

# Coding Workshop for Physicians and Advanced Practice Providers

2018 HCCA Compliance  
Institute

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## Agenda

Coding Basics - the  
definitive sources

Evaluation and  
Management Coding -  
the gray areas

Modifiers - the  
“magic” in coding  
(and the pitfalls!)

Medical Necessity -  
the intangible proof

Advanced Practice  
Providers - how to use  
them effectively and  
compliantly in the  
physician practice

## Have you read the back of the form?

“I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were furnished by me, or were furnished incident to my professional services by my employee under my immediate supervision. NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.”

## Code Sets

Used for physician coding/billing

- ▶ CPT - Current Procedural Coding
- ▶ HCPCS - Healthcare Common Procedural Coding System
- ▶ ICD-10-CM - International Classification of Diseases - 10<sup>th</sup> edition - Clinical Modifications

# 411

Where to find the information?

- ▶ CPT
- ▶ ICD-10-CM Guidelines
- ▶ Medicare Physician Fee Schedule Database
- ▶ Medicare Claims Processing Manual
- ▶ National Correct Coding Initiative

These are the definitive resources for physician coding

## CPT

Current Procedural Terminology



Published by the American Medical Association

Codes are developed by the AMA, then valued by a subcommittee of the AMA, then referred to CMS for review to determine how Medicare will handle the code.



Considered level I of the Healthcare Common Procedural Coding System - HCPCS

## HCPCS Level II

Codes not adequately/completely described in CPT

- ▶ Medicare-specific covered services - usually G-codes
- ▶ Medications/injections - J-codes
- ▶ Pass-through codes for hospital billing - C-codes
- ▶ Codes for durable medical equipment

Level III (local codes) deleted with HIPAA

## CPT

- ▶ Category I - “regular” CPT codes
  - ▶ 5 digits
- ▶ Category II - performance measures
  - ▶ 4 digits followed by the letter “F”
- ▶ Category III - New Technology
  - ▶ 4 digits followed by the letter “T”

Official guidance published in CPT Assistant

## CPT Assistant

- ▶ Published monthly
- ▶ References available in Professional edition
- ▶ Review by last date - as guidance may change

## CPT Assistant Example

- 19303** Mastectomy, simple, complete  
➔ *CPT Changes: An Insider's View 2007*  
➔ *CPT Assistant* Feb 07:4, Mar 15:5
- ▶ (Intraoperative placement of clip[s] is not separately reported) ◀
- (For immediate or delayed insertion of implant, see 19340, 19342)  
(For gynecomastia, use 19300)
- 19304** Mastectomy, subcutaneous  
➔ *CPT Changes: An Insider's View 2007*  
➔ *CPT Assistant* Feb 07:4, Dec 07:7, 8

### March 2015

- ▶ **Question:** How should I code for nipple-sparing mastectomy and skin-sparing mastectomy to distinguish them from total mastectomy?
- ▶ **Answer:** All of these procedures are classified mastectomy for cancer and should all be reported with code 19303. No special distinctions are made for the type of incision. The operative report should use state “total nipple-sparing” or “total skin-sparing” mastectomy to avoid confusion with a subcutaneous mastectomy.

## ICD-10-CM

- ▶ Developed by World Health Organization
- ▶ Maintained by AHA, AHIMA, NCHS, CMS
- ▶ Updated yearly - October 1 - no grace period
- ▶ Official guidance published by AHA - Coding Clinic
- ▶ Complete guidelines available at:  
<https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2018-ICD-10-CM-Coding-Guidelines.pdf>
- ▶ Used by all HIPAA-compliant entities (Worker's compensation will not be required to use it, but ICD-9 will not be maintained.)

NOTE: ICD-10-PCS not used for physician billing

## Example - Coding Clinic Guidance

- ▶ When the type of arthritis is not specified, the default is primary. 4Q 2016
- ▶ Previously confusing advice as to whether the surgeon can code from pathology report. Clarified that the surgeon can code from the pathologist's diagnosis, even though the operative report does not contain the diagnosis. 1Q 2017
  - ▶ For example, operative report states "breast mass" - but the pathology report states "fibroadenoma" - the correct code would be D24.\*
- ▶ Screening colonoscopy - The primary code should be Z12.11 - any findings should be coded as additional codes, but the primary code should reflect the reason for the visit. A patient who is status post removal of polyps returns for surveillance colonoscopy. The primary code would be Z12.11 for screening - a surveillance colonoscopy is coded as a screening. Z86.010 should be coded additionally for history of polyps. 1Q 2017

# Diagnosis Coding Example - Diabetes

Patient has uncontrolled diabetes with several complications, including retinopathy, neuropathy, and vascular insufficiency with foot ulcers

Physician codes unspecified diabetes E11.9

Cost of care for patient far exceeds that expected for the uncomplicated, in-control condition that has been coded.

## Example of Expected Costs for Diabetes Care

Dx Code	Dx Description	Expected Annual Cost of Care
E11.9	Diabetes with no complications	\$1,400
E11.319	Diabetic retinopathy	\$2,200
E11.40	Diabetic neuropathy	\$3,500
E11.22	Diabetic chronic kidney disease	\$4,300

## Keeping Up with Change

### ICD-10-CM codes updated in October -

- Changes first published in June - can review agenda/minutes of meetings online

### CPT codes updated in January

- Annual publication - CPT Changes
- Symposium - November
- AAPC and AHIMA chapter meetings

### Medicare Changes -

- Sign up for CMS updates
- [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/What\\_Is\\_MLNMatters.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/What_Is_MLNMatters.pdf)

## Professional Organizations for Coders

Two most prominent organizations -

- ▶ American Academy of Professional Coders

<http://www.aapc.com>

CPC - Certified Professional Coder

- ▶ American Health Information Management Association

<http://www.ahima.org>

CCS-P - Certified Coding Specialist - Physician-Based



## Medicare Physician Fee Schedule Database

- ▶ HUGE Excel spreadsheet - information on every HCPCS code -
  - ▶ Status
  - ▶ RVUs
  - ▶ Is a modifier allowed?
  - ▶ Is an asst surg payable?
  - ▶ Is a co-surgeon payable?
  - ▶ % of fee that applies to pre-op, surg, post-op

## Medicare Physician Fee Schedule Database

HCPCS	MOD	DESCRIPTION	STATUS CODE	GLOB DAYS	PRE OP	INTRA OP	POST OP	MULT PROC	BILAT SURG	ASST SURG	CO- SURG	TEAM SURG	ENDO BASE	CONV FACTOR
47562		Laparoscopic cholecystectomy	A	090	0.09	0.81	0.10	2	0	2	1	0		37.8975
47563		Laparo cholecystectomy/graph	A	090	0.09	0.81	0.10	2	0	2	1	0		37.8975
47564		Laparo cholecystectomy/explor	A	090	0.09	0.81	0.10	2	0	2	1	0		37.8975
47570		Laparo cholecystoenterostomy	A	090	0.09	0.81	0.10	2	0	2	1	0		37.8975
47579		Laparoscope proc, biliary	C	YYY	0.00	0.00	0.00	2	1	2	0	0		37.8975
47600		Removal of gallbladder	A	090	0.09	0.81	0.10	2	0	2	1	0		37.8975
47605		Removal of gallbladder	A	090	0.09	0.81	0.10	2	0	2	1	0		37.8975
47610		Removal of gallbladder	A	090	0.09	0.81	0.10	2	0	2	1	0		37.8975
47612		Removal of gallbladder	A	090	0.09	0.81	0.10	2	0	2	1	0		37.8975
47620		Removal of gallbladder	A	090	0.09	0.81	0.10	2	0	2	1	0		37.8975
47630		Remove bile duct stone	A	090	0.09	0.81	0.10	2	0	1	1	0		37.8975
47700		Exploration of bile ducts	A	090	0.09	0.81	0.10	2	0	2	1	0		37.8975
47701		Bile duct revision	A	090	0.09	0.81	0.10	2	0	0	0	0		37.8975
47711		Excision of bile duct tumor	A	090	0.09	0.81	0.10	2	0	2	1	0		37.8975
47712		Excision of bile duct tumor	A	090	0.09	0.81	0.10	2	0	2	1	0		37.8975
47715		Excision of bile duct cyst	A	090	0.09	0.81	0.10	2	0	2	1	0		37.8975
47716		Fusion of bile duct cyst	A	090	0.09	0.81	0.10	2	0	2	1	0		37.8975
47720		Fuse gallbladder & bowel	A	090	0.09	0.81	0.10	2	0	2	1	0		37.8975
47721		Fuse upper gi structures	A	090	0.09	0.81	0.10	2	0	2	1	0		37.8975
47740		Fuse gallbladder & bowel	A	090	0.09	0.81	0.10	2	0	2	1	0		37.8975

## Medicare Claims Processing Manual

CMS instructions to local carriers/MACs on how to pay a claim -

- ▶ Specific information on codes

Chapter 12 is for physicians and other providers -

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

Also consider -

Benefit Policy Manual

Program Integrity Manual

## Other Resources

Not definitive, but helpful -

- ▶ Optum360 Coders' Desk Reference
- ▶ Optum360 Specialty Coding Companion
- ▶ Specialty societies
- ▶ Newsletters from other publishers
  - ▶ Pay attention to the author - or the source being quoted

## The Basics of Evaluation and Management

- ▶ Documentation Guidelines

Two sets of guidelines established by CMS

- ▶ 1995 Documentation Guidelines
- ▶ 1997 Documentation Guidelines

Providers may use whichever they choose.

Auditors are instructed to audit under both sets of guidelines and allow the physician to use whichever benefits him/her.

## Gray Areas

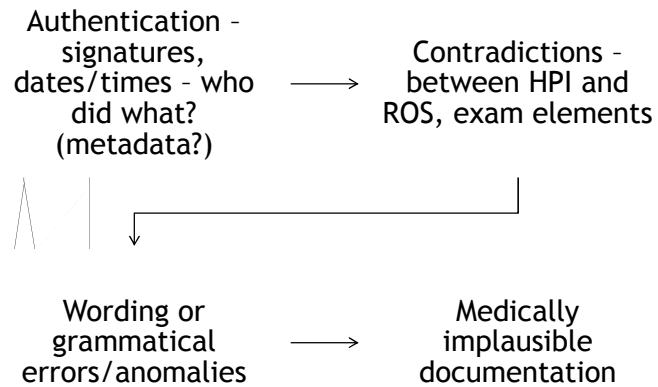
Coding, especially evaluation and management coding, is full of gray areas. How will you interpret these?

Examples -

- ▶ Which components are accepted or mandatory for established patients?
- ▶ Is “non-contributory” acceptable documentation?
- ▶ What is a detailed examination under the 1995 CMS Documentation Guidelines

Some of these may be answered by your MAC - but will you extend those definitions to all payers?

## Evaluation and Management EHR Issues



## Modifier Magic!

If there is any magic in coding, it's in the appropriate use of modifiers!

- ▶ Modifiers to receive payment for services that would be included in the global surgical package
- ▶ Modifiers to bypass bundling edits
- ▶ Other payment modifiers

CPT modifiers are numeric

HCPCS modifiers are alpha-numeric

## Medicare Global Surgical Package

Payment for the surgical CPT code includes

- ▶ Preoperative visit after the decision to perform surgery
- ▶ Intraoperative services
- ▶ Complications
- ▶ Postoperative visits
- ▶ Supplies

## Not Included in Surgical Package

- ▶ Initial evaluation to determine the need for surgery
- ▶ Visits unrelated to the diagnosis for which the surgery is performed
- ▶ Treatment for the underlying condition
- ▶ Diagnostic tests and procedures
- ▶ Return to the OR

## Differs from the CPT Surgical Package

- ▶ Whether complications are included in the surgical fee
  - ▶ CPT says typical postoperative care - anything not “typical” can be billed separately
  - ▶ Medicare says anything short of taking the patient back to the OR is included in the surgical fee

## National Correct Coding Initiative

“The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative to promote national correct coding methodologies and to eliminate improper coding. CCI edits are developed based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.”

<http://www.cms.hhs.gov/physicians/cciedits/>

## NCCI Example

CPT codes and descriptions only are copyright 2002 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Apply.

Column1/Column 2 Edits				
Column 1	Column 2	Effective Date	Deletion Date * = no data	Modifier 0 = not allowed 1 = allowed 9 = not applicable
47600	36000	20021001	*	1
47600	36410	20021001	*	1
47600	37202	20021001	*	1
47600	38500	* 1996010	*	1
47600	43752	20040101	*	1
47600	44005	* 1996010	*	0
47600	44200	20000605	*	0
47600	44820	19970401	*	0
47600	44850	19970101	*	0
47600	44950	* 1996010	*	0
47600	47420	19970101	*	1
47600	47480	* 1996010	*	1
47600	47562	20010101	*	0
47600	47564	20000605	*	0
47600	49000	* 1996010	*	0

## Use of Modifiers with CCI Edits

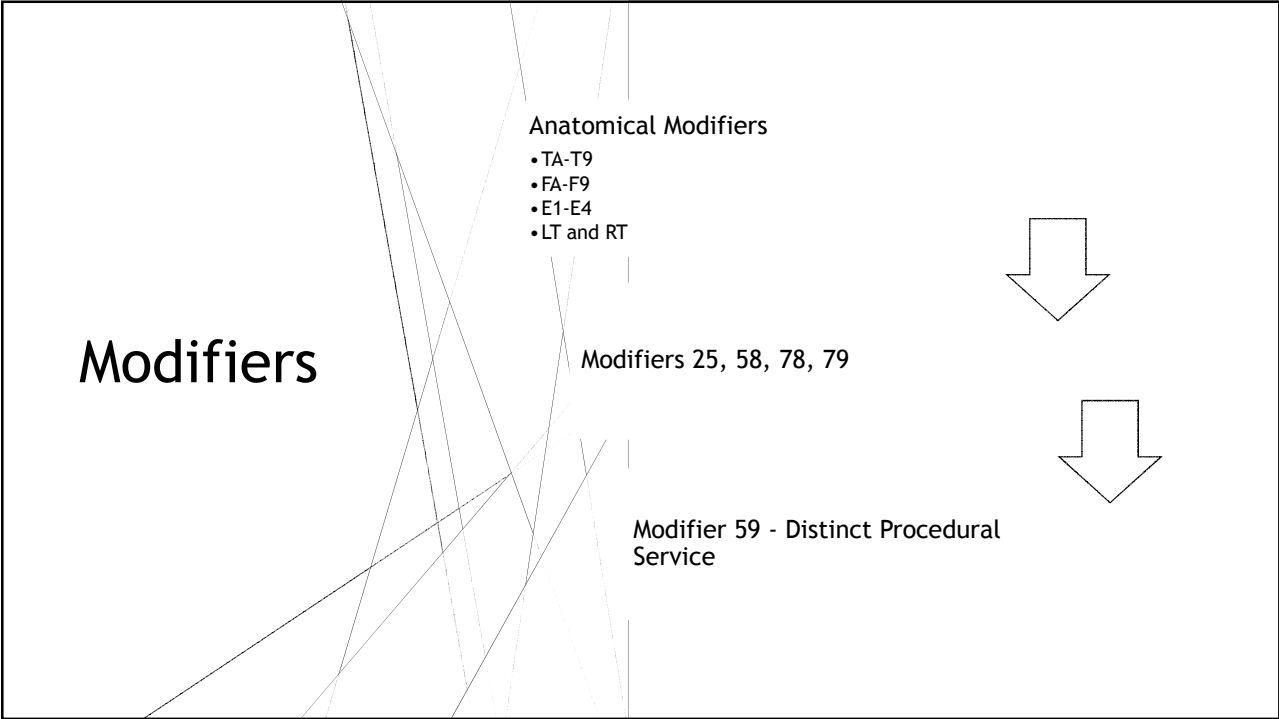
### Indicators

0 - modifier does not apply

1 - modifier does apply

9 - policy not set

► Modifier attached to Column 2 code



## Medically Unlikely Edits

- ▶ Refer to the maximum number of units of a service that is likely to be performed.
- ▶ Not all are published.

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html>

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Applicable FARS/IDFARS Restrictions Apply to Government Use.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for the data contained or not contained herein.

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
11012	2	3 Date of Service Edit: Clinical	Clinical: Data
11042	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
11043	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
11044	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
11045	12	3 Date of Service Edit: Clinical	Clinical: Data
11046	10	3 Date of Service Edit: Clinical	Clinical: Data
11047	10	3 Date of Service Edit: Clinical	Clinical: Data
11055	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
11056	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
11057	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
11100	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
11101	6	3 Date of Service Edit: Clinical	Clinical: Data
11200	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
11201	0	3 Date of Service Edit: Clinical	Clinical: CMS Workgroup
11300	5	3 Date of Service Edit: Clinical	Clinical: Data
11301	6	3 Date of Service Edit: Clinical	Clinical: Data



## Modifier 24

### Unrelated E&M Service by the Same Physician During the Postop Period

- ▶ Unrelated?
  - ▶ Different diagnosis
  - ▶ Same diagnosis, but treating the underlying condition rather than complications/normal recovery from surgery

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## Modifier 25

### Significant, Separately Identifiable E&M Service by the Same Physician on the Same Day of Procedure or Other Service

- ▶ Beyond the usual preop and postop care
- ▶ Different diagnosis is not required

Not to be used on procedures

- ▶ NCCI: “The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service.”

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## Modifier 57

### Decision for Surgery

- ▶ Used on E&M the day before or day of surgery
- ▶ Bypasses the global surgery edit

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## Modifier 25 versus 57

### Medicare Guideline

- ▶ Use -25 with minor surgery  
(0 - 10 postop days)
- ▶ Use -57 with major surgery  
(90 postop days)

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## Modifiers 54, 55, 56

- 54 - Surgical Care Only
- 55 - Postoperative Management Only
- 56 - Preoperative Management Only

► Splits the global surgical package and fee

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## Modifier 58 or 78 or 79?

When performing a procedure in the postop period, one of these three modifiers will be assigned.

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## Modifier 58

### Staged or Related Procedure

- ▶ Three Circumstances
  - ▶ Planned at the time of the original procedure
  - ▶ More extensive than the original procedure
  - ▶ Therapeutic following a diagnostic
- ▶ Fee is not reduced
- ▶ Postop period starts over

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## Modifier 78

### Return to the OR for a Related Procedure During a Postop Period

- ▶ Postop complications
- ▶ Fee is reduced to intraoperative portion
- ▶ Postop period does not start over - assume the postop period of the original procedure

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## Modifier 79

### Unrelated Procedure or Service by the Same Physician During the Postoperative Period

- ▶ May be same diagnosis - if treatment is for underlying disease process
- ▶ Fee is not reduced
- ▶ Postop period starts over

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## Modifier 59

### Distinct Procedural Service

- ▶ Procedures and services that are not normally reported together, but are appropriate under the circumstances
  - ▶ Different session or encounter
  - ▶ Different site or organ system
  - ▶ Separate incision/excision
  - ▶ Separate injury

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## Modifiers 76 and 77

- ▶ Modifier 76 - Repeat Procedure or Service by Same Physician
- ▶ Modifier 77 - Repeat Procedure or Service by Another Physician

Not for Evaluation and Management Services

## Modifier 22

**Increased** procedural service - not just unusual -

“When the work required to provide a service is substantially greater than typically required....

Documentation must support the substantial additional work (ie., increased intensity, time, technical difficulty of procedure, severity of patient’s condition, physical and mental effort required.”

Not to be used on E&M services

## Modifier 22

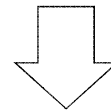
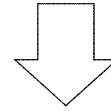
Use when case is outside the norm for that procedure code

- Extra time
- Unusual anatomy
- Profuse bleeding
- Major scarring - significant adhesions

Don't use when

- Laparoscopic procedure but no lap code
- A procedure is inherently hard
- The patient possesses conditions that affect the anesthesia risk, but the surgeon is not monitoring/administering the anesthesia

No set amount for fee increase



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## Modifier 23

Unusual Anesthesia

- ▶ Used on anesthesia code - when general or regional anesthesia is used for a procedure normally done without anesthesia or with only local anesthesia

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## Modifiers 26 (PC) and TC

26 - Professional Component

- ▶ Physician's interpretation

TC - Technical Component

- ▶ Not to be used when the CPT code specifies professional or technical component.

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## Modifier 33

- ▶ Identifies preventive services mandated by PPACA - denotes no costsharing by the patient

- ▶ Not to be used when the CPT code specifies preventive medicine service

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## Modifier 47

### Anesthesia by Surgeon

- ▶ Used when surgeon administers regional or general anesthesia
- ▶ Appended to the surgery code

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## Modifier 50 or LT and RT

### Bilateral Procedure

- ▶ Don't forget other anatomical modifiers
  - ▶ E1, E2, E3, E4
  - ▶ TA - T9
  - ▶ F1 - F9
- ▶ Preference varies by carrier/payer

50

## Modifier 51

### Multiple Procedures

- ▶ Careful not to use on add-on codes or modifier -51 exempt codes ∅
- ▶ Usually indicates fee reduction for multiple procedures

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## Modifier 52

### Reduced Services

- ▶ Service is reduced or partially eliminated at the physician's discretion
- ▶ No set fee reduction

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## Modifier 53

### Discontinued Procedure

- ▶ Procedure terminated due to extenuating circumstances or those that affect the well-being of the patient
- ▶ No set fee reduction

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## Modifier 52 versus 53

### Modifier 52

Intended for procedures that accomplished some result, but less than expected.

Bilateral procedure performed on only one side

### Modifier 53

The procedure was started but was discontinued before completion due to the patient's condition or extenuating circumstances

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## Modifier 63

### Procedure Performed on Infants less than 4 kg

- ▶ Not to be used with E&M codes
- ▶ Not to be used with age-specific codes

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## Modifier 62

### Two Surgeons

- ▶ Two surgeons performing distinct parts of one CPT code.
- ▶ Two operative reports needed.
- ▶ Don't use if there are separate CPT codes for each physician's work.
- ▶ Reimbursement is generally 62.5% of the Medicare allowable.

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## Modifier 66

### Surgical Team

- ▶ The procedure requires the concomitant services of several physicians
  - ▶ Usually different specialties

57

## Modifier 80

### Assistant Surgeon

- ▶ May not be appropriate for PAs - some payers prefer -AS
- ▶ Medicare lists approved procedures - Hospital may also have list of procedures for which it requires an assistant.
- ▶ Medicare payment is 16% of allowable for surgery.
- ▶ Other payers allow 20-25% of allowable

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## Modifiers 81 and 82

### Modifier 81 - Minimum Assistant Surgeon

- ▶ Rarely recognized
- ▶ Sometimes used with 2<sup>nd</sup> or 3<sup>rd</sup> assistant

### Modifier 82 - Assistant Surgeon when qualified resident not available

- ▶ May also be used to indicate that this surgeon never uses residents in the care of his patients.

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## Modifier 90

### Reference (Outside) Laboratory

- ▶ When you are billing for the test, but you are sending it out to be performed.
- ▶ Rarely used - most payers require the performing provider to bill.

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## Modifier 91

### Repeat Clinical Diagnostic Laboratory Test

- ▶ Separated by time
- ▶ Repeated in order to treat the patient
- ▶ Don't use if CPT code indicates a series
- ▶ Distinguished from modifier 59:
  - ▶ -59 used for different site/specimen

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## Modifier 92

- ▶ Specifically for HIV testing (86701-86703) done in location other than healthcare facility. Requested by CDC-

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## Modifiers 96 and 97

- ▶ 96 - Habilitative services help an individual learn skills and functioning for daily living that the individual has not yet developed, and then keep and/or improve those learned skills. Habilitative services also help an individual keep, learn, or improve skills and functioning for daily living.
- ▶ 97 - Services that help individual keep, get back, or improve skills and functioning for daily living that have been lost or impaired due to being sick, hurt, disabled

## Sequencing

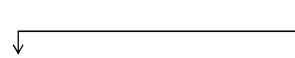
Modifiers that affect payment are sequenced first

Information-only modifiers are sequenced last



# Medical Necessity

Definition → Finding the Guidelines/Policies



Documenting → Appealing



Teaching Your Providers

# Wikipedia definition

- ▶ **Medical necessity** is a United States legal doctrine, related to activities which may be justified as reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care. Other countries may have medical doctrines or legal rules covering broadly similar grounds. The term **clinical medical necessity** is also used.

## About.com definition

- ▶ Health insurance companies provide coverage only for health-related services that they define or determine to be medically necessary. Medicare, for example, defines *medically necessary* as: “Services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice.”
- ▶ Medical necessity refers to a decision by your health plan that your treatment, test, or procedure is necessary for your health or to treat a diagnosed medical problem.

## Attorney definition

As explained to a client undergoing a Medicaid audit

- ▶ There is a difference between clinical medical necessity and billing medical necessity
- ▶ Just because YOU think it's medical necessary doesn't mean it's going to be

## AMA Definition

Services or procedures that a prudent physician would provide to a patient in order to prevent, diagnose or treat an illness, injury or disease or the associated symptoms in a manner that is:

- ▶ In accordance with the generally accepted standard of medical practice.
- ▶ Clinically appropriate in terms of frequency, type, extent, site and duration.
- ▶ Not for the intended for the economic benefit of the health plan or purchaser or the convenience of the patient, physician or other health care provider.

## Medicare Definition

Medical necessity from a Medicare perspective is defined under Title XVIII of the Social Security Act, Section 1862 (a) (1) (a):

“No payment may be made under Part A or Part B for expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

## Back to the Claim Form

“I certify that the services shown on this form were ***medically indicated and necessary*** for the health of the patient”

## Diagnosis Coding

- ▶ Correct/appropriate/specific diagnosis coding is critical -
- ▶ But many diagnosis codes are not specific enough in themselves:
  - For example, one insurer has the following policy for Supartz
  - ▶ Failure of conservative treatment, i.e., physical therapy, weight loss, analgesic meds
  - ▶ Duration of 6 months or longer
  - ▶ X-ray confirmation of diagnosis (Grade II or III)
- None of that information is conveyed by the diagnosis code
- ▶ ICD-10 helps - but does not solve the problem

## Finding the Information

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CMS - National Coverage Determination

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MAC - Local Coverage Determination

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Other Payers

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CPT “stays out of it” - does give scenarios in CPT Assistant and other publications but does not proscribe medical necessity

## Medicare

<http://www.cms.gov/medicare-coverage-database/>

Can search for both National Coverage Determinations - NCDs as well as Local Coverage Determinations - LCDs

LCDs formerly known as LMRPs - Local Medical Review Policies

## Other Payors

(Including Medicaid)

- ▶ May or may not have specific information available

## Evaluation and Management

From the American Academy of Family Practice

Medical necessity of an E&M service is generally expressed in two ways: frequency of services and intensity of service (CPT level)

- ▶ Medicare's determination of medical necessity is separate from its determination that the E/M service was rendered as billed.
- ▶ Medicare determines medical necessity largely through the experience and judgment of clinician coders along with the limited tools provided in CPT and by CMS.
- ▶ During an audit, Medicare will deny or adjust E/M services that, in its judgment, exceed the patient's documented needs

## Evaluation and Management

Per CMS - Medicare Claims Processing Manual -

Medical necessity 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 evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.”

## Evaluation and Management Nature of Presenting Problem (from the Table of Risk)

Nature of Presenting Problem	Level of Service	
	Office	Inpatient
Self-limited or minor problem	99201/99202 - 99212	
Two or more self-limited or minor problems One stable chronic illness Acute uncomplicated illness or injury	99203 - 99213	99221 - 99231
One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis Acute illness with systemic symptoms Acute complicated injury	99204 - 99214	99222 - 99232
One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illness or injury that poses a threat to life or bodily function Abrupt change in neurologic status	99205 - 99215	99223 - 99233

## Balancing Medical Necessity and Meaningful Use

Bringing forward medical history in an EMR is an important aspect of meaningful use

Does this mean that you can count that comprehensive history toward the level of service for every office visit now and forevermore?

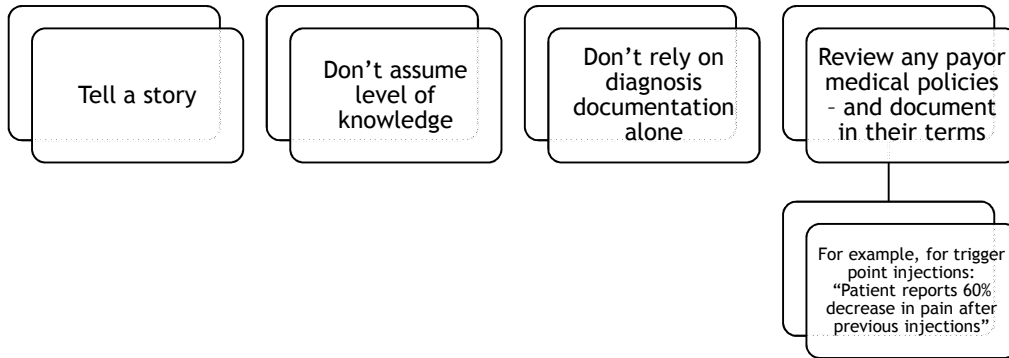
## Certificate of Medical Necessity

Used for Durable Medical Equipment

- ▶ Often completed by DME provider and brought to physician for signature
- ▶ Physician is responsible for information submitted



## How to Document Medical Necessity



## How to Document

Reason for any services ordered - labs, EKGs, X-rays, other diagnostic studies -

- CMS Documentation Guidelines:
- “If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.”

## Who can judge?

- ▶ Debate among coding professionals/auditors as to whether they can judge medical necessity
- ▶ Quote from Alabama Medicaid: “All services must be reasonable and necessary in the specific case and must meet the criteria of specific governing policies. Medical record documentation must support coding utilized in claim and/or prior authorization submission.
- ▶ An outside auditor may judge your physician on medical necessity. Are you doing him/her a disservice by not reviewing this?

## How to Teach Your Providers

### Respectfully...

- ▶ You don't know what they know
- ▶ Give them a chance to tell you
- ▶ Suggest appropriate documentation in lay terms
- ▶ Remind them that someone who does not know this patient may ultimately be deciding that what was done was appropriate

## Advanced Beneficiary Notification

Notifies a Medicare beneficiary that you have reason to believe that the services they are to receive today are not covered by Medicare - and asks the patient to agree to pay for the services

"Advance Beneficiary Notices advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment for them. ABNs allow beneficiaries to make informed consumer decisions about receiving items or services for which they may have to pay out-of-pocket and to be more active participants in their own health care treatment decisions."

## Modifiers for ABNs and NEMBs

GA - ABN on file

GY - service statutorily excluded or does not meet the definition of any Medicare benefit

GZ - service expected to be denied as not reasonable and necessary

Careful with use - these are on the OIG Workplan

Affects the language on the patient's Medicare Summary Notice

## MSN Language

### Example

- ▶ The information provided does not support the need for this many services or items in this period of time but you do not have to pay this amount.
- ▶ You cannot be billed separately for this item or service. You do not have to pay this amount.

## Not Medically Necessary vs. Non-covered Services

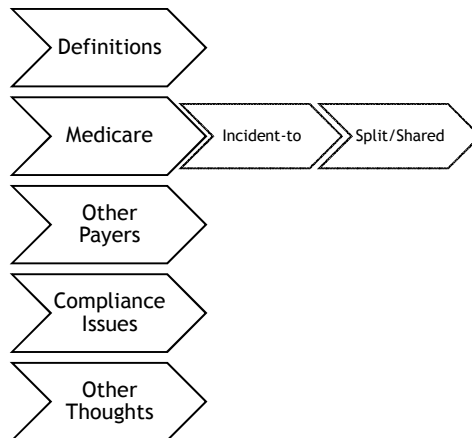
### Not medically necessary

- ▶ The patient does not have a diagnosis for which the service is normally covered
- ▶ The service is being provided more often than is approved
- ▶ May only bill the patient if ABN has been signed

### Non-covered services

- ▶ Never, ever paid by Medicare
- ▶ May always bill the patient

## Non-Physician Practitioner Coding and Billing



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## Non-Physician Practitioners

- ▶ Nurse Practitioner (APN, APRN, CRNP, etc.)
- ▶ Clinical Nurse Specialist
- ▶ Certified Nurse Midwife
- ▶ Physician Assistant

Different rules for different insurers - must pay attention to the patient's insurance when deciding how to utilize these providers in your practice.

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## Medicare

### Billing options

- ▶ NPPs own provider number
- ▶ Incident-to physician's service
- ▶ Shared visit

Nurse Practitioners must have Master's or Doctorate in Nursing (or credentialed prior to 1/1/2003)

Nurse Practitioners can be paid directly, but PA payment must go to the employer.

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## NPP's Provider Number

- ▶ Any services allowed by the NPP's state scope of practice
- ▶ Reimbursed at 85% of the physician fee schedule
- ▶ 100% for nurse midwives, beginning 1/1/2011 - previously 65%

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## Incident-to

- ▶ “Incident-to” a Medicare term
  - ▶ NPP must be eligible
- ▶ Billed under the physician’s number
- ▶ Paid at 100% of the physician’s fee schedule

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## Incident-to Rules

- ▶ Incident to a physician’s professional service
- ▶ In the physician’s office
- ▶ Under the physician’s direct supervision
- ▶ Furnished by an individual who qualifies as an employee - either W-2 employee or contracted employee

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## Incident-to

Incident-to a physician's professional service

- ▶ An integral, though incidental part of the physician's professional service
  - ▶ Following a plan of care established by the physician
  - ▶ Physician must perform initial service and be involved in subsequent services of a "frequency which reflect active participation and management"
  - ▶ Some MACs give more specific requirements - Cahaba, for example, requires cosignature
- ▶ Furnished in the physician's office or clinic

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## Direct Supervision

Under the physician's direct supervision

- ▶ In the office suite and immediately available
  - ▶ What constitutes an office suite?
  - ▶ How do you prove immediately available?
- ▶ Supervision can be provided by another physician in the group practice
  - ▶ Service billed under supervising physician
  - ▶ Ordering physician's name and NPI entered in box 17

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## Employee of the Physician

- ▶ W-2 employee of the physician, group practice or legal entity that employs the physician
- ▶ 1099 contracted/leased employee
- ▶ Under the control of the physician
- ▶ Must represent an expense to the physician, group practice, or legal entity

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## Services Incident-to NPP

Services performed by auxiliary personnel supervised by NPP and following plan of care established by NPP.

Billed under the provider who ordered the service and who is supervising - the NPP, not the collaborating physician

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# CMS Clarifications - 2016

Must be billed under supervising physician (the one who is actually in the office at the time of service)

Provider cannot be excluded from any federal program

Provider can't have had Medicare enrollment revoked

In compliance with state law

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# Shared Visits

Internet Only Manual section 30.6.1.B

“When a hospital inpatient/hospital outpatient or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician’s or the NPP’s UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient’s medical record) then the service may only be billed under the NPP’s UPIN/PIN. Payment will be made at the appropriate physician fee schedule rate based on the UPIN/PIN entered on the claim.”

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## Shared Visit Documentation

Per Terrence Kay, Director of the Division of Practitioner and Ambulatory Care in the Center for Medicare Management, CMS -

“...any face-to-face portion of an E/M encounter (i.e., history, physical exam, or medical decision-making in whole or in part). A social salutation alone does not constitute a face-to-face portion or “physician work” of an E/M service.”

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## Shared Visits

- ▶ As long as there is evidence of a face-to-face service by both the MD and NPP, the work is combined and billed under the MD - both must see the patient in the hospital setting
- ▶ Must be clear what portions of the service each performed
- ▶ “Seen and agree” not sufficient
- ▶ Expect to see documentation of physician repeating some portion of the examination or discussion with patient
- ▶ Some MACs audit for “substantive” involvement of physician

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# NOT Shared Visits

**01**  
Procedures

**02**  
Welcome to Medicare

**03**  
Critical Care

# Shared Visits in the Office

Must still meet incident-to guidelines

If visit dominated by and coded based on counseling and coordination of care, can combine NPP and physician time

Take care not to  
confuse shared visit  
rules with Teaching  
Physician guidelines!

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## Scribes

- ▶ CMS Program Integrity Manual update June 2017 on scribes - no signature by scribe required
- ▶ MACs may have more restrictive policies on scribes
- ▶ “Human dictaphone” - cannot add any observations of their own (other than ROS and PFSH as allowed by Documentation Guidelines)
- ▶ Best Practice: Sign as “Scribed by --- for Dr. ---”
- ▶ Opinion: Suspicion of use of employee at the level of NPP as clerical staff

## CIGNA on Scribes

- ▶ If a nurse or mid-level provider (PA, NP, CNS) acts as a scribe for the physician, the individual writing the note (or history or discharge summary, or any entry in the record) should note "written by xxxx, acting as scribe for Dr. yyy." Then, Dr. yyyy should co-sign, indicating that the note accurately reflects work and decisions made by him/her. **Note: The scribe is functioning as a "living recorder," recording in real time the actions and words of the physician as they are done. If this is done in any other way, it is inappropriate. This should be clearly documented as noted, by both the scribe and the physician. Failure to comply with these instructions may result in denial of claims.**

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## Scenarios for Medicare Patients

Always bill under NPP's number

Always bill under MD's number

Documentation for visit determines how to bill -

may vary from patient-to-patient, visit-to-visit

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## Limitation on Level of Service?

- ▶ Officially no limitation on level of service billed
- ▶ Some consultants consider higher levels of medical decision-making “what it means to be a physician”
- ▶ Some payers limit the levels of service payable to NPPs

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## Other Payers?

Some allow billing under the MD regardless of incident-to guidelines or physician presence



Some credential separately and allow independent billing

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## Other Payers - Example

Definition of “incident-to” is not the same as Medicare

- ▶ Physician must also see the patient on the date of service
- ▶ Not specified which portions of the service each can perform
- ▶ Billed under the physician and paid at the physician fee schedule

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## Other Payers - Example

For some payers, NPPs can be credentialed and billed under their own NPI

- ▶ Payment may be based on patient’s contract benefits
- ▶ Only certain CPT codes (E&M codes and some minor surgery - some exclude hospital visits)
- ▶ Payment usually at 70-80% of physician fee schedule and may vary by CPT code)
- ▶ Must be billed this way when the MD does not see the patient on the same date of service

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## Other Payers - United Healthcare

Starting 9/1/2017 - when  
patient is seen by NPP and  
claim billed under physician

- ▶ Modifier SA
- ▶ Rendering provider NPI in  
field 24J

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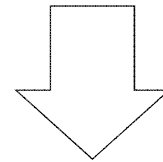
## Other Payers - Example

BCBS of Alabama - new  
policy effective 1/1/2015

- Visit must be billed under  
the provider who  
documents the History of  
Present Illness

BCBS of Arkansas -

- Nurse practitioners limited to  
moderate complexity medical  
decision-making: 99201,  
99202, 99203 - 99211, 99212,  
99213, 99214 and minor  
procedures
- PAs limited to assistant at  
surgery, lower level ED  
services - no inpatient



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## Compliance Issues - Red Flags

**01**

High number of visits billed under physician's provider number

**02**

Physician did not know he/she was "supervising physician"

**03**

Patient dissatisfaction

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## Auditing Considerations - Medicare

Office Service - Need entire medical record - not just one date of service

- ▶ Are incident-to requirements met?
  - ▶ Established patient - established problem
  - ▶ Previous visit to establish plan to treat this problem
  - ▶ Visits by physician addressing this problem - does your MAC/payer establish frequency requirements?
  - ▶ Established patient - "minor" problem
  - ▶ If requirements met, and more than 50% of the visit is counseling, can combine MD and NPP time
- ▶ If requirements not met, must bill under NPP's own provider number

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## Auditing Considerations - Medicare

### Hospital Service

- ▶ Admission, Subsequent Visit or Discharge
  - ▶ Is there a face-to-face visit by the MD?
  - ▶ Combine documentation from both MD and NPP to determine level of service
- ▶ Consultation
  - ▶ Cannot combine documentation - must bill under either the MD or the NPP based on each individual's documentation

### Nursing Facility Service

- ▶ Must bill under NPP's own number

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## Resources for NPP Billing

- ▶ Nurse Practitioner Scope of Practice  
<http://www.acnpweb.org/i4a/pages/index.cfm?pageid=3465>
- ▶ American Academy of Physician Assistants  
<http://www.aapa.org/>
- ▶ Medicare Benefit Policy Manual, chapter 15, section 60 -  
<http://www.cms.gov/manuals/Downloads/bp102c15.pdf>
- ▶ Medicare Claims Processing Manual, chapter 12, section 30.6.1-  
<http://www.cms.gov/manuals/downloads/clm104c12.pdf>

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**Thank You!**

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