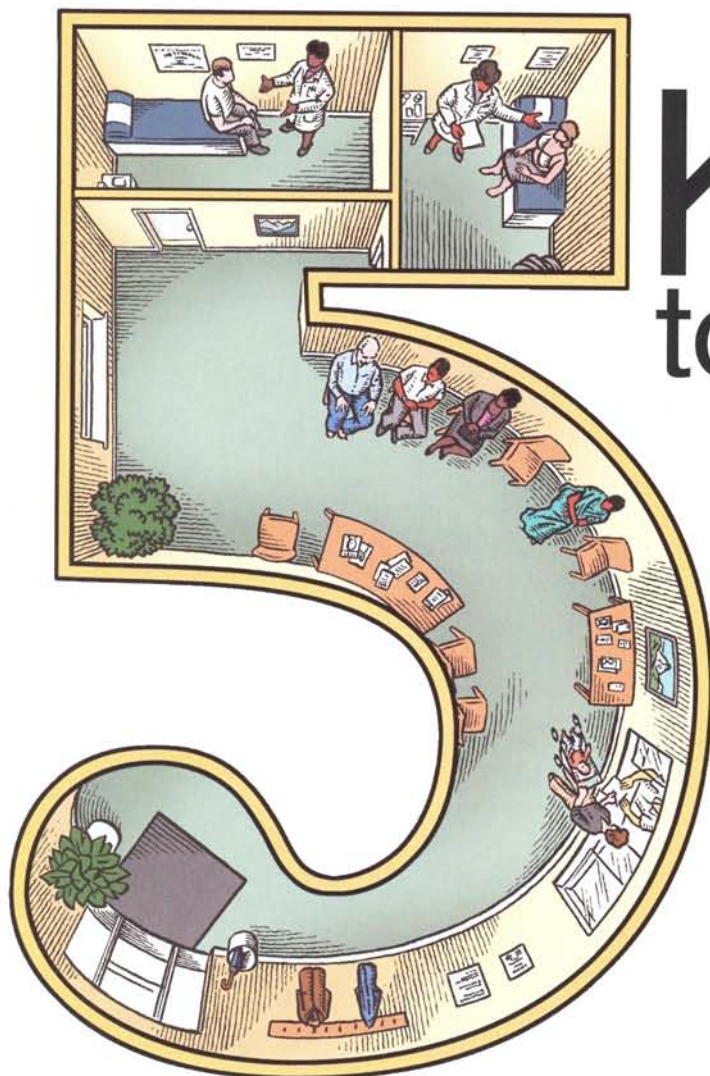


PHYSICIANS PRACTICE



Keys to Patient SERVICE

YOUR COMPLETE GUIDE

(YES, YOU *SHOULD* SWEAT
THE SMALL STUFF)

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RULES TO CODE BY

**TO GET PAID MORE —
AND FASTER — FOCUS
ON THESE KEY AREAS.**

BY PAMELA MOORE

Debbie Alverson's team bills for 54 providers. That's about 575 claims a day, says the COO of Cornerstone Medical Management. With all that experience, you'd think they'd have coding down cold.

But Alverson says even they get overwhelmed. "Coding in today's world is very complex, and the coding rules are very complex, and it's very overwhelming to keep up with all the changes. When you are keying all these things, and the physicians are rushing around, and patients are waiting ... you are going to make mistakes."

Trouble is, every mistake means lost or delayed revenue. Every bounced claim or denial means even more work for your staff, work that they sometimes never get around to doing.

The solution? Send out claims that get paid the first time, every time.

How is that possible? Well, at the very least, correct common mistakes in E&M coding, using modifiers, and coordinate CPT and ICD-9 codes — the hot spots for errors in most practices.

Here's your guide.

BETTER E&M CODING

E&M visits account for more than 50 percent of revenue in most primary-care practices. And Medicare reimbursements for E&M visits across specialties added up to around \$30 billion in recent years — more than 1 percent of the entire federal budget. So you better believe Medicare carriers are paying attention to how you are using these codes.

But most physicians are rather uncomfortable with them. “Physicians don’t clearly understand the requirements for each level of service, so they can end up upcoding and undercoding,” says La Verne Jones, director of evaluation and management services for The Coding Network. Jones performs chart audits for physician practices and regularly sees upcoding for level four and five visits.

Here’s a quickie primer:

- **Level four visits require a moderate level of medical decision-making.**
- **Level five visits require a high level of medical decision-making** (see chart below for an extended explanation).
- **Both level four and level five visits require a comprehensive history.** That means including:

- A history of the chief complaint;
- An extended history of the present illness;
- A review of relevant systems *plus* a review of other systems following either the 1995 or 1997 guidelines;
- Complete past, family, and social histories. (This is the part Jones often finds left off. “It may be true that family history isn’t relevant to some specialties, say in orthopedics with a fracture,” she admits. But if you think the level of care is a four or five, you are required to have a family history.)

Still confused? Many practices have templates for physicians to follow — either on paper or through an EMR — to make sure they cover what’s needed. For some samples, visit the tools section of www.PhysiciansPractice.com.

Here’s another great idea: Have a coder visit your practice, audit your charts, and show you what is specifically missing from *your* documentation. That can be more efficient than abstract education, although it might also be worthwhile to invest a day studying E&M documentation alongside an expert. Getting it right reduces the risk of a Medicare audit going south

and may also translate into more revenue, especially if you routinely undercode now. In truth, there’s no way to avoid taking the time to learn the basics.

CONSULT OR NEW-PATIENT VISIT?

Picking the right code level is the big issue in E&M, but practices also make mistakes when determining whether an encounter is a consult or a new-patient visit, says Jones. Consults pay better, so it’s worth getting right.

What’s the difference? “The focus has to be on the intent of the visit — whether another provider is requesting advice on the patient or if the physician has already determined that care needs to be transferred to the specialist,” Jones explains. In short, if another physician just wants your opinion, it’s a consult. If he is actually transferring care to you, it’s a new-patient visit (or established patient if you or anyone in your practice in the same specialty has seen this patient in the past three years).

For a consult, make sure to document the “Three Rs”:

- The **R**eason for the consult;
- The **R**equesting physician’s name; and
- The **R**eport back to the requesting physician.

HOW TO ASSESS YOUR DECISION-MAKING

E&M VISIT	PRESENTING PROBLEM	SAMPLE TREATMENT OPTIONS
LEVEL 4: MODERATE MEDICAL DECISION-MAKING	<ul style="list-style-type: none"> ■ 3+ self-limited problems ■ 1+ chronic illnesses or self-limited problem with mild exacerbation ■ 2 or 3 stable chronic illnesses ■ Undiagnosed new illness, injury, or problem with uncertain prognosis ■ Acute illness with systemic symptoms 	<ul style="list-style-type: none"> ■ Referrals requiring detailed discussion ■ Management of medications with moderate risk ■ Hospitalization for noncritical illness/injury ■ Initiation of total parenteral nutrition ■ Referral for comprehensive pain management rehabilitation
LEVEL 5: HIGH MEDICAL DECISION-MAKING	<ul style="list-style-type: none"> ■ 1+ chronic illnesses w/severe exacerbation ■ 4+ stable chronic illnesses ■ Acute complicated injury ■ Acute/chronic illness or injury posing threat to life or bodily function ■ An abrupt change in bodily function 	<ul style="list-style-type: none"> ■ Emergency hospitalization ■ Medications requiring intensive monitoring ■ Surgery or procedure with ASA 2* or higher risk status ■ Decision not to resuscitate or to de-escalate care because of poor prognosis ■ Mechanical ventilator management

(Source: Bill Dacey, CPC, MBA, MHA, principal in the Dacey Group. Original source AMA 1999 revised Table of Risk)

TIMING IS EVERYTHING

If you spend more than half of an E&M visit counseling the patient or coordinating their care face-to-face, you can bill the visit based on time. "Say a patient is coming in after an MRI and you have concerns about a neoplasm. The visit is going to be going over the MRI and treatment options with risks and benefits. Maybe there is no exam, but there is medical decision-making and probably some history," Jones explains. This can all take a good chunk of time — the sort of visit where you should consider a time-based code.

In many instances, this can be more lucrative than a bill based on the exam, history, and medical decision-making. Just make sure to document the time you spent and what the discussion was about.

MODIFY MODIFIER USE

"Modifier use is one of the easiest ways for an office to mitigate denials as well as improve their cash flow, but modifiers tend to stymie people," says Belinda Ratcliff, director of client services for Global Healthcare Alliance, which offers Web-based claims processing software and services to physicians.

IN SUMMARY

Today's practices need to get paid right the first time — not spend time working denials or rejected claims. Correct coding can help. To get a grip on your coding, focus on these common trouble spots:

- **E&M codes:** Create templates that help you remember what you need to document for each level of service.
- **Use modifiers the right way** to help you get paid correctly for your hard work. Review the definitions for problem modifiers such as 25, 26, and 59.
- **Learn to manage edits properly.** Consider using technology to keep up with medical necessity and bundling edits from payers.

"Over the past 90 days, we've had over 300 questions that relate to modifier use," adds Jill Wolf, vice president, content and service integrity for Accuro Business Intelligence, confirming the complexity of the problem.

A TWO-DIGIT PROBLEM "Modifiers tend to stymie people."

Belinda Ratcliff

But you can get this. Grab some EOBs and review your use of these three core modifiers:

26 – Professional component: Attaching this modifier indicates that you performed only the professional part of a service (studying a report) but not the technical component (such as actually taking an X-ray). It means you should get paid for just a portion of the service. The big mistake here, says Ratcliff, is overuse of the modifier. "It's OK to bill for complete reimbursement if the equipment and overhead [the technical component] is yours."

25 – Significant, separately identifiable, evaluation and management service by the same physician on the same day of the procedure or other service:

Practices have a tendency not to use this modifier, or not to bill an E&M at all if they do a separate procedure or other service the same day, Ratcliff says. But this is simply choosing to perform the service for free, because "if you don't use it, you will not be paid." If there is a complete E&M and a completely separate service — say, for example, you notice a lesion in the course of an exam for bronchitis and you remove it — then add the 25 modifier to the E&M and also bill the lesion removal. Payers may still balk at paying you, but at least you've coded correctly.

59 – Distinct procedural service:

If you need to use a combination of codes that would usually be bundled, but should not be in this instance (say, because you focused on more than one part of the body),

this modifier alerts the payer that it should not bundle. The secret here is (a) knowing what is usually bundled, and (b) knowing when it's appropriate to unbundle. Ask your coder or biller to sit down and explain when you should indicate

that there are unusual circumstances for procedures that are commonly bundled. "It all boils back down to being educated," Ratcliff says.

MANAGE THOSE EDITS

Sometimes, the biggest problem for a practice isn't picking the right codes, but pairing them to avoid denials for medical necessity and watching for inappropriate bundling edits.

Most medical necessity denials happen because diagnosis codes (ICD-9 codes) on the claim don't match up with procedural codes (CPT codes). "The connection between ICD and CPT is very crucial from a medical necessity standpoint," says Wolf. "This is where physicians often fall down."

Imagine if you saw a claim that indicated the patient was suffering from an ear infection, but the

READ MORE ABOUT IT!

Visit PhysiciansPractice.com for more advice on coding and claims collections:

- Read more about technologies that can help you code right the first time by typing "coding software" in our Search Articles box.
- Get answers to common coding questions by typing "coding" in our Search Q&A box.
- Read additional feature articles on good coding practices by clicking on the "Coding" bar on the left-hand side of our home page.

procedure coded was for a colonoscopy. You'd know right away that something was wrong; that's what payers see, too. But most CPT/ICD-9 problem pairs aren't this obvious. "You'd like to think [the edits] are built on common sense, but one of the things we see is ... CMS issues a coverage determination, and then it's up to the individual contractors to determine how they are going to operationalize that," Wolf says. In other words, every Medicare carrier, and every commercial payer for that matter, may have its own rules about what can be billed with what.

Mismatches can also occur because of failure to follow the dreaded Local Medical Review Policies or National Coverage Determinations. These are Medicare's policies about what carriers will cover. Commercial payers roughly follow Medicare, but also make up their own rules on what is OK to do for every possible diagnosis.

Bundling edits are another mess. Every payer makes up its own rules as to what services it considers part of a larger service. If you send it a

bill for two services, it will bundle it and pay you for one. That's an accounting nightmare. Plus, if your practice isn't on its toes, you may miss the chance to appropriately unbundle the services with a 59 modifier, or payers might suggest that you are purposefully trying to overcharge them.

Between the complexities of basic coding, medical necessity edits, and bundling edits, "it's really mind boggling," says Ken Bradley, Navicure's vice president, transaction and interface development. "It's basically impossible unless you do practice with a single payer, but that's not a common situation. Payers are certainly not going to tell the practice how to file a claim for maximum reimbursement."

So, what to do?

It may help to have your billing staff organized by payer, so that they gain expertise in the rules of individual companies. But an increasing number of physicians are also investing in technology that keeps track of all the edits for them. (For a description of the

options, see "Coding Made Easier" from our July 2007 issue. You can find it at www.PhysiciansPractice.com).

Even with technology's help, coding rules may seem overwhelming. Take the time to track the major errors in your own practice; they may well be one of those listed here. Then focus on fixing one at a time for better results. Your goal: Reduce the number of claims that need to be reworked. "The goal is always that your collectors are exception processors. They shouldn't touch every claim," says Ratcliff. ■

Pamela Moore is senior editor for Physicians Practice. She can be reached at pmoore@physicianspractice.com.

5 QUICK TIPS

Simple ways to get paid

- **Update your charge slip or super bill at least once a year.** CPT and ICD-9 codes change annually. Make sure your charge slip stays up to date so you can code to the highest level of specificity and don't use deleted codes.
- **Get a new HCPCS book every year.** The codes you need for medications and other supplies also get updated every year.
- **Pay attention to injection coding.** Too many bill just for administration, not for the material itself, or vice versa. Remember that Medicare typically has different codes than commercial payers for immunizations.
- **Do a quick spot-check of claims for typos and blanks before hitting send.** "Most of your errors really come from simple mistakes," Alverson says. "You transpose an ID number, or leave an ID number out, or get a patient's new insurance card but it doesn't get onto the claim. Everyone is in a hurry, everyone is asking you questions, you are trying to accommodate so many people, it's easy to make mistakes. I tell staff, 'Every time you key in an ID number, look at the screen and look at the card and make sure it's right.'"
- **Appeal denials daily.** It's too hard psychologically to tackle a pile of claims that need to be reworked, and waiting just delays payment. Work to minimize denials, but if you do get one, appeal as quickly as you can.

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SOMEBODY'S WATCHING YOU

Each fiscal year, the Office of Inspector General for the Department of Health and Human Services publishes a work plan. Basically, it's a list of items it will be paying special attention to on Medicare claims. Here are some of its focus areas for physicians in 2008, direct from the work plan. Watch your coding and billing for problems.

Place-of-Service Errors: We will review physician coding of place of service on claims for services performed in ambulatory surgical centers and hospital outpatient departments.

Evaluation and Management Services During Global Surgery Periods: We will review industry practices related to the number of E&M services provided by physicians and reimbursed as part of the global surgery fee. CMS's "Medicare Claims Processing Manual," Chapter 12, section 40, contains the criteria for the global surgery policy. Under the global surgery fee concept, physicians bill a single fee for all of their services usually associated with a surgical procedure and related E&M services provided during the global surgery period.

Medicare Payments for Psychiatric Services: We will review Medicare payments for psychiatric services. Section 1862 (a)(1)(A) of the Social Security Act provides that Medicare will pay for items or services only if they are reasonable and medically necessary. We will determine whether claims submitted for psychiatric services were supported and billed in accordance with Medicare requirements.

Medicare Payments for Selected Physician Services: We will review the appropriateness of Medicare Part B payments for selected physician services. ... Section 1833(e) of the Social Security Act precludes payments to any provider of services unless the provider has furnished the information necessary to determine the amounts due such provider. We will review the appropriateness of Medicare payments for various types of physician services to determine whether these services were paid in accordance with Medicare requirements.

Medicare "Incident to" Services: We will examine the Medicare services that selected physicians bill "incident to" their professional services and the qualifications and appropriateness of

the staff who perform them. This study will review medical necessity, documentation, and quality of care for "incident to" services.

Assignment Rules by Medicare Providers: We will review whether Medicare providers are adhering to assignment rules in billing Medicare beneficiaries. Section 1866(2)(A) of the Social Security Act precludes participating physicians/suppliers from charging Medicare beneficiaries more than the deductible and coinsurance based upon the approved Medicare payment amount determination. Providers who accept assignment must accept Medicare's payment and beneficiary copayment, referred to as the Medicare allowed amount, as payment in full for all covered services. Providers cannot "balance bill" beneficiaries for amounts in excess of the Medicare allowed amounts.

Physician Reassignment of Benefits: We will review the extent to which Medicare physicians reassign their benefits to other entities. Section 1842(b)(6) of the Social Security Act prohibits physicians who provide services for Medicare beneficiaries from reassigning their right to Medicare payments to other entities, unless a specific exception applies. For example, physicians are permitted to reassign to other entities enrolled in Medicare when contractual arrangements exist between the physicians and the entities that meet certain program integrity safeguards or when payments are being made to the physicians' employers. ... Having a large number of reassignments may be indicative of fraudulent or abusive activity. We will examine a national sample of Medicare physicians to determine the extent to which they reassign their benefits to other entities and the extent to which the physicians are aware of reassignments requested on their behalf.

(Source: oig.hhs.gov/publications/workplan.html)

FAQs

BY PAMELA MOORE, PHD, CPC

Still stymied by particular coding problems? Maybe the answers to these common questions can help:

LEARN ONLY WHAT YOU NEED

Q *I am a physician and don't have time to learn the every CPT code. I just want to get mine right. How do I learn what I need to know?*

A One of the most efficient ways for physicians to learn about coding is to invite a coding consultant into their practices to review charts and tell them where they are making mistakes (whether in coding or documentation). It's also absolutely worthwhile to invest an hour or two in reading the CPT manual for your areas of practice. The basics are all there.

APPEALING DENIED MODIFIERS

Q *I've discovered that the majority of our denials come in response to modifier codes — specifically, modifiers 22, 57, and 59 — and are more from private insurers than Medicare. Any tips on how to proceed? Do we drop the use of modifiers for private payers due to the amount of time spent appealing?*

A It is very common to receive denials for these modifiers. Sadly, many carriers do not recognize them, unless the practice appeals them.

I would analyze resources by modifier. You'll need to do this analysis based on how much money is at stake and how many resources are expended to get that money. If you can send out a generic appeal letter to get the 22s paid, for example, it's worth your time. That said, be sure to establish boundaries for your staff. For example:

- Appeal once over the phone for all denials;
- Send a written appeal for denials of more than \$25;
- Send two written appeals for denials exceeding \$100; and
- Solicit physician involvement for denials of more than \$500.

These are just sample guidelines. Figure out your own based on your experience and practice needs.