for transparency – Recovery Audit Contractors (RACs), Comprehensive Error Rate Testing (CERT) Contractors, and Medicare Administrative Contractors (MACs)
- Local and National Coverage determinations (LCDs and NCDs) requiring not only ICD-9 codes but also clinical parameters to support medical necessity
- Increasing denials and reclaimed payments made (clawbacks) usually due to lack of supporting documentation (medical necessity)
- Increasing cost of devices and drugs
- Declining profit margins for procedures aligned with high cost devices

Objectives

- Discuss clinical documentation requirements to support medical necessity;
- Identify common coding and billing errors to mitigate compliance risk and optimize reimbursement;
- Provide key strategies to improve compliance with documentation, coding, and billing regulations;

With respect to high-cost drugs and devices
Common High Cost Devices and Drugs

Common high cost medical devices:
- Cardiac, e.g. Pacemakers, Defibrillators
- Joint replacement, e.g., Knee and Hip replacements

Common high cost drugs:
- Chemotherapy Drugs
- Biologics, e.g., Remicade (Infliximab), Herceptin (Trastuzumab)

Documentation

- If it was not documented…
  - Please finish the sentence
  - …it was not done.
- Who agrees with that statement (show of hands)?
Our experience- High Cost Drug and Device Audits

- 16% of claims for hip and knee joint placements did not meet the coverage criteria due to the documentation did not support medical necessity

- 36% of claims for pacemaker and defibrillator placements did not meet the coverage criteria due to lack of documentation

- 62% of drug charges where incorrectly billed with the wrong number of units and 33% had missed charges

How can we prevent more horror stories?

- Documented data needs to be of the highest quality, accurate, and accessible
  - Incomplete or missing data leads to:
    - Compromised patient care
    - Incorrect assumptions made by policy makers
    - Inaccurate research findings
    - Reimbursement problems
Documentation Requirements for High Cost Drugs and Devices

Overall
- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)
- Not based solely on ICD-9 codes-clinical criteria may apply

Documentation May Include:
- History of present illness
- Physical exam of joints
- Route of administration
- Dosage
- Physician orders

Common Coding and Billing Errors
- Missing or Incomplete Documentation
- Coding
- Charging
- Charge Description Master (CDM)
Common Coding and Billing Errors

Missing or Incomplete Documentation of:

- Physician orders
- Medication administration record
- Operative notes
- Device invoice
- Physician signatures
- Dosage or route of administration
- Drug wastage
- Start and stop times

Common Coding and Billing Errors

Coding

- Incorrect CPT, HCPCS or ICD-9 codes
- Missing or incorrectly coded diagnoses to support medical necessity
- Modifier error
Common Coding and Billing Errors

Charging Errors
- Incorrect units of service
- Missing charges

CDM Errors
- Inaccurate Revenue Codes
- Inaccurate pricing
- Pricing override for high cost devices
- Inconsistent mark-up formulae for supplies
- Incorrect system unit conversions for drugs

Coding and Billing- High Cost Devices

What is wrong with this scenario?

<table>
<thead>
<tr>
<th>Charge Description</th>
<th>Revenue code</th>
<th>HCPCS</th>
<th>Units</th>
<th>Medicare APC Payment (National)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dual Chamber pacemaker insertion</td>
<td>360</td>
<td>33208</td>
<td>1</td>
<td>$10,588.4</td>
</tr>
<tr>
<td>Pacemaker, dual chamber, rate-responsive (implantable)</td>
<td>272</td>
<td>C1785</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td>$10,588.4</td>
</tr>
</tbody>
</table>
Coding and Billing - High Cost Drugs

What is wrong with this scenario?

<table>
<thead>
<tr>
<th>Charge Description</th>
<th>Revenue code</th>
<th>HCPCS</th>
<th>Units</th>
<th>Medicare APC Payment (National)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rituximab 500 mg (Single use vial)</td>
<td>250</td>
<td>J9310</td>
<td>1</td>
<td>$693.36 X1</td>
</tr>
<tr>
<td>Administered 500 mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trastuzumab 440 mg (Multi-use vial)</td>
<td>636</td>
<td>J9355</td>
<td>44</td>
<td>$80.59 44</td>
</tr>
<tr>
<td>Administered 126 mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- J9310 - Injection Rituximab, 100 mg
- J9355 – Injection Trastuzumab, 10 mg

Key Strategies

- Monitoring
  - Chart-to-Bill Audits
  - Focused CDM Review
- Accurate Coding and Billing
- Complete and Correct Documentation
- Education and Training
Key Strategies

Monitoring

- Chart-to-Bill Audits (internal or external audits)
  - Types of errors (coding, charging, system induced)
  - Volume of errors
  - Reimbursement impact
  - Track and trend findings

(continued)

- Focused CDM Review
  - Review and correct the following:
    - Drug/device HCPCS codes
    - Related revenue codes
    - ‘Units multiplier’ for drugs
    - Drug and device charge
Key Strategies

Accurate Coding and Billing

- Report accurate HCPCS/CPT (per date of service)
- Report correct revenue codes
- Report device units based on the number of times a device was inserted
- Report drug units based on the full HCPCS descriptor (not based on packaged/stocked vial size)
- Report modifiers as necessary

Key Strategies

Complete and Correct Documentation

- Physician buy-in
  - Reimbursement impact
  - Educate (LCD/NCD documentation requirements)
- Physician documentation should include the following: (not all inclusive)
  - Detailed history
  - Detailed examination
  - Documentation of specific conditions
Key Strategies

Complete and Correct Documentation (continued)

- Clinical Judgment:
  - Reasons for deviating from a stepped-care approach

- Investigations:
  - Preoperative imaging studies, e.g. X-rays, MRIs

- Operative note:
  - Document procedures performed and any complications/additional treatments
  - State the specific device/s and specialty supplies used

Key Strategies

Education and Training

- Keep staff up-to-date on regulations and interpretations of regulations
  - Conduct regularly scheduled training sessions
  - Reinforce what is learned via follow-up
    - “What did you see as most important from our recent update?”
- Formal certifications for coders and billers
In Summary-Our Objectives

- Discuss clinical documentation requirements to support medical necessity;
- Identify common coding and billing errors to mitigate compliance risk and optimize reimbursement;
- Provide key strategies to improve compliance with documentation, coding, and billing regulations;

*With respect to high-cost drugs and devices*

Questions
Contact Information

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