Documentation's Impact on Reimbursement

Presented by

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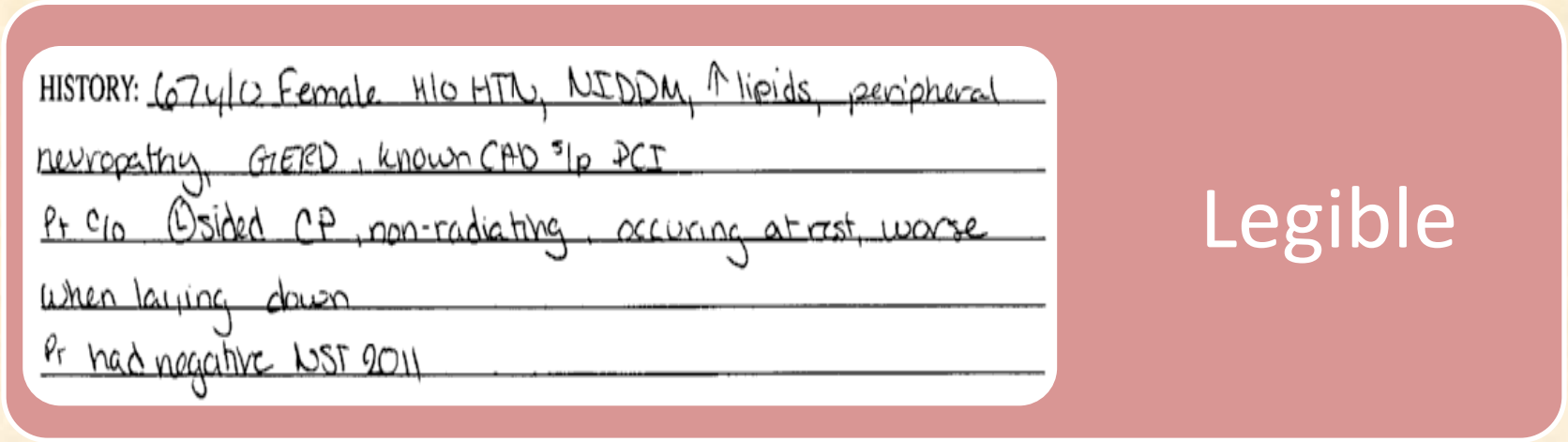
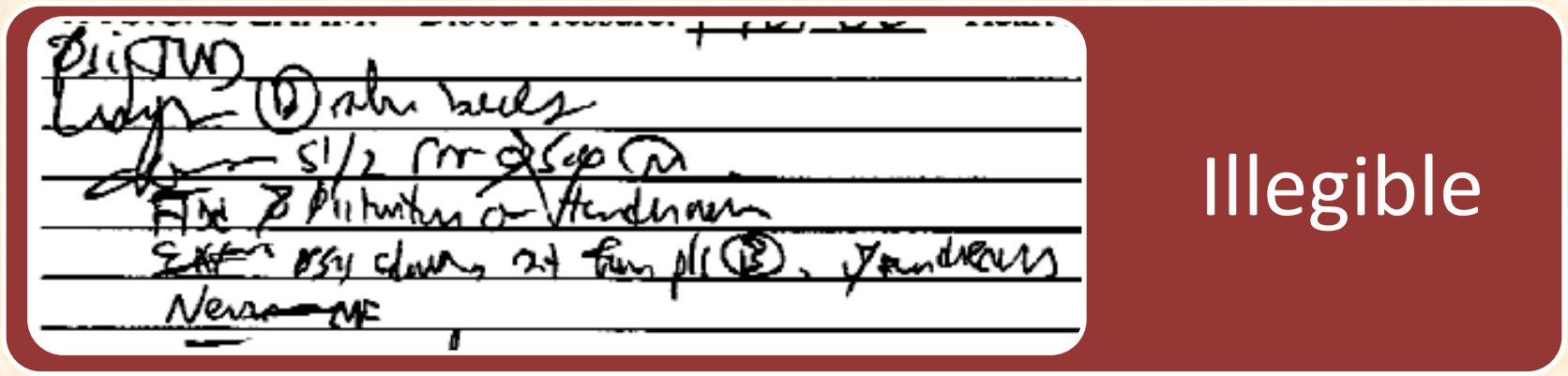
Agenda

- Principles of Documentation
- Status Codes
- Golden Rule
- Impact on Reimbursement
- Medical Necessity
- ABN
- Approach
- Resources
- Conclusion
- Questions

Principles of Documentation

- Legible





Principles of Documentation

- Complete
  - Date of Service
  - Reason for Encounter
  - History and Physical Examination
  - Review of Labs/X-rays and/or any other ancillaries

Principles of Documentation

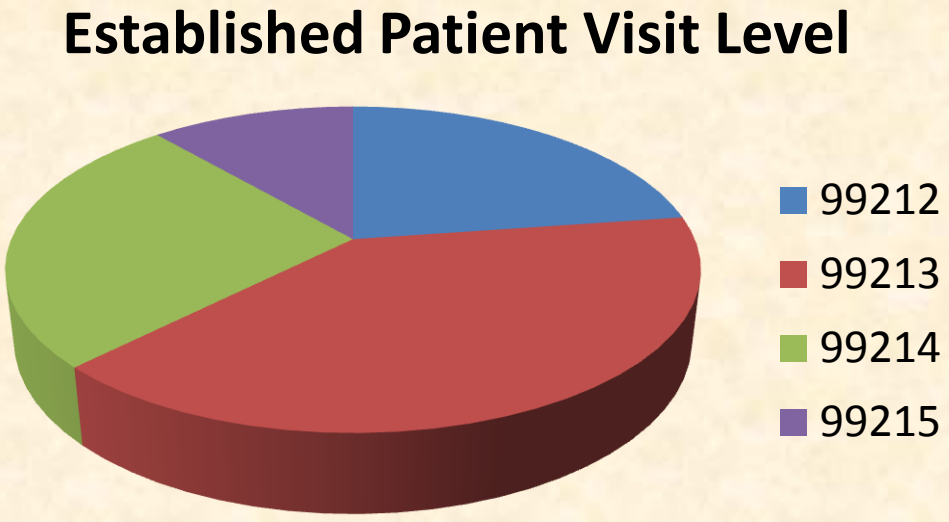
- Patient's Progress:
  - Response to Treatment
  - Change in Treatment
  - Change in Diagnosis
  - Patient Non-Compliant

Principles of Documentation

- Plan of Care
  - Treatments and Medications
  - Frequency and Dosage
  - Patient and/or Family Education
  - Referrals/Consultations
  - Follow-up Instructions

Principles of Documentation

- Documentation must support:
  - Intensity of evaluation/treatment
  - Complexity of medical decision making.



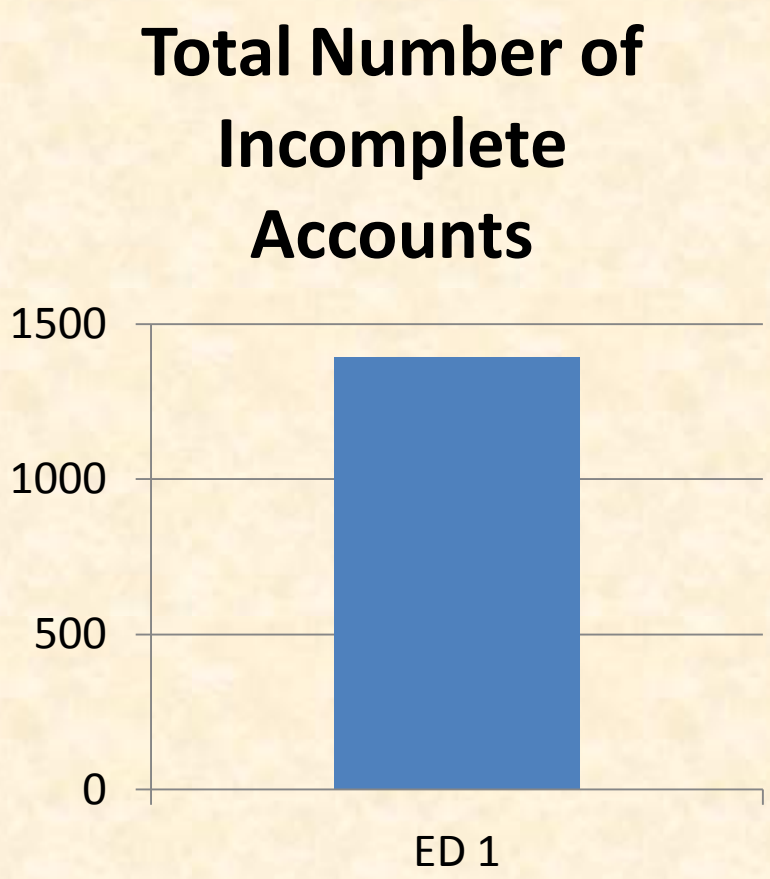
Principles of Documentation

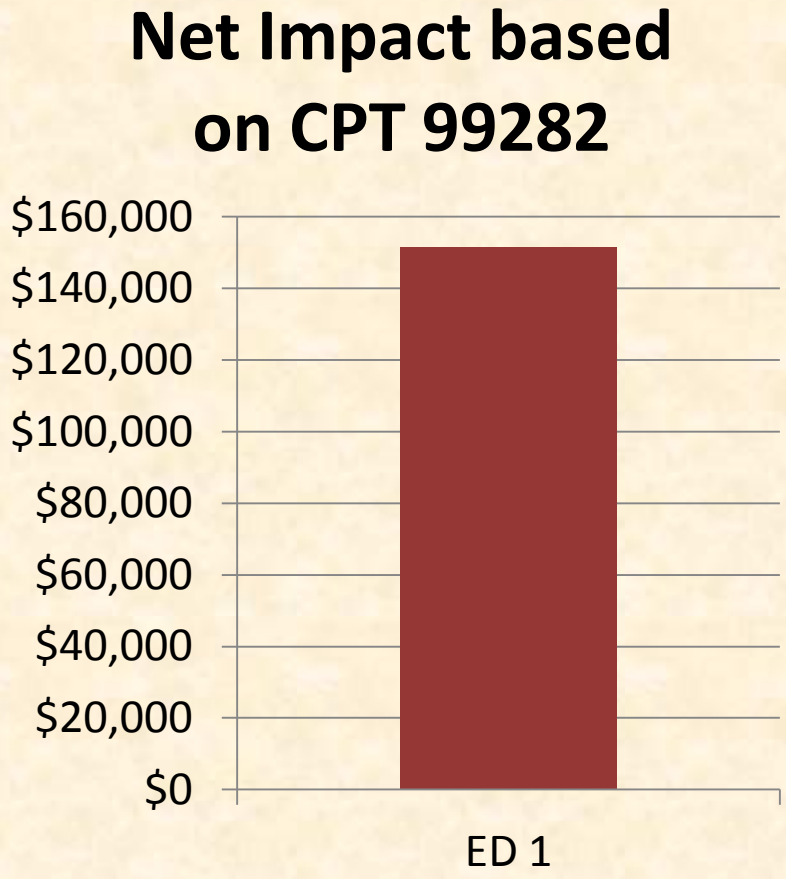
- Signature Required:
  - Qualified Healthcare provider
  - Nurse
- Don’t Forget Time:
  - Time based codes must include the time

Principles of Documentation

- Electronic Health Record (EHR):
  - ✓Legible
  - ✓Complete
  - ✓Date and Time stamped
- Some Potential Problems:
  - ✓Cookie Cutter Notes
  - ✓Documentation not authenticated by qualified healthcare provider

Impact on Reimbursement





Principles of Documentation

"Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management."

Status Codes

- Must be documented in order to be coded:
  - Contributes to complexity level of encounter
  - Demonstrates complexity of patient population

"Risk adjustment is a method of adjusting capitation payments to health plans, either higher or lower, to account for the differences in expected health costs of individuals. "

Evaluation of the CMS-HCC Risk Adjustment Model

Status Codes

- Must be documented in order to be coded:
  - Contributes to complexity level of encounter
  - Demonstrates complexity of patient population

Renal Dialysis Status	V45.11
Tracheostomy Status	V44.0
Respiratory Dependence	V46.11
Lower Limb Amputee	V49.7x

Status Codes

- Status codes will still be relevant when ICD-10-CM is implemented

	ICD-9-CM	ICD-10-CM
Bariatric Surgery Status	V45.86	Z98.84
Arthrodesis status	V45.4	Z98.1
Kidney transplant status	V42.0	Z94.0

Golden Rule of Documentation

- If it is not documented, it is not done; therefore, it is not billable.
- If you can't read it, it is not documented; therefore, it is not billable.

Principles of Documentation

- Chemotherapy
  - Chemo Initiation of prolonged infusion (pump)
  - Chemo Infusions
  - Chemo IV Injections
- Therapeutic/Prophylaxis/Diagnosis
  - Initiation of prolonged infusion (pump)
  - Non-chemo Infusions
  - Non-chemo IV Injections
- Hydration

Principles of Documentation

- Required documentation:
  - Physician order
  - Medically necessary
  - Route of administration
  - Site of administration
  - Start and stop times for each substance infused
  - Volume and rate
  - Substance

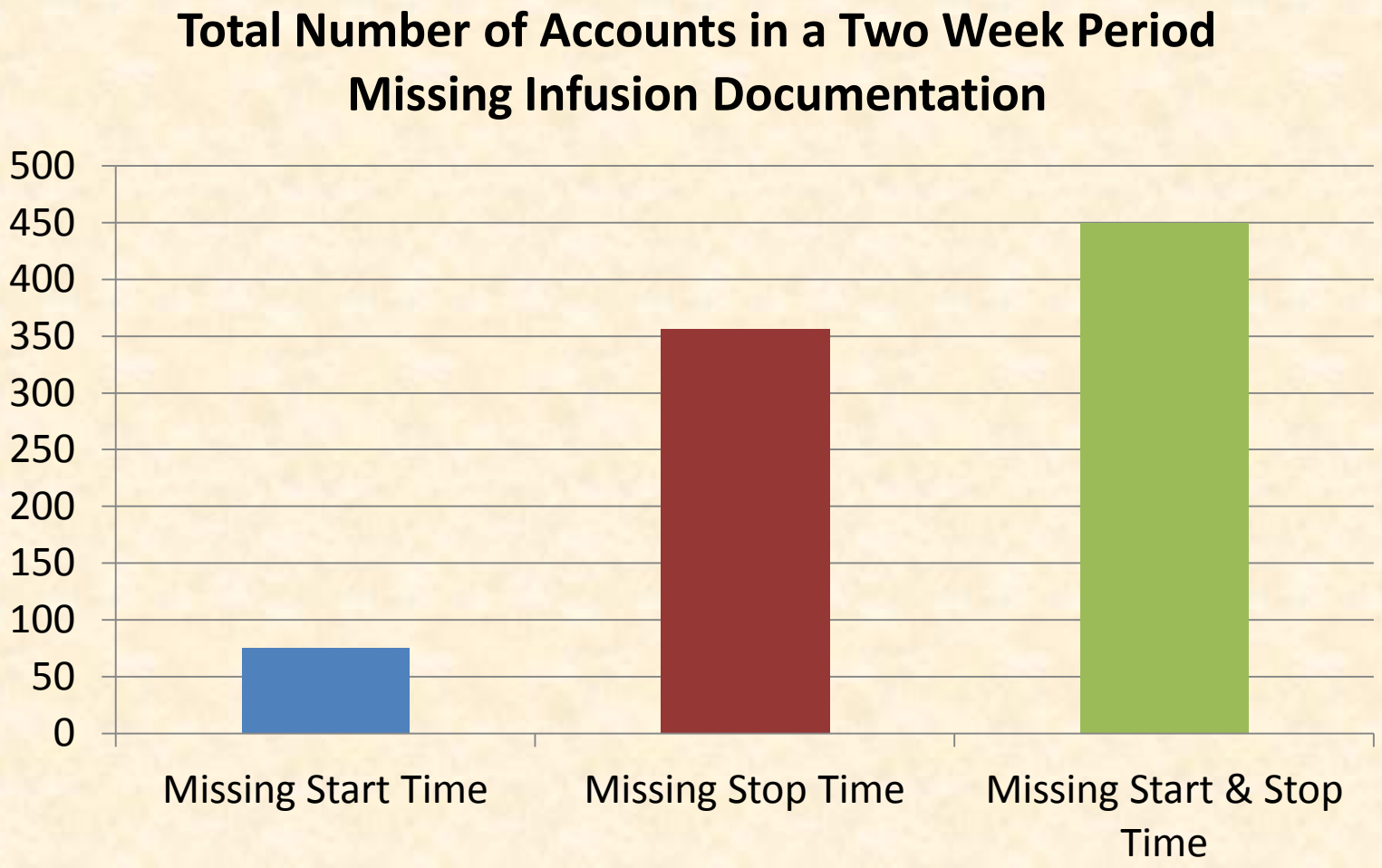
Principles of Documentation

- Incomplete documentation IV fluids:
  - IV Infusion coding is time based
  - IV infusion of therapeutic, prophylactic or diagnostic substance without a stop time must be down coded from an IV infusion to an IV push*
  - IV Hydration Services without the stop time cannot be coded

*check with your FI

Impact on Reimbursement

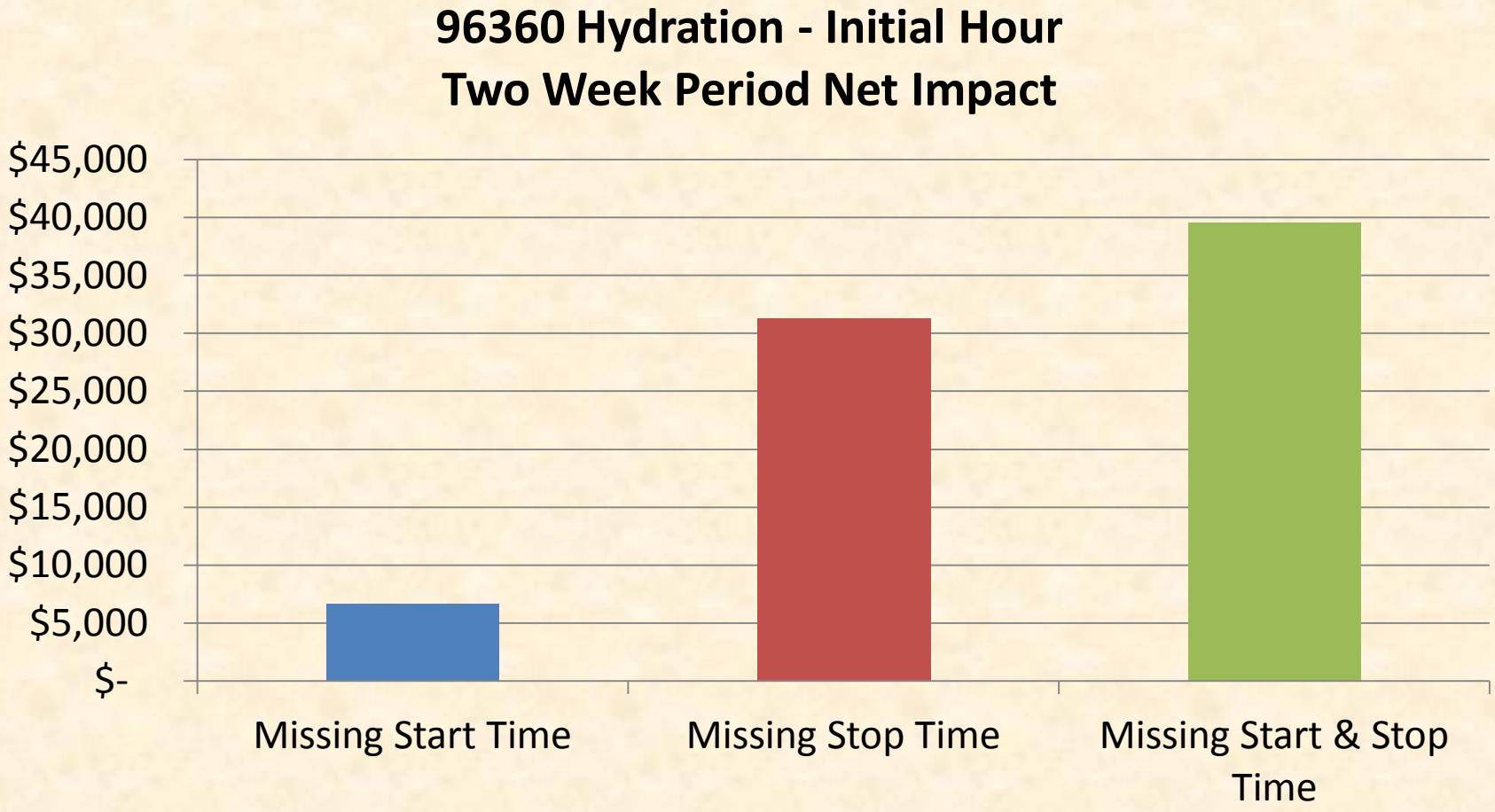
Example: 1



Total Number of Hydration Services that cannot be billed = 881

Impact on Reimbursement

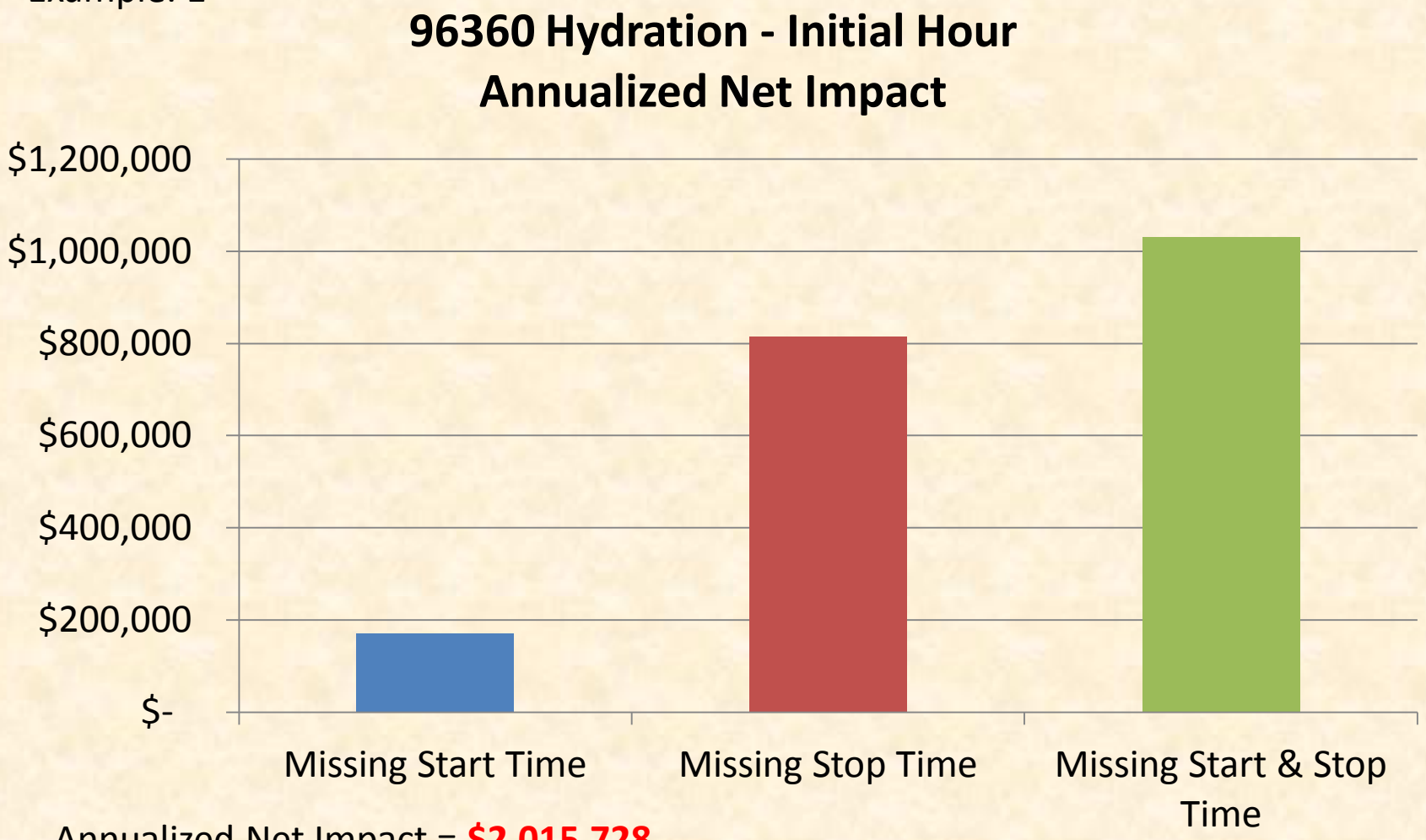
Example: 1



Two Week Net Impact = **$77,528**

Impact on Reimbursement

Example: 1



Annualized Net Impact = **$2,015,728**

Impact on Reimbursement

Example #2		
IV Infusion Therapeutic Drug	Duration: 45 min Stop time NOT documented	Services rendered but cannot code: 96365 Initial up to 1hr = $172.30*
		Services coded due to lack of documentation: 96374 IV push-Initial = $46.10*
		Lost revenue per infusion = $126.20

*2013 1stQ Weight Adj. APC - NYC

Impact on Reimbursement

Example # 2 - IV infusion > 15 min w/o stop time			
IV Infusion 45 min:	**Total # of Accounts**	**APC***	**Net**
96365	1600/mo.	$172.30	$275,680

Stop time *NOT* Documented - Expected NET reimbursement			
IV Infusion 45 min:	**Total # of Accounts**	**APC***	**Net**
20% w/o stop time -96374 (down coded)	320/mo.	$46.10	$14,752
80% w/both start/stop time – 96365	1280/mo.	$172.30	$220,544
		Total	$235,296

Expected Annualized Net if all accounts have stop time:	$3,308,160
Annualized Net based on 20/80 example:	$2,823,552
Annual Net *LOSS* payments:	$484,608

*2013 1stQ Weight Adj. APC - NYC

Impact on Reimbursement

Example #3		
IV Infusion Therapeutic Drug	Duration: 1 hr and 45 min Stop time NOT documented	Services Rendered but cannot code: 96365 Initial up to 1hr = $172.30* 96366 ea. addl. hr = $31.82*
		Services Coded due to lack of documentation: 96374 IV push-Initial = $46.10*
		Lost Revenue per Infusion = $158.02

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Impact on Reimbursement

Example # 3 - IV infusion > 15 min w/o stop time			
IV infusion 1hr and 45min.	Total # of Accounts	APC*	Net
96365	2,000/mo.	$172.30	$344,600
96366 x1	2,000/mo.	$31.82	$63,640
		Total:	$408,240

40% w/o stop time – 96374 (down coded)	800/mo.	$46.10	$36,880
60% w/both start/stop time – 96365	1600/mo.	$172.30	$275,680
60% w/both start/stop time – 96366	1600/mo.	$31.82	$50,912
		Total	$363,472

Expected Annualized Net if all accounts have stop time:	$4,898,880
Annualized Net based on 40/60 example:	$4,361,664
Annual Net *LOSS* in payments:	$537,216

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Impact on Reimbursement

Example # 4		
IV Hydration	Duration: 3 hours Stop time NOT documented	Services Rendered but cannot code: 96360 – IV Hydration 1st hr $88.00* 96361 – Ea. addl. hr = $31.82* x2
		Hydration without stop time cannot be coded.
		Lost Revenue per Infusion = $151.64

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Impact on Reimbursement

Example # 4 Three Hours Hydration w/o stop time			
Hydration 3 hours	Total # of Accounts	APC*	Net
96360	2,000/mo.	$88.00	$176,000
96361 x2	2,000/mo.	$63.64	$127,280
		Total:	$303,280

Expected Annualized Net if all accounts have stop time:	$3,639,360
Annual Net *LOSS* in payments:	$3,639,360

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Impact on Reimbursement

Cumulative Net Impact	
Example:	Net
#1. Not billable – Missing time ER Hydration Services:	$2,015,728
#2. Down Coded – Missing stop time Non-Chemo 1st hour Infusion:	$484,608
#3. Down Coded – Missing stop time Non-Chemo 1 hr. 45 min. infusion:	$537,216
#4. Not billable – Three hours Hydration:	$3,639,360

Total Net Impact:	$6,676,912

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Medical Necessity

- Medically Necessary:
  - "Services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice"

Medicare.gov

Medical Necessity

- NCD/LCD:
  - “National coverage determinations (NCDs) are made through an evidence-based process, with opportunities for public participation. In some cases, CMS' own research is supplemented by an outside technology assessment and/or consultation with the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC). In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors based on a local coverage determination (LCD)”

CMS.gov

Medical Necessity

- CMS National Coverage Policy
  - "Title XVIII of the Social Security Act (SSA):
    - Section 1862(a)(1)(A) excludes 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.
    - Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim."

Medical Necessity

- Pain Management Example
- LCD ID: L28529 – New York – Entire Region
  - CPT 62311 Lumbar/Sacral Injection billed with Diagnosis code 724.2 – Low Back Pain
  - Denied – Did not meet medical necessity

Medical Necessity

– Epidural and Intrathecal Injections: Interlaminar and Caudal (CPT codes 62310, 62311, 62318, 62319)

722.2	DISPLACEMENT OF INTERVERTEBRAL DISC SITE UNSPECIFIED WITHOUT MYELOPATHY
722.4	DEGENERATION OF CERVICAL INTERVERTEBRAL DISC
722.51	DEGENERATION OF THORACIC OR THORACOLUMBAR INTERVERTEBRAL DISC
722.52	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC
722.71	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY CERVICAL REGION
722.72	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY THORACIC REGION
722.73	INTERVERTEBRAL DISC DISORDER WITH MYELOPATHY LUMBAR REGION
722.81	POSTLAMINECTOMY SYNDROME OF CERVICAL REGION
722.82	POSTLAMINECTOMY SYNDROME OF THORACIC REGION
722.83	POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
723.0	SPINAL STENOSIS IN CERVICAL REGION
723.4	BRACHIAL NEURITIS OR RADICULITIS NOS
724.01	SPINAL STENOSIS OF THORACIC REGION
724.02	SPINAL STENOSIS, LUMBAR REGION, WITHOUT NEUROGENIC CLAUDICATION
724.03	SPINAL STENOSIS, LUMBAR REGION, WITH NEUROGENIC CLAUDICATION
724.3	SCIATICA
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED
733.13	PATHOLOGICAL FRACTURE OF VERTEBRAE

Impact on Reimbursement

Medical Necessity Example # 1			
Pain Management	Total # of Accounts	APC*	Net
62311	1250	$666.57	$833,213
30% Failed Medical Necessity	375	$666.57	$249,964
70% Met Medical Necessity	875	$666.57	$583,249
Annual loss due to Failed Medical Necessity:			$249,964

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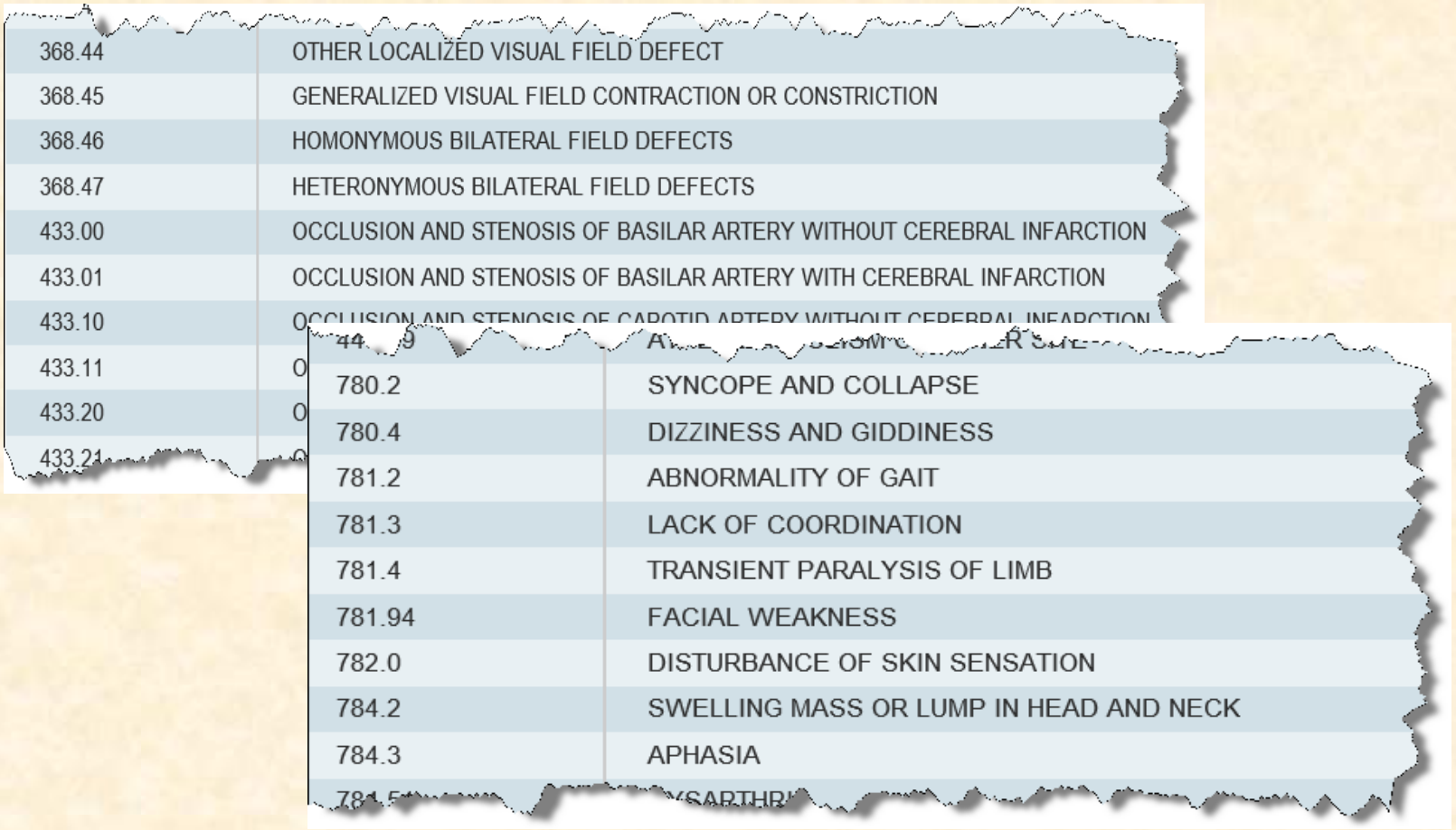
Medical Necessity

- Non-Invasive Vascular Studies
- LCD ID: L27355 – New York; Connecticut; Region V
  - CPT 93880 Duplex scan of extracranial arteries; complete bilateral study billed with Diagnosis code 414.01 - Arteriosclerotic heart disease
  - Denied – Did not meet medical necessity

Medical Necessity

– Cerebrovascular Evaluation (93880, 93882)



368.44	OTHER LOCALIZED VISUAL FIELD DEFECT
368.45	GENERALIZED VISUAL FIELD CONTRACTION OR CONSTRICTION
368.46	HOMONYMOUS BILATERAL FIELD DEFECTS
368.47	HETERONYMOUS BILATERAL FIELD DEFECTS
433.00	OCCLUSION AND STENOSIS OF BASILAR ARTERY WITHOUT CEREBRAL INFARCTION
433.01	OCCLUSION AND STENOSIS OF BASILAR ARTERY WITH CEREBRAL INFARCTION
433.10	OCCLUSION AND STENOSIS OF CAROTID ARTERY WITHOUT CEREBRAL INFARCTION
433.11	O
433.20	O
433.21	O

780.2	SYNCOPE AND COLLAPSE
780.4	DIZZINESS AND GIDDINESS
781.2	ABNORMALITY OF GAIT
781.3	LACK OF COORDINATION
781.4	TRANSIENT PARALYSIS OF LIMB
781.94	FACIAL WEAKNESS
782.0	DISTURBANCE OF SKIN SENSATION
784.2	SWELLING MASS OR LUMP IN HEAD AND NECK
784.3	APHASIA

Impact on Reimbursement

Medical Necessity Example # 2			
Non-Invasive Vascular Studies	Total # of Accounts	APC*	Net
93880	1380	$182.31	$251,588
70% Failed Medical Necessity	966	$182.31	$176,111
30% Met Medical Necessity	414	$182.31	$75,476
Annual loss due to Failed Medical Necessity:			$176,111

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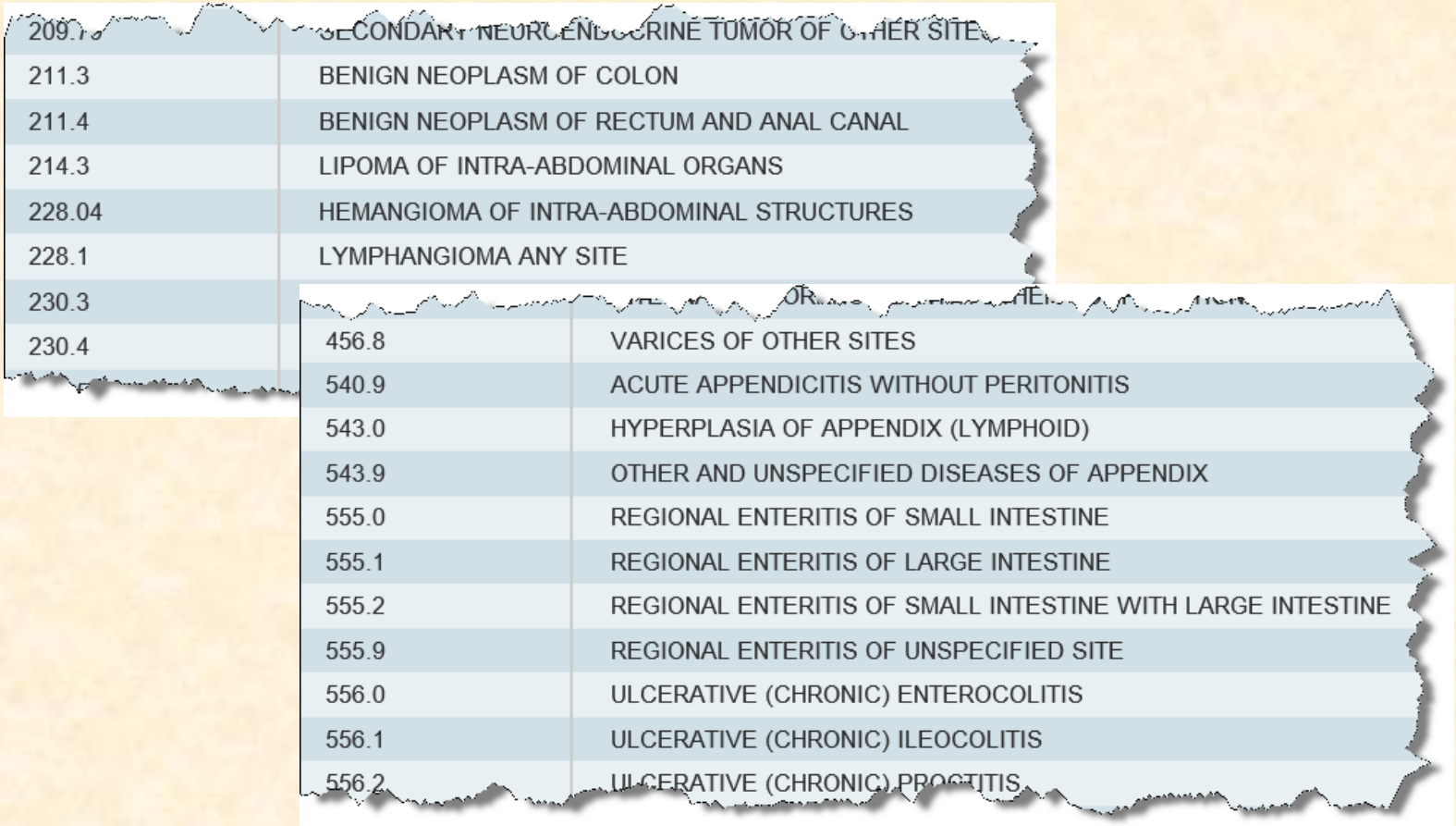
Medical Necessity

- Colonoscopy/ Sigmoidoscopy/ Proctosigmoidoscopy
- LCD ID: L26404 – New York – Entire State
  - CPT 45380 Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple billed with 535.10 Atrophic gastritis; without mention of hemorrhage
  - Denied – Did not meet medical necessity

Medical Necessity

- Colonoscopy



209.7	SECONDARY NEUROENDOCRINE TUMOR OF OTHER SITE
211.3	BENIGN NEOPLASM OF COLON
211.4	BENIGN NEOPLASM OF RECTUM AND ANAL CANAL
214.3	LIPOMA OF INTRA-ABDOMINAL ORGANS
228.04	HEMANGIOMA OF INTRA-ABDOMINAL STRUCTURES
228.1	LYMPHANGIOMA ANY SITE
230.3	
230.4	
456.8	VARICES OF OTHER SITES
540.9	ACUTE APPENDICITIS WITHOUT PERITONITIS
543.0	HYPERPLASIA OF APPENDIX (LYMPHOID)
543.9	OTHER AND UNSPECIFIED DISEASES OF APPENDIX
555.0	REGIONAL ENTERITIS OF SMALL INTESTINE
555.1	REGIONAL ENTERITIS OF LARGE INTESTINE
555.2	REGIONAL ENTERITIS OF SMALL INTESTINE WITH LARGE INTESTINE
555.9	REGIONAL ENTERITIS OF UNSPECIFIED SITE
556.0	ULCERATIVE (CHRONIC) ENTEROCOLITIS
556.1	ULCERATIVE (CHRONIC) ILEOCOLITIS
556.2	ULCERATIVE (CHRONIC) PROCTITIS

Impact on Reimbursement

Medical Necessity Example # 3			
Colonoscopy	Total # of Accounts	APC*	Net
45380	1551	$814.51	$1,263,305
15% Failed Medical Necessity	233	$814.51	$189,781
85% Meets Medical Necessity	1318	$814.51	$1,073,524
Annual loss due to Failed Medical Necessity:			$189,781

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Impact on Reimbursement

Cumulative Net Impact	
Failed Medical Necessity Examples:	Net
#1. 62311	$249,964
#2. 93880	$176,111
#3. 45380	$189,781
Annual loss due to Failed Medical Necessity:	$615,856

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Advance Beneficiary Notice (ABN)

- An ABN, Form CMS-R-131, is a standardized notice that you or your designee must issue to a Medicare beneficiary, before providing certain Medicare Part B (outpatient) or Part A (limited to hospice and Religious Nonmedical Healthcare Institutions only) items or services. You must issue the ABN when:
  - You believe Medicare may not pay for an item or service,
  - Medicare usually covers the item or service, and
  - Medicare may not consider it medically reasonable and necessary for this patient in this particular instance.

Advance Beneficiary Notice (ABN)

- Is the service covered?
  - Review the National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs)
  - Know what services have Frequency Limits

- Explain in beneficiary friendly language why you believe Medicare may deny
  - Medicare does not pay for this test for your condition
  - Medicare does not pay for this test as often as this
  - Medicare does not pay for experimental/research tests

Advance Beneficiary Notice (ABN)

- Modifiers:
- GA - Waiver of liability statement issued as REQUIRED BY PAYER POLICY
  - Service not meeting medical necessity
  - ABN on file in the patient's records

Advance Beneficiary Notice (ABN)

- Modifiers:
- GZ - Item or service expected to be denied as not reasonable and necessary and ABN was not issued
  - Services not reasonable and necessary
  - No ABN issued
  - Auto deny
    - This is typically used when there is a secondary payer that requires the Medicare denial before they pay benefits.

Advance Beneficiary Notice (ABN)

- Modifiers:
- GY - ABN not required for service
  - Statutorily non covered
  - Without a benefit category
  - ABN not required
  - Auto deny

Advance Beneficiary Notice (ABN)

- Modifiers:
- GX - MM6563 - Notice of liability statement issued, voluntary under payer policy
- Never use a GX on the same service that includes a GA, GZ or GY
  - Statutorily noncovered
  - Without a benefit category
  - ABN not required
  - Auto deny
  - DMEPOS suppliers do not use a GX

Approach

- Infusion
  - Infusion services performed in the Emergency Room and Infusion clinics
  - Check for all required documentation: MD order, Medical Necessity, site of injection, etc.
  - Confirm start and stop times are clearly documented
  - Create Pre-bill edit report
- Tools
  - LCDs/NCDs
  - NCCIs
- Education
- Feedback

Approach

- Medical Necessity Process changes
  - Check for medical necessity when ordering a service
  - Check for medical necessity before providing a service
  - Issue an ABN per policy guidelines
  - Create a Pre-Denial Report
- Tools
  - LCDs/NCDs
  - NCCI
- Education
- Feedback

Resources

- The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) http://www.cdc.gov/nchs/icd/icd9cm.htm
- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) http://www.cdc.gov/nchs/icd/icd10cm.htm
- The Medicare Coverage Database (MCD) contains all National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), local articles, and proposed NCD decisions. http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx?clickon=search
- National Government Services http://www.ngsmedicare.com/wps/portal/ngsmedicare/welcome
- ABN http://www.cms.gov/BNI; MLN Network Booklet - http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/abn_booklet_icn006266.pdf
- NCCI http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html
- Infusion http://www.ama-assn.org/resources/doc/cpt/no-index/cpt-assistant-december-2011.pdf

Questions

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