Hot Buttons for Payers
April 17, 2013
FIRST DRAFT

Presented by Jonnie Massey, CPC, CPC-P, CPC-I, CPMA, AHFI
DISCLAIMER
This course was current at the time it was written. The materials are offered as a tool to assist the participant in understanding how to ensure that code selection decisions are accurate as a means of improving correct coding and billing as well as avoiding post payment risk. Every reasonable effort has been made to assure the accuracy of the information within these pages. Proper coding may require analysis of statutes, regulations or carrier policies and as a result, the proper code result may vary between payers. This presentation is based on the experience and knowledge of the presenter. Every effort has been made to ensure accuracy.

NOTICES
All Rights Reserved. CPT® is a registered trademark of the American Medical Association (AMA).
Hot Buttons of Today

- DME
- The EMR
- Vendors and DME
- Billing Companies
- Time Bandits
- Drug Diversion
- Excessive patterns - rebilling / Corrected billing/Split claims
- Pattern of Claim Denials
- Disgruntled patients
- Disgruntled employees
- Advertisements – free exams
Hot Buttons of Today, con’t.

- Costly to physicians – payment denials, re-billing, audits, recoupment's/audit repayment, licensure issues, increased administrative cost
- Costly to patients – increased premiums, decreased benefits
- Costly to Payers/Health plans – members denied benefits, unhappy members/groups, costs to administer benefits, audits and reprocessing
What is different in 2013

- The changing economy
- More attention to the cost of health care
- Decreased benefits
- More attention to Healthcare Fraud and Abuse
- Changing laws impacting US Healthcare
- Audits, audits, audits
- Recoupment's
More Scrutiny over Claims

- Health Plan Customer Demand it
  - Employer Groups, Agents, Individual members
- Health care premiums are increasing
- Less employers offer health care as benefit
- Denied claims cost everyone
- Many errors are avoidable
The cost of U.S. Health Care

• Trillions of dollars spent annually was spent on health care
• 4 billion health insurance claims processed
• Estimates that $100 billion is lost to improper payments/fraud – and increasing
• $960 estimated per family each year to cover the cost
According to the Office of Management and Budget

• The Centers for Medicare & Medicaid Services (CMS) declares more than $10 billion is made in improper payments

• Government and private payers taking a proactive approach to safeguard Medicare program
  – Comprehensive Error Rate Testing (CERT) program produced error rates and estimates of improper payments
  – CMS uses error rate data to identify existing problems and target improvement efforts including audits
  – RAC audits
  – Federal, state and private audits increasing
According to a January 2008 Government Accountability Office (GAO) report, Medicare is one of the top three federal programs with improper payments.
The Hot Buttons
#1. New Equipment

- Is it FDA approved?
  - See: http://www.fda.gov/MedicalDevices/default.htm
- Does it require a pre-auth/pre-cert?
- Do the Payers have a policy re this device?
- Should not be referred to as ‘cash cow’
- Consider utilization – is the new test/service medically necessary?
- Frequency appropriate for condition?
- Would you have ordered the same service for your patient prior to the new equipment?
- Have you validated the correct code selection?
New Equipment – con’t

• Research – acceptable frequency
• Research – acceptable diagnosis
• Specialty society recommendation?
• Health Plan – medical/reimbursement policy – its free and online!
• Provider representative/consultant
• Medicare/government program patients – verify rules
TIPS

• Run utilization report pre and post equipment purchase (did you outsource previously?)
• Are new services/increased utilization supported by Medical Necessity of the patient?
• Watch for some outside testing
  – Excessive units
  – Medical necessity issues
  – Supported by diagnosis
  – Generally accepted medical care?
#2 EMR System

- Areas to watch
  - Easy to import more information due to system suggestion
  - Cloned or canned notes – not unique to each visit
    - Are vitals same as last visit?
    - Same verbiage patient to patient, visit to visit
  - Is free text utilized within EMR?
  - Provider must use best judgment
    - Accept all suggestions EMR gives?
Coding Process Reminders

- Service must be medically necessary
- Provide service based on need of patient
- Document service provided
- Select appropriate CPT/HCPCS Level II code for medically necessary service, select appropriate ICD-9-CM code(s), use modifiers appropriately
#3 Vendors and DME

- Remember: vendors are *selling* something
- Validate code selection given by vendor
- Do not agree purchase until service and codes are validated
- Consult with payers (government and private)
- Be VERY specific if pre-auth or pre-cert – use name of device/manufacturer
- Keep a file – all pertinent documentation
Vendor’s and DME – Examples

• Examples of areas to watch
  – Tens – verify tens vs. other similar device
    • Verify forms and billing
    • Rental or purchase
    • Give to patient or mailed
  – Cold/Compression Devices
    • FDA approved?
    • Who bills – provider, ASC, vendor?
    • Which codes
    • Covered by insurance?
Scenario:
Vendor approached physicians for billing TENS units for patients. Equipment was hand delivered to patients. Patients signed a release which included an agreement (in fine print) for ongoing supplies.

$2175 billed monthly for each patient, even when the unit was returned.
Breakdown of Monthly Charges – Per Patient

- 2 month rental - $190
- Purchase price (rental not subtracted) - $405
- Delivery and set up - $50 (remember, hand delivered)
- 138 electrodes - $1253
- Alcohol wipes - $113
- 9 volt batteries - $45 each
- Lead wires - $65
- Shipping charges - $65
Vendor sells physician device for patients post-surgery. Device is placed on patient in recovery room. Patients/physician report positive outcomes post surgery. Claims are made that device promotes quicker healing, less pain, swelling, and meds. Clinical trials not published and is considered a ‘patient convenience’ item – not covered by health plans.
Example

- Vendor supplied codes ‘that paid’
- Patient waivers signed
- Vague description of device
- Patients not aware of what they were signing (under the influence in recovery?)
-Rentals were $6k for 6 weeks rental per patient.
- Physician did not verify correct code selection
- Payers had published medical policy
- Claims were denied/recovered – significant $$
Moral of the Story

• Validate the procedure codes suggested by vendor
• Contact health plans prior to agreeing to devices – be specific, in writing is best
• See AAPC link to health plan medical policy!
• Ask questions
• Keep records of guidelines – code selection, conversations, medical/payer policy
#4 The Billing Company

- Who exactly does the billing?
  - Certified coders?
  - Students?
- What is in your contract with a vendor?
- Does the vendor accept responsibility for incorrect coding / audits?
- Do you conduct a self audit A to Z, including the billing companies work product?
Billing Companies – con’t

Example:

Local billing company is owned and operated by individual that claims to employ coders. Work is done by students completing externship from trade school. Mistakes are carried from extern to extern. Billing company is in a garage. Numerous mistakes trigger audits of clients resulting in significant recoveries for auditors and negative financial impact to numerous medical offices. Billing company does not accept responsibility for audit errors.
Billing Companies

True Story:

• Physical Therapy office submitting claims for lab codes along with therapy codes. Scope of practice – Yes? No?
• PT office did not validate codes, billing, EOB’s, or patients – complete trust in billing company
• PT office was financially responsible for billing company errors
#5 Rebilling, Corrected Billing, Split Claims

Rebilling Claims:

• Ok to rebill when and if appropriate
• Always best to ‘get it right’ the first time
• Consider self audit – before claim submitted
• Review frequency of rebilling – every 30 days?
• Pattern of submitting duplicate claims…..why?
• Track why claims denied
• *Patterns* of rebilling are red flags
#6  Drug Diversion / Drug Seekers

- Physicians Beware
- Patients seeking drugs/narcotics
- Oxycontin – drug of choice, high street value
- Who is patient, really?
  - Did you ask for picture id?
  - Copy of Insurance Card?
  - Vague pain complaints, requesting narcotics
  - Dental pain, but in the ER seeking pain meds
Oxycontin Facts

• 16.3 million American admitted to non-medical use of pain relievers
• 1.3 million have taken Oxycontin
• Known as rx. equivalent to heroine
• High school – new drug of choice
• It all starts with a prescription
• Actively investigated by law enforcement – including prescribers, pharmacies, and patients
<table>
<thead>
<tr>
<th>Prescription Cost per tablet</th>
<th>Street Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxycontin - 40mg - $5.66 per tablet</td>
<td>Oxycontin – 40mg - $20-$40 per tablet</td>
</tr>
<tr>
<td>Oxycodone – 40mg - $4.54 per tablet</td>
<td>Oxycodone – 40mg $6 - $8 per tablet</td>
</tr>
</tbody>
</table>
Hot Buttons:

- *Patterns* of changing routine to medical
- *Patterns* of changing medical to routine
- Patterns of changing codes on claims
- Changing diagnosis/procedure because patient calls and asks to have claim changed ‘so it gets paid’
- Always indicate on claims ‘corrected’
#8 Split Claims

Split claims: Submitting codes/claims on more than one CMS 1500 when one form is adequate

Examples:
- Multiple surgery
- Modifier 25 eligible claims
- Lab codes
- Global Surgery
- Two visits same day
Split Claims – Con’t.

• Split claims - easy to find during data mining
• Many computer programs/detection software
• Patterns of splitting are investigated
  • Can trigger audits
  • Can trigger financial recoupment/recovery
#9 Disgruntled Patients

- Do they have questions answered in the office?
- Do they understand the charges on the claim/EOB?
- Often contact authorities/investigators – ‘My bill is too high’
- Think ahead to ICD-10….questions they will need to answer due to I-10
- Apply the ‘Ounce of prevention’ theory
Why is my bill so high?
I was not the patient
I don’t know who this physician was?
My doctor did not spend much time with me
I never see my doctor
I always have a lot of tests
#11 Disgruntled Employees

- Considered to be the best witnesses – they know everything
  - Loved by Law Enforcement, Investigators, Auditors
- Often report suspicious billing/coding patterns
- Can often help prove intent
- Did you conduct an exit interview?
#12 Advertisement Hot Buttons

- Free Exams
- Free ‘Anything’
  – Are you offering inducement for services?
- New Equipment – new laser?
- New X-ray?
- Special training?
- Better techniques?
- Promises, promises, promises……
Tips for Protecting Your Practice

• Validate all codes selections
• Know your business partners
• Take responsibility for your coding and billing
• Consider post service audits
  – Internal? Self Audits?
• Hire outside auditors if you need to
• Keep files/records – codes, unique services and/or equipment – keep current
• Track who you talked to
Preventive Measures

- Track claim denials – by codes, payers
- Hold internal education sessions
- Keep current on coding
- Keep current on new laws, rules, regs
- Have a compliance Plan
- Seek help when needed
- Do what you document, document what you do
Conduct a Self Audit

- Know and understand your practice
- Recover lost revenue
- Continue and document good habits
- Avoid costly recoupment's, refunds requests, legal fees
- Internal education — enhanced documentation and coding opportunities!
  - Learn from your mistakes
  - Correct errors
Hot Button Examples for Self Audits

- Claims requiring face-to-face vs. long distance
  - check policy
    - Telemedicine
    - Telehealth

- Patterns related to utilization – see previous slides

- New equipment

- New physicians to practice
  - Education needed?
    - Early auditing needed prior to claims submitted?

- Pattern of denials/rebills
Tips for Selecting Claims to Audit

From the OIG work plan and health plan audits:

• Place of service errors
• E&M services during global periods
• Modifier 25 & 59
• Services performed by licensed clinical social workers — exclusively billing 90808?
• New codes in 2013
• Outpatient physical therapy – timed-base codes, medical necessity
Tools Needed to Conduct an Audit

- Audit templates/forms
- Medical record
- Encounter form/super bill
- Claim form/billed reports — pertinent for post-payment reviews
- Explanation of benefits and remittance advice — pertinent for post-pay reviews
- Payer policies — available online — no charge
  - See also AAPC website link
- Coding manuals and aids — current for year service was rendered
Tips for Understanding Denials

• Research and track claim denials – why?
  • Coverage terminated?
  • Waiting for information from patient (accident report, COB)?
  • Can be a missed opportunity to fix simple errors
• Contact carrier by phone/Web portal for reason denied (often reason is simple)
• Appealing?
  • Send in current and pertinent documentation — do NOT send an article from 1994 supporting your position.
Claim Denials are Often Avoidable

- Ensure patient insurance information is updated regularly
  - New insurance? Job change or loss?
  - Photocopy insurance card-front and back
  - Secondary coverage
  - Group or health plan change (same carrier)
- Check benefits
- Use health plan resources
- Know how and when to access carrier policy
More Tips for Self Audits

- Remember, audits (and RACs) are often triggered by known industry problems
- Track and log claim billing patterns
- Track whom you talked to — name, phone number/extension, and date
- Keep a file with current documentation supporting coding, billing, services, CMS guidance
Compliance Plans

• Do you have one?
• Ensure accurate claims
  • Correct practitioner, easily identified each record
  • Appropriate modifiers?
  • Correct procedure and diagnosis codes that support medical necessity
  • Patient name, date of service for each entry
  • How soon after service is documentation completed?
What to Do With Your Findings

• Keep track of audit findings – good and bad
• Conduct follow-up meetings with staff
  • Education needed?
  • Regular self audits needed?
  • Independent audit needed?
  • Compliance Plan?

• Continue to improve claims submission and processes
What to Do With Your Findings

• Review the process each year and make improvements when necessary
• Consider hiring a credible external coding auditor annually to validate the practice’s progress
• Don’t be afraid to ask for help
• Remain on alert!
• Enforce disciplinary standards in the practice
Conclusion

• Continued education of practitioner and staff is vital
• Reinforce importance of correct coding
• Provide clear, accurate, and detailed information for every patient encounter
• Understand “if it is not documented, it cannot be billed” aka “if it is not documented, it did not happen.”
Conclusion – con’t.

• NEVER create records
• NEVER alter records
• Okay to make corrections — date and sign/initial addendum to file
• Submit “corrected claims” when appropriate, better to do it right the first time
• Missing documentation will not be considered if not present in the file
  • Keep files organized
Questions?
Jonnie Massey, CPC, CPC-P, CPC-I, CPMA, AHFI

jonnie.massey@blueshieldca.com