

**BEYOND THE BASICS:
CODING FOR PEDIATRIC LEADERS**
WHAT YOU HAVE TO KNOW TO TAKE YOUR GAME TO THE HIGHEST LEVEL

Joel Bradley, MD, FAAP
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Faculty disclosure

Faculty Disclosure Information

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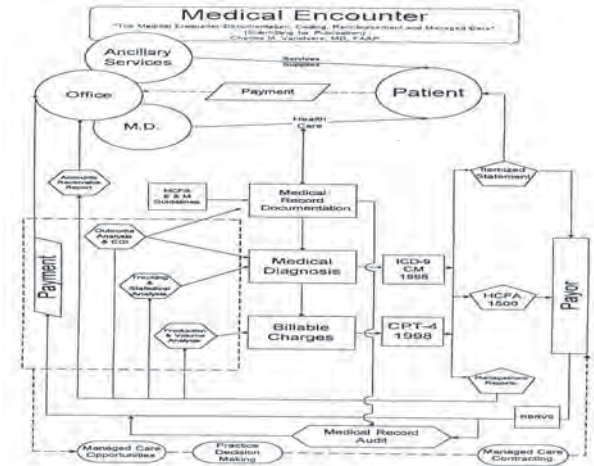
We do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.

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Learning Objectives

- Based on this presentation, changes you may wish to make in practice:
 - Better understand the language of payment – ICD, CPT coding and the RBRVS
 - Improve your business decision making skills on issues of payment and value based contracting
 - Understand the coding basis for compliance – audits, RAC, payment integrity evaluations

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**The Basics for Pediatric Leaders:
Coding and Payment**

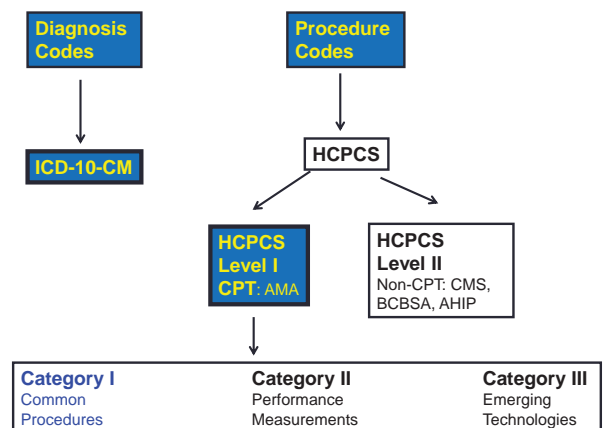
Know this “cold”-It is your bread and butter!

As a leader these form basic skill set for-

- Claims, denials, appeals
- Contracting and contract performance
- Quality programs P4P
- Compliance
- Building a Business case

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HIPAA-mandated standardized code sets



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Current Procedural Terminology (CPT)

- Copyrighted publication by the AMA
- Used as the standard Medicare code set since 1990's
- Tell payers what service was performed by a physician on a given patient on a given date
- Provides common definitions for physician work based on
 - Nature and amount of work
 - Place and type of service
 - Patient's health and age (in some cases)



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ICD-10-CM

- Published by the World Health Organization for epidemiological tracking of illness and injury
- The clinical modification in the US is controlled by the 'cooperating parties'
 - CMS
 - National Center for Health Statistics/CDC
 - American Hospital Association
 - American Health Information Management Association
- Tells Payers about the **Medical Necessity** of services



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ICD- 10 CM: Which is Correct?

- A. Was implemented on OCT 1 this year!
- B. Has Been delayed for one year until October 2016
- C. A "grace " period is in effect allowing me to bill either one until July 1 2016



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Why the switch to ICD 10?

- ICD-9-CM is no longer robust enough to meet current and future health care needs
- Some of content is no longer clinically accurate
 - (a lot has changed in 30 years)
- Structure limits the ability to expand to meet new demands for codes
- Makes comparison of State, National and International morbidity and mortality data difficult



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ICD-10-CM Benefits

- Reflects advances in medicine and medical technology
 - uses current medical terminology and classification of diseases
 - more specificity
 - able to identify more precise diagnosis
 - can help support in making clinical decisions
- Flexible
 - can quickly incorporate emerging diagnoses



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ICD-10-CM Benefits

- More room for expansion
- Has more pre-coordination of diagnostic terms
- Injuries are coded by "episode of care"
- Drug and Chemical Table has new category
 - "Under-dosing"



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ICD-10-CM Benefits

- Improved specificity makes it easier to
 - measure health care services
 - quality metrics measurement
 - identifying fraud and abuse
- Supports improved public health surveillance and epidemiological research
- Allows easier comparison of mortality and morbidity diagnosis data



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How does the increased specificity help?

- Demonstrate severity of disease
 - Acute suppurative otitis media of right ear, recurrent (H66.004)
 - Seizure disorder, poorly controlled with break-through seizures, without status epilepticus (G40.919)
- Better quality metrics
 - Mild persistent asthma, uncomplicated (J45.30)
 - Intentional under-dosing of medication due to financial hardship (Z91.120)
- Differentiate specific primary care services
 - Routine child health examination with abnormal findings (Z00.121)
 - Sports physicals (Z02.5)
- Demonstrate health risks
 - Exposure to second hand tobacco smoke (Z77.22)
 - Severe obesity due to excess calories (E66.01)



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The most important “KEY” element of an EM service used to select the level of service (e.g. 99213 vs a 99214) is-

- A. The History
- B. The Physical Examination
- C. The Medical Decision Making
- D. My EHR coding generator



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CMS Evaluation and Management Documentation Guidelines

- EM Documentation Guidelines
 - Centers for Medicare and Medicaid Services (CMS)
 - formerly Health Care Finance Administration (HCFA)
 - Have become the de facto industry standard
 - <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html>



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Medical Decision Making [MDM]: A CPT change in “philosophy”

- CPT carefully examined the role that the key element of **medical decision making** plays in the correct selection of Evaluation and Management codes.
 - EMR-related “upcoding” based on the easy capture of history and exam items is one of the causes for the review
- Consideration was given to requiring MDM as one of the “**required**” key elements in the selection of all EM codes
- A decision was made to NOT include this requirement in CPT 2015
- Although not requirement (yet), consider MDM to **the** element that reflects the complexity of a given problem, and the MDM drives the EM code selection. Learn the documentation requirement for this key element



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Clinical presentation of patient

- Physicians use their clinical judgment and assess the nature of the patient's clinical presentation to determine the depth of the history and exam needed to complete the service and extent of medical decision-making needed to establish a diagnosis and/or select a management option
- Consider E/M service levels that are clinically relevant to the patient presentation. This does not mean that all elements of examination, for example, require individual justification. The extent of the patient presentation may not be known until data from sources such as history, examination, and old records are considered.



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CMS and clinical presentation

- **Medical necessity of a 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 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.**

Medicare Claims Processing Manual 30.6.1(A)



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CMS and medical necessity

“...no payment may be made under Part A or Part B for any 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.”
(Medicare definition of **medical necessity** under Title XVIII of the Social Security Act, section 1862 (a)(1)(a))

Thus, the patient's clinical presentation:

- Guides the level of history, exam, and decision-making for E/M
- Supports the medical necessity and reasonableness of the level of service billed



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NCCI is a...

- A prime time crime investigation show
- A national coding edit system that has been implemented by CMS
- A national cancer treatment compendium



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Role of NCCI in guiding physician claims (59 and 25)

- Created by CMS (Center for Medicare Services) for Medicare but adopted by many payers and now required by Medicaid
- Identify pairs of services that normally should not be billed by the same physician for the same patient on the same date of service
- Specialists focus on those code pairs of relevance (such as cardiology and cardiovascular within the 9300 series of codes.
- CMS updates these edits quarterly



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Integrating of CPT and NCCI guidance

CPT Assistant, April 2000: “For example, a 7-year-old patient who has newly-diagnosed asthma and thick secretions... The patient is placed on a metered-dose inhaler with a chamber. The patient's mother... is instructed in the appropriate use of the device and medication. The patient is observed using the medication and evaluated for its appropriate use and response.”

NCCI: “CPT code 94640 (pressurized or non-pressurized inhalation treatment for acute airway obstruction...) and CPT code 94664 (demonstration and/or evaluation of patient utilization of an aerosol generator...) generally should not be reported for the same patient encounter. The demonstration and/or evaluation described by CPT code 94664 is included in CPT code 94640 if it utilizes the same device (e.g., aerosol generator) that is used in the performance of CPT code 94640. If performed at separate patient encounters on the same date of service, the two services may be reported separately.”

Medical necessity takes precedence over NCCI in scenarios where provider instruction is necessary to appropriately inform of use of the inhaler—even when the inhaler is the same as that applied to the patient in the office.



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NCCI: role of 25 (significant, separate E/M)

- Modifier 25 may be appended to E/M services reported with minor surgical procedures (global period of 000 or 010 days) or procedures not covered by global surgery rules (global indicator of XXX). Since minor surgical procedures and XXX procedures include pre-procedure, intra-procedure, and post-procedure work inherent in the procedure, the provider should not report an E/M service for this work. Furthermore, Medicare Global Surgery rules prevent the reporting of a separate E/M service for the work associated with the decision to perform a minor surgical procedure whether the patient is a new or established patient.



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CPT Code Categories

Category I:

- Most commonly used codes for billing for patients services-numeric

Category II:

- Performance improvement or tracking codes pay for performance (P4P) measures
- Alphanumeric

Category III:

- New procedures and technology
- Can be used for payment, alphanumeric

Terminology for "Getting Paid"

Reporting:

- the "billing" of CPT codes to a payer for services rendered so they can be paid or tracked (entered into a database)

Licensure:

- a state entity allowing the provider to perform a service under a "scope of practice" law, act, or regulation

Credentialing:

- certification by a public or private payer defining the services for which the provider will be paid

How to Improve Coding and Payment

Measure your coding profiles

Participate in a practice-based coding education program with regular self auditing of medical records (compliance program)

Always focus on correctly coding

- dollars will follow and you will minimize risk of audits or recoveries

Basic Principles of Payment and RBRVS

- The Medicare Fee Schedule- fee for service
- Learn the key feature of the RBRVS



The Revenue Cycle (Getting Paid)

- Provide the service
- Find the correct codes
- Assign your fee
- Report (Bill) the claim
- Receive your EOB (explanation of benefit)
- Deposit your payment or a denial with a reason

Most Fee schedules in contracts with payers are based on.....

- A. A Black Box
- B. Usual and Customary Fees
- C. RBRVS

The Medicare Physician Fee Schedule Resource Based Relative Value System

- Is updated each year by CMS- in November Federal Register – “Final Rule”
- Is used by the majority of private and public payers (CMS by Year)
- Most CPT codes have a relative value unit - “RVU”
- Each year an updated conversion factor is published- 2015 Payment- $rvu \times cf$



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The Medicare Physician Fee Schedule Resource Based Relative Value System

- 2015 -conversion factor = \$35.83
- Payment Example-
 - 99213- office visit
 - RVU = 2.05
 - CF= \$35.83
 - So Fee= $2.05 \times \$35.83 = \73.45



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NEW CPT codes for 2016

- Announced in October 2015 by the AMA
- Go into effect 1 Jan 2016
- Review your superbill (and can relook at ICD 10 (re)changes)
- Review or request payment status/coverage **now** with payers before providing and billing



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New CPT Codes for 2016

- EM- “Team care”
 - Prolonged Clinical Staff Services
 - Behavior Change Intervention- Tobacco, Drug, ETOH
- Medicine- Eyes and Ears
 - Instrument Based Screening
 - Cerumen Removal by irrigation
 - Inhalation Treatments



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Case Study: A 6 week old with fever...

A 6 week old established patient has a low grade fever- you perform an EM office visit and prescribe a fluid challenge and the nurse monitors the patient for an addition 45 minutes. The baby feeds well, has a normal CBC/UA, and gives you a smile for all the care. MD time is 40 minutes, and the additional clinical staff time is 60 minutes.
You report-

- A. 99215 only
- B. 99415 and 99416
- C. 99215 and 99415



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Team Care- “Observation Care in the Office”

- **99415** Prolonged Clinical Staff Services- first hour of face to face time (45 – 74 minutes)
- **99416** Each Additional 30 minutes
- Report in addition to the EM code

Allows reporting of the additional *physician supervised clinical staff time* to treat and observe a patient **beyond** the typical EM time. Must document the time and the reason .



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Behavior Change Intervention- Integrating Behavioral Health into the practice

- **99406-99409** describe EM screening and behavior interventions (counseling) for tobacco and substance use
- Previously considered to be part of an EM service when performed together
- In 2016 can be reported separately (use -25 modifier)



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In 2016 you provide instrument based eye screens or infants and preschoolers with an instrument that self gives the outcome on site.

You then report-

- 99172
- 99173
- 99174
- 99177



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2016- Revision of Instrument Based Ocular Screening

- 99174- (existing code)- revised- ...screening (photoscreening, auto refraction, bilateral, with remote analysis.)
- 99177- “with on-site analysis”



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2016- A 6 year old is evaluated for hearing problems. He has bilateral cerumen impactions. Your nurse irrigates the ear and clears both impactions.

In addition to the EM service, you bill-

- A. 69209- 50 Removal using instrumentation , unilateral
- B. 69207- 50 Removal using irrigation or lavage
- C. 99213-25, and 69207 -50
- D. 99213 only



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2016- Cerumen Impaction Removal by Clinical Staff

- **69209** Existing code- removal using instrumentation , unilateral
- **69207** New- removal using irrigation or lavage
- For both ears use modifier 50
- Can report each same visit if done on separate ears
- *Removal of non-impacted cerumen – is part of the EM service*



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Pulmonary- Inhalation Services

- **94640-** can bill for “breathing treatments” in the office
- New language excludes separate billing with other pulmonary services in which the treatment is already a component
- (eg 94060- pre/post spirometry to assess bronchodilator responsiveness)



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You are asked by a local school to provide school based services for a large pediatric population. You tried this a few years ago by placing an MD or an NP onsite- the model failed financially. They will furnish telehealth technology/clinical staff as an option. You...

- A. Say yes and carve out some time each day in your schedule after considering additional visits income
- B. Review state regulations on telehealth
- C. Review payer policies on coverage and billing
- D. Say maybe, and do B,C.



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Telehealth -the New Frontier... New Codes coming

- Will change the way we practice medicine more than anything else we have seen
- Many EM services can be delivered by telehealth-
- Patients/Families want convenience with quality and lower cost
- Multiple applications- to improve access (after hours care, school based clinics, integrating behavioral health services)
- Retail model with rapidly expand as state law and rules allow (Teledoc, Now Clinic)



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Getting Paid for Telehealth

- Check state laws and rules for who can provide (licensing boards)
- Check the CMS policy (CMS.GOV)- is the standard now for other payers- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfct_sht.pdf
- Review all Payer policies which are evolving
- Learn the codes



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Getting Paid for Telehealth- Codes

- Asynchronous vs Real Time audio visual
- Selective EM Services(CMS wont allow Consult codes)
- Originating Site- where the patient is- CMS defines clinics or hospitals (not schools or in home)
- Provider at remote site bills EM service with a -GT modifier for service provided "via interactive audio and video telecommunications systems" (eg 99213-GT)
- CMS also pays an originating site fee to the clinic -Q3014



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Coding for Care Coordination

- Care management services such as **Complex Chronic Care Management** service value only physician work and time and not the time of clinical staff.
- A. True
 - B. False



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Best Coding Revenue Opportunity for 2016

- Learn to use the Care Management codes new for CPT 2014-2016
- All of these are covered by most payers
- Allow you to implement team based care and get paid for the staff and MD time



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New “Care Management Services” Section

- Provides overarching guidelines over the two new subsections
 1. Chronic Care Management
 2. Complex Chronic Care Management

Care management services are defined as “management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional, to a patient residing at home or in a domiciliary, rest home, or assisted living facility.”



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New “Care Management Services” Section

Care Management Services may include

- establishing, implementing, revising, or monitoring the **care plan**
- coordinating the care of other professionals and agencies
- educating the patient or caregiver about the patient's condition, care plan, and prognosis
- The physician or other qualified health care professional provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living (**Comprehensive !**)



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A Care Plan Is Required

- Must be documented and shared with the patient and/or caregiver.
- Is based on a physical, mental, cognitive, social, functional, and environmental assessment
- It is a comprehensive plan of care for all health problems.
- Includes, but is not limited to, the following elements:
 - problem list
 - expected outcome and prognosis
 - measurable treatment goals
 - symptom management
 - planned interventions
 - medication management
 - community/social services ordered
 - how the services of agencies and specialists unconnected to the practice will be directed/coordinated
 - identification of the individuals responsible for each intervention,
 - requirements for periodic review, and, when applicable, revision of the care plan.



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Care Management Services

- Report only once per calendar month
- Report only by the single physician or other qualified health care professional who assumes the care management role with a particular patient for the calendar month
- Time spent by the clinical staff in communicating with the patient and/or family, caregivers, other professionals, and agencies; revising, documenting, and implementing the care plan; or teaching self-management is used in determining the care management clinical staff time for the month
- Only the time of the clinical staff of the reporting professional is counted
- Only count the time of one clinical staff member when two or more clinical staff members are meeting about the patient
- Do not count any clinical staff time on a day when the physician or qualified health care professional reports an E/M service



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Care Management Services

- *Typically* include:
 - communication with home health agencies and other community services utilized by the patient
 - assessment and support for treatment regimen adherence and medication management
 - identification of available community and health resources
 - facilitating access to care and services needed by the patient and/or family
 - management of care transitions not reported as part of transitional care management (99495, 99496);
 - ongoing review of patient status, including review of laboratory and other studies not reported as part of an E/M service
 - development, communication, and maintenance of a comprehensive care plan.



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Care Management Services

- The care management office/practice must have the following capabilities:
 - provide **24/7 access** to physicians or other qualified health care professionals or clinical staff
 - provide **continuity of care** with a designated member of the care team
 - provide **timely access and management for follow-up after an emergency department visit or facility discharge**
 - **utilize an EHR system** so that care providers have timely access to clinical information
 - use a **standardized methodology to identify patients** who require these services and ensure that those patients identified begin receiving them in a timely manner
 - use a **form** and format in the medical record that is **standardized within the practice**
 - be able to **engage and educate patients and caregivers** as well as coordinate care



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Chronic Care Management Services

99490 Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- comprehensive care plan established, implemented, revised, or monitored.

(Chronic care management services of less than 20 minutes duration, in a calendar month, **are not reported separately**)



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Complex Chronic Care Management Services

99487 Complex chronic care management services, with the following required elements:

- same as 99490 plus
- establishment or **substantial revision** of a comprehensive care plan
- moderate or high complexity** medical decision making
- 60 minutes of clinical staff time** directed by a physician or other qualified health care professional, **per calendar month**

+99489 each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

(Report **99489** with **99487**)



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Chronic Care Management *excludes*

- Do not report chronic care management codes (99487, 99489, 99490) in the same calendar month as:
 - Non-Direct Prolonged Services (99358-99359)
 - Medical Team Conference (99366-99368)
 - Transition Care Management (99495-99496)
 - Care Plan Oversight (99339-99340, 99374-99380)
 - Telephone Care (99441-99443 and 98966-98968)
 - On-line Medical Evaluation (99444 and 98969)
 - Anticoagulant Management (99363-99364)
 - ESRD Related Management (90951-90970)
 - Education and Training (98960-98962, 99071, 99078)
 - Preparation of special reports (99080)
 - Analysis of data (99090, 99091)
 - Medication therapy management services (99605-99607)



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Chronic Care Vs Complex Chronic Care

	Chronic Care 99490	Complex Chronic Care 99487, 99489
Two or more chronic conditions	√	√
Comprehensive care plan established, implemented, revised or monitored	√	√
Chronic conditions place patient at significant risk of death, acute exacerbation or decompensation or functional decline	√	√
Establishment or substantial revision of a comprehensive care plan		√
Moderate or high complexity of MDM		√
Clinical staff time	20 minutes	60 minutes



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MPFS and Care Management Services

CPT/HCPCS	Status	Description	Work RVUs	NF PE RVUs	Malpractice RVUs	Total NF RVUs	Total F RVUs	Global
99487	B	Cmplx chron care w/o pt vsit	0.00	0.00	0.00	0.00	0.00	XXX
99489	B	Cmplx chron care addl 30 min	0.00	0.00	0.00	0.00	0.00	ZZZ
99490	A	Chron care mgmt srvc 20 min	0.61	0.54	0.04	1.19	NA	XXX

Payment 1.19 x \$35.8228= **\$42.63**

A – Active Status; B - Bundled; F – Facility; MPFS – Medicare Physician Fee Schedule; NF – Non-Facility; PE – practice expense; RVUs – relative value units



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Clinical Example

- The clinical nursing staff spend 45 minutes of non face to face time in July both on and off the telephone providing care coordination and management services to a 8 year old with Type I Diabetes and severe persistent asthma that is not well controlled.
- The care plan was monitored and slightly revised to ensure the patient managed their condition and stayed out of the emergency department.
- What to code?
 - Time spent was 45 minutes
 - Care plan was monitored and slightly revised
 - Patient has 2 or more chronic conditions



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Clinical Example

- Report **99490**
 - While many of the criteria were met for complex chronic care, there was no documentation of a **substantial revision** to the care plan



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Transitional Care Management (TCM): 2013

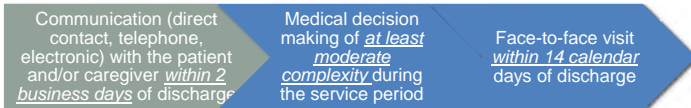
- Manage transition from hospital care setting
 - acute inpatient
 - rehabilitation
 - long-term acute care
 - observation status
- To the patient's community setting
 - home
 - domiciliary
 - assisted living facility
- New or Established patient (2014)



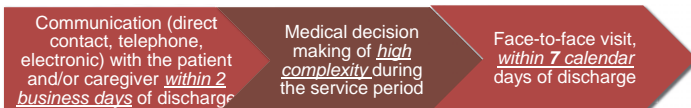
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Transitional Care Management elements

- 99495



- 99496



- 6.79/5.81 RVUs non-facility/facility



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TCM Requirements

- Covers services begin of the day of discharge and continues next through the next 29 days
- Interactive contact with the patient or caregiver must occur within 2 business days of discharge
 - contact can be face-to-face, by phone or electronic means
 - business days = Monday through Friday
- Must be a face-to-face visit within 14 (moderate MDM) or 7 calendar days (high MDM)
 - additional visits may be separately reported
- Medication reconciliation and management must occur no later than date of first face-to-face visit



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All 3 criteria of the codes must be met

- Report **99495** if-
 1. contact within 2 business days
 2. **moderate** complexity MDM
 3. visit within **14** calendar days
- **99496** must include:
 1. contact within 2 business days
 2. **high** complexity MDM
 3. visit within **7** calendar days

MFS 2015- 99495- \$164.78
(99214- \$108)

99496- \$232.49
(99215- \$145)



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Care Plan Oversight- Reporting Physician Non face to face time

- Oversight of services for children with special health care needs and chronic medical conditions by primary care physicians
- Coordinate medical care management with other medical and non-medical service providers and family
- May encompass oversight of work or school programs the patient may be attending where therapy is provided
- Includes
 - review of patient records, reports and labs
 - communications for assessment and care decisions
 - To other health care professional
 - To family, caregiver or guardian



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Care plan oversight

Service	15- 30 minutes	>30 minutes
Home services not involving home health agency	99339 2.25 RVU	99340 3.15 RVU
Home health agency	99374 2.03/1.61 RVU non-facility/facility	99375 3.04/2.54 RVU non-facility/facility
Hospice	99377 2.03/1.61 RVU non-facility/facility	99378 3.04/2.54 RVU non-facility/facility

- Patient is not present
- Count the time spent by the MD or "OQHCP"
- Services are "per calendar month"
- Payment MFS- 99339- \$78.45 **99340- \$109.62**



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Basic Principles of Compliance

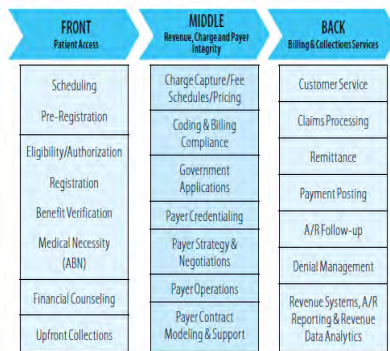
- Coding language of Audits, RAC, payment integrity evaluations



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RCM functions in office billing

Revenue Cycle Management (RCM)



Hill, Tina. Shrink Revenue Leakage with Strategic Communication. Healthcare Business Monthly. Sept 2015: 44-47.



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RCM functions

- Front office (scheduling, intake, pre-registration)
- Clinical operations (physicians, nurses, ancillary staff, etc)
- Coding, charge entry, charge description master, contracting
- Back end (payment posting, accounts receivable, customer service, denials)
- Finance and accounting



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Front-end communication

- Obtaining sufficient information to submit a clean claim
- Communicate with back-end staff to understand basis for denials
- Communicate with back-end staff to validate outdated demographic data, inaccurate insurance information, or unsupported medical necessity
- Access physician orders to guide ordering of tests
- Access supportive ICD10 codes when registering physician-ordered tests
- Ensure that performing/billing provider is enrolled with payer



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RCM functions among office staff

- Upfront collections
 - More common in era of higher patient liability
 - Provide real-time upfront estimates of patient eligibility and total upfront payment responsibility, including real-time assessment of contracted allowables.
- Charge capture and reconciliation
 - Communication between coders and clinical staff
 - Validate performed services and reconcile against day's schedule



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Office assessment of coding changes

- Assess use of new codes by clinical staff
- Incorporate new codes into charge capture tools such as billing worksheets.
- Provide documentation education on use of new services.
- Monitor and assess for changes in payer guidance



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Back-end denial management

- Role of root-cause analysis as foundation to improve office processes.
- Common reasons for denial: inaccurate demographics, inaccurate pre-authorization, code unbundling, lack of medical necessity
- Communication with providers to guide supportive documentation.
- Communication with office leadership regarding financial impact of denials.



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Federal Fraud and Abuse Laws

- False Claims Act
 - (31 USC 3729)
- Anti-Kickback Act
 - (42 USC 1320a-7b(b))
- Stark Laws
 - (42 USC 1395 nn & nn(h)(6))
 - HIPAA creates a new category of offenses which includes Health care fraud
- These laws are upheld through a nationwide network of audits, investigations and inspections



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Pediatricians and Risk

- High rates of participation in government Programs- Medicaid, CHIP, TriCare
- Have a high rate of EM billings- more difficult coding rules
- Many pediatricians do not know the CMS documentation rules or have compliance programs
- Now joining larger groups and may “inherit” compliance risk



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Audience Survey:

Pediatricians who utilize automated coding algorithms embedded within their EHR systems can be reassured that E/M billing risk is assuredly avoided based on faultless accuracy of these systems.

- A. True
- B. False



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The evolving nature of E&M coding

“Health information technology experts believe that the transformative potential of electronic health records (EHRs) has been seriously hindered because software developers have been oriented toward providing documentation needed to satisfy auditors rather than developing important functions such as clinical decision support that would improve patient care.”

Berenson et al, NEJM 364; 20 (2011)



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Do E&M elements contribute to care?

"...the office-visit descriptors and interpretive guidelines emphasize often-irrelevant elements of patients' clinical histories and examinations, rather than decision-making and care-management activities"

"Studies show that EHRs pay for themselves within a few years and then generate profit partly because of facilitated coding, not greater practice efficiency."



Berenson et al. NEJM 364: 20 (2011)
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The RAC- Ouch!!



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The "RAC" Recovery Audit Contractor Program

- In 2006, the Tax Relief and Health Care Act made permanent the Medicare Recovery Audit Contractor (RAC) program for identifying improper Medicare payments in all 50 states
- **The ACA required state Medicaid programs to hire RAC contractors to audit payments, effective Dec. 31, 2010. The RAC program will apply to physician Medicaid payments**
- RAC's are Private auditing firms contracted by the Centers for Medicare & Medicaid Services (CMS) and paid on a contingency fee basis and use sophistic claims data analytics to recognize improper payments, aberrant trends, and utilization variance
- RACs may review the three preceding years of a provider's claims and review medical records (per your contract and state insurance laws)



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Coding/Billing Areas of Risk

- EM "Upcoding" - 99214-99215
- Afterhours Care- billing add-ons incorrectly
- Unbundling of comprehensive services- overuse of modifiers which break CCI edits
- Billing services during a global period
- Failure to document time in using time based codes
- Billing for "New" patients who are by definition established in the practice
- Billing 90461 to VFC, or using 90460/1 when the MD does not counsel



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The Bad News: How Is it Delivered?

- Request for Records: the payment audit
 - Request by payer for medical records of given patient to review documentation of coding on claims which were flagged in an audit
- Recovery Letter: the request for money
 - Request for money- based on a claims review using sophisticated algorithms you have incorrectly submitted claims for a number of patients amounting to \$XX



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Compliance Programs

- A comprehensive set of policies and procedures, along with a method of independent verification, to ensure that all applicable laws regulations, and rules of an organization are followed. (i.e. a proactive method to prevent, detect and rectify improper practices)



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Change...Is Constant in Health Care

“It is not necessary to change... Survival is not mandatory”

- Edward Deming

- Speaking to a group of Detroit automaker executives 1970s

(there will likely be no “Pediatric” bailout)

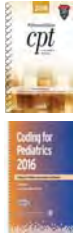


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References

For more information on this subject, see the following publications:

- **AMA 2016 CPT Professional Edition**
- **AAP Coding for Pediatrics 2016**
- **Hill, Tina. Shrink Revenue Linkage with Strategic Communication. Healthcare Business Monthly. Sept 2015: 44-47**



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