# Billing Audit Deeper Dive: Coding and Documentation

A Close Encounter of the Billing Kind…
Are You Ready?

Wednesday, March 14, 2018

Practice Protectors | Forward Lookers | Solution Partners

Copyright ©2018 Conventus, All rights reserved

## Disclaimer

The information provided is intended to be a general summary and for educational purposes only. It may also contain references or links to statutes, laws, regulations, or other materials. NIP Management Co., LLC/Conventus takes reasonable efforts to provide accurate information but cannot guarantee its accuracy or that it meets local, state, or federal statutes, laws, or regulations. You should not rely on the presentation contents to meet any federal, state, and/or local statutes, laws, regulations and rules.

NIP/Conventus disclaims any and all liability for reliance upon the information contained therein, regardless of whether the information is presented by NIP/Conventus or an external vendor. We encourage you to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents, as well as how it applies to you and/or your organization. It is also suggested that you consult your legal counsel or other professional consultants about how it pertains to your specific situation.

Copyright ©2018 Conventus, All rights reserved

## 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**

Copyright ©2018 Conventus, All rights reserved


## 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

Copyright ©2018 Conventus, All rights reserved

# 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.


Copyright ©2018 Conventus, All rights reserved


# 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

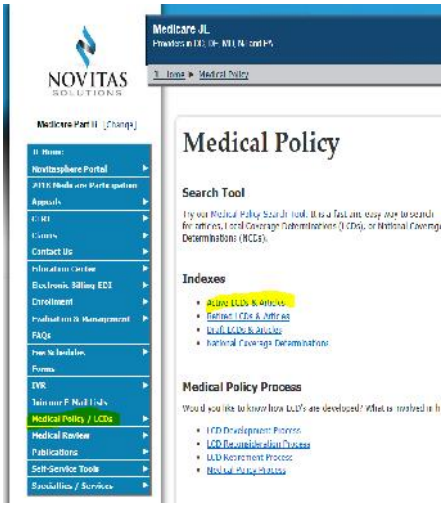

Copyright ©2018 Conventus, All rights reserved

# 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.

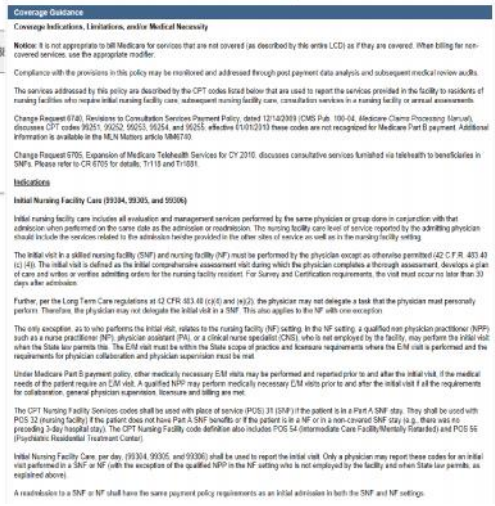




Copyright ©2018 Conventus, All rights reserved


# Medical Necessity: LCD Policies

| | | | |
|---|---|---|---|
| Epidural Injections for Pain Management | L36920 | N/A | 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327, 64479, 64480, 64483, 64484 |
| Evaluation and Management Services Provided in a Nursing Facility | L35068 | N/A | 99251, 99252, 99253, 99254, 99255, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318 |
| Flow Cytometry | L35032 | N/A | 88182, 88184, 88185, 88187, 8 |
| Frequency of Dialysis | L35014 | A55723 Frequency of Hemodialysis (Effective Date to be Determined) | 90999 |



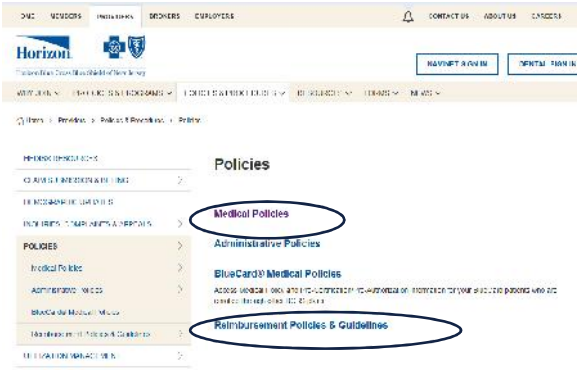


Copyright ©2018 Conventus, All rights reserved

## 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





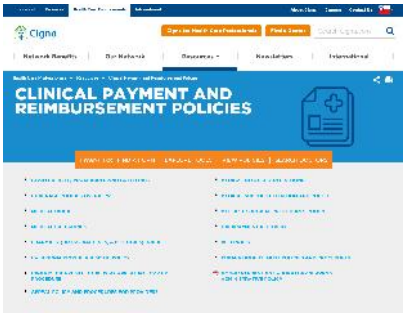
Copyright ©2018 Conventus, All rights reserved


## Medical Necessity: LCD Policies - Other Payers

***United Healthcare***
www.unitedhealthcareonline.com

The complete library of UnitedHealthcare Medical Policies, Medical Benefit Drug Policies, CDGs, URGs, and UOCGs is available at **UnitedHealthcareOnline.com** > *Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines.*

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





Copyright ©2018 Conventus, All rights reserved

# 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


Copyright ©2018 Conventus, All rights reserved


# 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


Copyright ©2018 Conventus, All rights reserved

# E/M Basics: Key Components

- When not by time, the key components determine code selection:
  - History (CC, HPI, ROS, PFSH)
  - 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).


Copyright ©2018 Conventus, All rights reserved


# 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


Copyright ©2018 Conventus, All rights reserved

# 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


Copyright ©2018 Conventus, All rights reserved


# 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!


Copyright ©2018 Conventus, All rights reserved

## 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.


Copyright ©2018 Conventus, All rights reserved


## 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


Copyright ©2018 Conventus, All rights reserved

## 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)


Copyright ©2018 Conventus, All rights reserved


## 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


Copyright ©2018 Conventus, All rights reserved

# 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.


Copyright ©2018 Conventus, All rights reserved


# 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 <u>not</u> 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


Copyright ©2018 Conventus, All rights reserved

## 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


Copyright ©2018 Conventus, All rights reserved


## 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


Copyright ©2018 Conventus, All rights reserved

## 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


Copyright ©2018 Conventus, All rights reserved




Copyright ©2018 Conventus, All rights reserved

# About Us

HealthCare Compliance Network

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

As New Jersey's premier professional liability insurer formed by and governed through an alliance of physicians, Conventus is devoted to serving the best interests of independent physician practices. Conventus members and their staff enjoy exclusive access to insurance products and highly personalized services, gaining the practical knowledge and expert resources they need to improve practice performance, better serve their patients, and remain independent. The Conventus team prides itself on being forward lookers and solution partners whose sole purpose is to help independent physician practices thrive in today's rapidly changing healthcare environment.


Copyright ©2018 Conventus, All rights reserved


# Contact Information

**Healthcare Compliance Network/Compliance Consortium, LLC**
10 Technology Drive, Suite 322, Hudson, MA 01749
Website: http://www.healthcarecompliancenetwork.com/

**Wiks Moffat, CHC**
Principal-Executive VP, Compliance
617-803-3352
wmoffat@hcompliance.com

**Jim Tudor, CPC**
Director, Coding & Billing Compliance
978-377-8862
jtudor@hcompliance.com

**Conventus**
900 Route 9 North, Woodbridge, NJ 07095
Website: https://www.convnetusnj.com

**Susan Lieberman, MBA**
Vice President, Practice Resources
732-362-5715
slieberman@conventusnj.com


Copyright ©2018 Conventus, All rights reserved