Strategies for Coding: 2018 and Beyond

Presented by
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- I have nothing to disclose

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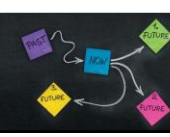

Path to Success - Coding

- Process for Success
  - Patient satisfaction
  - Staff involvement and retained
  - Encounters documented appropriately
  - Coding appropriately for documentation
  - Reimbursement received
  - Encounter closed
  - Patient returns for additional services

Path to Success - Physicians

- Physician wellness: Avoiding Burnout, finding balance
  - Personal satisfaction from practice
  - Minimizing hassles
    - Paperwork
    - Human resources
    - Rules and regulations
  - Time management

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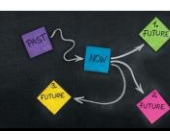

Path to Success - Physician

- Documentation
- Cash flow
- Collection incentives or turn overs to collection
- Communication and utilization of coding reports
- Efficiencies of time – physicians, staff, and patients

Path to Success - Physician

- Codes provide a review of the practice and the profitability of the practice
- Numbers are used to determine value for selling, merging, retiring
- “Blue sky” is difficult to sell

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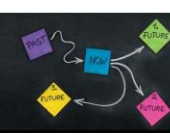
Path to Success - Practice

- Scope of Practice
  - Value of adding additional services
    - Coding
    - Offering services not covered by payers
    - Reimbursement
    - Competition in your area
  - Value of adding additional staff – mid level providers
    - Scope of patients to be seen
    - Recognition of mid level as a provider by payers
    - Acceptance by patients of mid level

Path to Success – Legal Guidelines

- Government Regulations
  - MACRA/MIPS
  - Coding guidelines
  - HIPAA
  - Privacy for patient information
- Private Payer Regulations
  - Coding and billing guidelines
  - Authorizations

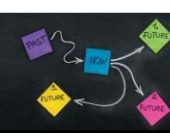


Path to Success – Human Resources

- Human Resources
  - Legal guidelines and requirements
  - Retention of employees
  - "Buy in" to the practice
  - "Show me the money"
  - Employee handbook
  - When should you use an attorney

Path to Success – Legal Guidelines

- Effective staff who understands the EOB's and codes submitted
- Claims are reviewed prior to submission for accuracy
- EOB's are reviewed for accuracy on payment
- Staff has the ability to communicate with patients regarding charges
- Staff reviews on a regular basis billing policies posted on payer websites.
- Reports are generated for physicians and others in practice for review



Path to Success – Technology
It is a new world

- Technology and Social Media
  - Online access for staff and patients?
  - Website
  - Twitter, Facebook, Snapchat, etc
  - Future patients - how will they find you?

Path to Success - Technology

- Patient has ability to pay on website
- Conversations regarding charges and coding available through the website
- Familiarity with the practice and employees through the website
- Patient use of website to fill out forms – history forms, financial statements, etc.

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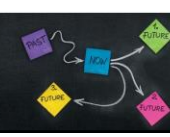
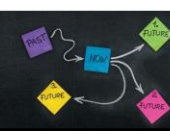


Path to Success – where should I practice?

- Practice location and style
  - Academics or private practice
  - The pros and cons
  - Staying in business as a department, specialty in a group practice or as a private practice
  - Coding – why is this important in making a decision

Path to Success – Where should I practice?

- Codes for diagnostic services are reimbursed differently in a facility versus a non-facility
- E/M services
- Immunotherapy – who captures the reimbursement for services

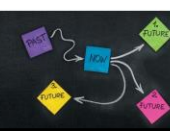


Path to Success – Audits

- Audits
- Regular occurrence
- Third party money
- Oversight by payers for compliance
  - Federal
    - Tax
    - Coding
    - EHR Incentive audits
  - State
    - Tax
    - Employment
    - Business tax

Path to Success - Telehealth

- Telehealth
  - Codes appropriate for services
  - Differences between CMS guidelines and payer guidelines
  - State regulations
  - Equipment requirements
  - Staff involvement
  - Patient satisfaction



Path to Success - Coding

- Coding
  - Changes are a “normal”
  - Keeping compliant with all of the guidelines
  - Justifying your services
  - Keeping your revenue
  - Documenting to defend your coding and revenue

Path to Success - Coding

- Advanced coding - E/M Chart audits
  - Step by step through the requirement for levels of services
  - Medical necessity – the over arching requirement
  - Case studies for practice

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Path to Success - Coding

- Advanced Coding – pulmonary and allergy services
  - Procedure coding for the allergist
  - Documenting for the services provided
  - Discussion of payer requirements for the procedures

Path to Success - Coding

- Beyond correct coding
  - Keeping your revenue
  - Denials from payers and how can you decrease the denials
  - Business decisions

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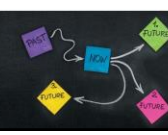

Path to Success - Coding

- Collection of co-pays and deductibles
- Insurance contracts and knowing fee schedules
- Insurance billing guidelines for coding edits – what system is used
- High deductibles – how does it change the patient's role with your practice?

Path to Success - Coding

- What does the patient know prior to the appointment about the costs and charges which may possibly be incurred
- Which department after the encounter is most likely to have interaction with the patient?
- Costs and payment plans – who communicates this information effectively to the patient?
- Does the patient understand the codes and who is responsible for the explanations?

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Insurance Contracts and Coding

- What has your practice agreed to provide? After hour care? Telephone care?
- What is your conversion rate with the payer and what year RVU schedule is the payer adapting for your contracts?
- What is your position in the community to negotiate your contract or should you hire an outside consultant?
- What is excluded and how do you handle it in everyday practice?

Path to Success: What's Legal and Coding

- Insurance write-offs?
- Professional courtesy?
- Mid level providers – what are the guidelines for your state?
- Charges submitted under the supervising physician or the mid level?
- Codes for services provided by staff – is it working?

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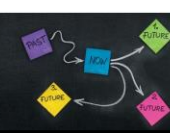

Path to Success: What's Legal and Coding

- USP and compounding issues
- Epi-Pen
- JW modifier required for CMS on biologic wastage
- RVU values reviewed by RUC for CMS: allergy testing – decrease in work RVU for 2018
- Venom RVU -?

Path to Success – Coding Updates

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Documentation

- If it's not recorded, it did not happen!
- If it is illegible – it did not happen!
- If it is cloned – it doesn't count
  - Watch your templates!
- Code to the level of knowledge at the time of the encounter

Documentation

HIPAA - Penalties

- $2,000-$10,000 per incident & limit increased to not more than three times the amount
- Presenting a claim for an item or service based on a code that a person knows or should know will result in greater payment than appropriate
- Third party payers are doing a percentage error rate and then multiplying it times the universe of payments

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Documentation

- Penalties
  - A person submits a claim that he/she knows or should know is for a medical item or service that is not medically necessary
  - Criminal penalties for "knowingly and willingly" attempting to defraud

Chief Complaint

Chief Complaint can be part of the HPI or separate

- Chief complaint is to be in the patient's own words or summary of the reason why the patient is seeking medical care
- If chief complaint is for a "procedure or diagnostic test," third party payers will consider the E/M "incidental" to the procedure or diagnostic test and will not reimburse for the E/M

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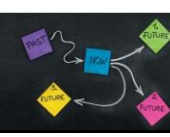

Relevant History

- The billing provider is responsible for obtaining and documenting the history of present illness. The review of systems, past, family and social history may be obtained by the staff, but it needs to be reviewed by the provider.

History Documentation

- You may list the CC, ROS, and PFSH as separate elements of history or you may include them in the description of the HPI.
- You do not need to re-record a ROS and/or a PFSH obtained during an earlier encounter if there is evidence that the physician reviewed and updated the previous information.
- This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. You may document the review and update by:
  - Describing any new ROS and/or PFSH information or noting there is no change in the information
  - Noting the date and location of the earlier ROS and/or PFSH
- **Ancillary staff may record the ROS and/or PFSH**. Alternatively, the patient may complete a form to provide the ROS and/or PFSH.
- You must provide a notation supplementing or confirming the information recorded by others to document that the physician reviewed the information.
- The physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.

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Documentation

- New problem to the provider within the same group?
- Problem better – or worsening?

Review and Updates for Diagnosis Coding 2018

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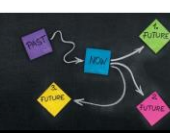

New Codes for October 1, 2019

- No changes to the urticaria or the asthma descriptions.
- No changes in the J – respiratory chapter
- K 52.21 - "FPIES" added to the descriptor (Food protein induced entercolitis syndrome)
- F12.23 – Cannabis dependence with withdrawal

New Diagnosis Codes for 2019

- H10.821 Rosacea conjunctivitis, right eye
- H10.822 Rosacea conjunctivitis, left eye
- H10.823 Rosacea conjunctivitis, bilateral
- H10.829 Rosacea conjunctivitis, unspecified eye

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Diagnosis Coding – Support your Claim

- Link and prioritize diagnosis codes appropriately to the procedure codes
- Multiple diagnosis codes may be submitted – up to 12 per claim
- Documentation in the note – does the diagnosis code match?

Signs and Symptoms Coding

- Use when a related definitive diagnosis has not been established by the provider
- Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes
- Additional signs and symptoms that may not be associated routinely with a disease should be coded when present

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Example

- New patient E & M provided
- Allergy testing and PFT performed
- Diagnoses at the conclusion of the visit are:
  1. Allergic rhinitis due to pollens J30.1
  2. Allergic rhinitis due to house dust mites J30.89
  3. Atopic dermatitis L 20.89
  4. Allergic conjunctivitis H10.45
  5. Mild persistent asthma – J45.30
  6. History of peanut allergy – Z91.010
  7. Post nasal drip unrelated – R09.82

Diagnosis Coding

- Chapter 19 - Subsection guidelines for poisoning by, adverse effects of and under-dosing of drugs, medicaments and biological substances (T36-T50)
  - Includes adverse effect of correct substance properly administered
  - Poisoning by wrong substance given or taken in error
  - Poisoning by overdose of substance
  - Under-dosing by (inadvertently)(deliberately) taking less substance than prescribed or instructed
- Code first, for adverse effects, the nature of the adverse
  - Dermatitis due to substances taken internally
  - Urticaria
  - Pruritus
  - Erythema
- Codes from the T36-T50 will be sequenced second

Diagnosis Coding

- Status - Indicates that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition.
  - The status code is informative, because the status may affect the course of treatment and its outcome.
- History – Indicates that the patient no longer has the condition
- Do not use the status code with a diagnosis code from one of the body system chapters if the diagnosis code includes the information provided by the status code.
- Alphabetical index list food and bee Z codes under “history – personal – allergy”

Diagnosis Coding

- Z codes
  - Z codes may be listed as the primary diagnosis code
  - Z23 is for encounters for vaccinations. The procedure code required will identify the actual administration of the injection and the type(s) of immunizations given.
  - Z01.82 – “Encounter for allergy testing without complaint, suspected or reported diagnosis”
  - Z51.6 – Encounter for desensitization to allergens
  - Z88.--- - Allergy status to drugs, medications and biological substances

Diagnosis coding – Support for Your Claim

- Are the additional codes for smoking, exposure to smoking, etc required?
- What does the Excludes 1 mean in the ICD-10CM book?
- Our physician treats a patient for allergies and asthma. However, this patient also has hypertension, ICD10 code I10. The physician reviews his medications for this condition and how they might interact with his allergy/asthma medications. The physician's medical decision making process takes into account the patient's hypertension, and this is documented in the chart notes.
- Question: Is it appropriate to add the diagnosis of I10 for hypertension?

Diagnosis coding – Support for Your Claim

- Frequently received questions:
  - What is the difference between the T codes and the Z codes for food allergy?
  - What is the maximum industry standard for billers submitting ICD-10 codes. Is it true that the provider can bill out as many ICD-10 codes but only the first four are captured? Is there a correlation between reimbursement and the number of ICD-10 codes submitted per CPT code?

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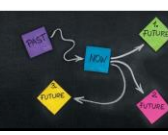

CPT Coding for 2018

CPT Codes for 2018

- 94617 Exercise Test for bronchospasm, including pre and post spirometry, eletrocardiographic recordings(s), and pulse oximetry
- RVU – total 2.70 Technical component 1.75, Professional - .95

- 94618 Pulmonary stress testing (eg, 6 minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed
- RVU – Total .97 Technical component .32, Professional - .65

- 94620 Deleted
- 94621 Cardiopulmonary exercise testing, including measurement of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings.
- RVU – Total – 4.68, Technical component 2.72, Professional – 1.96
- Check edits for bundles when performing multiple PFT tests

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Incident to 2018 Guidelines

- **<u>"Incident to" Policy for Calendar Year 2018</u>**
- In the calendar year 2014 PFS final rule, CMS required that, as a condition for Medicare Part B payment, all "incident to" services and supplies must be furnished in accordance with applicable state law.
- The definition of auxiliary personnel was also clarified to require that the individual furnishing "incident to" services must meet any applicable requirements to provide such services, including licensure, imposed by the state in which the services are furnished.

Incident to 2018 Guidelines

- In some cases, the physician or practitioner supervising the service is not the same individual treating the patient more broadly.
- CMS is finalizing a proposal to specify that, in those cases, only the supervising physician or practitioner may bill Medicare for "incident to" services.
- Additionally, CMS is finalizing a proposal to require that auxiliary personnel providing "incident to" services and supplies cannot have been excluded from Medicare, Medicaid, or other Federal health care programs by the Office of Inspector General, or have had their enrollment revoked for any reason at the time that they provide such services or supplies.

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Peak Flow Reading

- For Medicare/Medicaid it is included in the E/M
- S code for third party payers –
  - S8110 – Peak expiratory flow rate (physician services)

Modifier 25

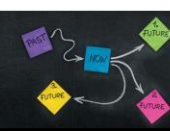
- NCCI Guidelines:
- With most "XXX" procedures, the physician may, however, perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the **same diagnosis** necessitating performance of the "XXX" procedure but **cannot include any work inherent** in the "XXX" procedure, **supervision of others performing** the "XXX" procedure, or time for **interpreting the result** of the "XXX" procedure.
- Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding. Examples of "XXX" procedures include allergy testing and immunotherapy, physical therapy services, and neurologic and vascular diagnostic testing procedures.

Modifier 25

- Third party payers requirements for use of 25 modifier
- Chart Reviews and audits for lack of documentation to support E/M and other services on same calendar day

Allergy Services in 2018

- Limits on the number of doses per payer
- Cigna
- United Health Care
- Aetna
  - Limits are from 80-120 units per year for some payers
- CMS – 30 units per day – MUE Edit
- BCBS – adopting the MUE from the NCCI edits

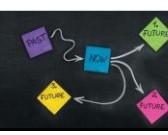


Procedure coding for Winning Strategies in 2018

- E/M codes for non-physician staff – 99415, 99416
  - Add on codes to physician encounter – 45 minutes after the typical time for a physician E/M
- Prolong Services with and without face to face time
- 2018 CMS covers without face to face time (99358, 99359)
  - 99358 – Prolonged E/M before and/or after direct patient care – 1st hour
  - 99359 – prolong E/M before and/or after direct patient care – each additional 30 min

Procedure coding for winning strategies in 2018

- Prolong services without face to face time – 99358, 99359
  - May be on the same day as patient encounter
  - May be on a different day than patient encounter
  - Must relate to a service or patient where face to face patient care has occurred or will occur and relate to ongoing patient management.
  - Typical time for the primary service need not be established within the CPT code set
  - Time does not need to be continuous
  - 99358 is only used once per date
  - Must have more than 30 minutes to report 99358



Procedure coding for winning strategies in 2017

- 96160 – Administration of patient-focused health risk assessment instrument
  - (ACT) with scoring and documentation per standardized instrument
- Codes for subcutaneous allergy testing? – 96372
  - Hydration, Therapeutic, Prophylactic, diagnostic injections

Procedure coding for winning strategies in 2018

- Xolair and Nucala injections – 96372 or 96401
  - 96401 – Per the CPT book "96401-96549 for the administration of chemotherapy or other highly complex drugs or high complex biologic agent services. These services require advanced practice training and competency for staff who provide these services; special considerations for preparation, dosage or disposal; and commonly, these services entail significant patient risk and frequent monitoring."
  - Payer guidelines -

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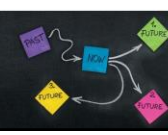

Procedure coding for winning strategies in 2018

- Drug Testing – CPT 95018 includes percutaneous and intradermal testing
  - MUE – 19
  - Cost of the drug is included in the testing
  - Drug Challenge – oral or subcutaneous
    - 95076 – Per the CPT – "ingestion challenge sequential and incremental ingestion of test items" – initial 120 minutes
    - 95079 – each additional 60 minutes

Procedure Coding for 2018

- What are MUE – Medical Unlikely Edits?
- Created by CMS as part of the NCCI (more abbreviations:/)
- Updated on a quarterly basis
- Use by third party payers as edits for their payment systems

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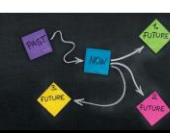
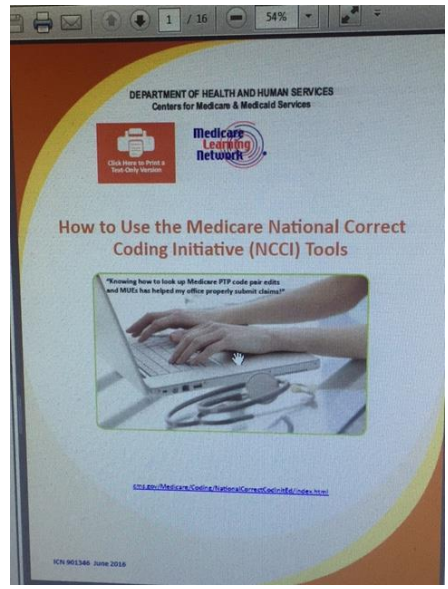


Procedure Coding for 2018



Procedure Coding for 2018

- What is the Medicare National Correct Coding Initiative (NCCI)
- NCCI Procedure-to-Procedure (PTP) code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for payment
- Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a date of service for a single beneficiary.
- For information about the Medicaid NCCI program, refer to The National Correct Coding Initiative in Medicaid webpage

Procedure Coding for 2018

- When is a code the reimbursable code of a PTP code pair?
- The Column 1/Column 2 tables are comprised of PTP code pairs. If a provider submits the two codes of an edit pair for payment for the same beneficiary on the same date of service, the Column 1 code is eligible for payment and the Column 2 code is denied.
- However, if both codes are clinically appropriate and an appropriate NCCI-associated modifier is used, the codes in both columns are eligible for payment. Supporting documentation must be in the beneficiary's medical record.

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Examples from the NCCI edits

94060	94010	19960101	*	0	HCPCS/CPT procedure code definition
94060	94011	20110701	*	1	Misuse of column two code with column one code
94060	94012	20110701	*	1	Misuse of column two code with column one code
94060	94150	20120101	*	1	CPT Manual or CMS manual coding instructions
94060	94150	19970101	19970101	9	CPT "separate procedure" definition
94060	94160	19960101	19970331	0	Standards of medical / surgical practice
94060	94200	19960101	*	1	HCPCS/CPT procedure code definition
94060	94375	19960101	*	0	Standards of medical / surgical practice
94060	94620	19960101	19960101	9	Mutually exclusive procedures
94060	94640	19960101	*	1	CPT Manual or CMS manual coding instructions
94060	94650	19960101	20030331	1	Standards of medical / surgical practice
94060	94664	19980401	*	1	Standards of medical / surgical practice

Examples from the NCCI edits – PTP edits

94060	94760	19960101	19960101	9	Standards of medical / surgical practice
94060	94761	19960101	19960101	9	Standards of medical / surgical practice
94060	94770	19960101	*	1	Standards of medical / surgical practice
94060	95070	19960101	19960101	9	Mutually exclusive procedures
94060	95071	19960101	*	1	Mutually exclusive procedures
94060	96360	20090101	*	1	Standards of medical / surgical practice
94060	96365	20090101	*	1	Standards of medical / surgical practice
94060	96372	20090101	*	1	Standards of medical / surgical practice

NCCI Guidelines - 94640

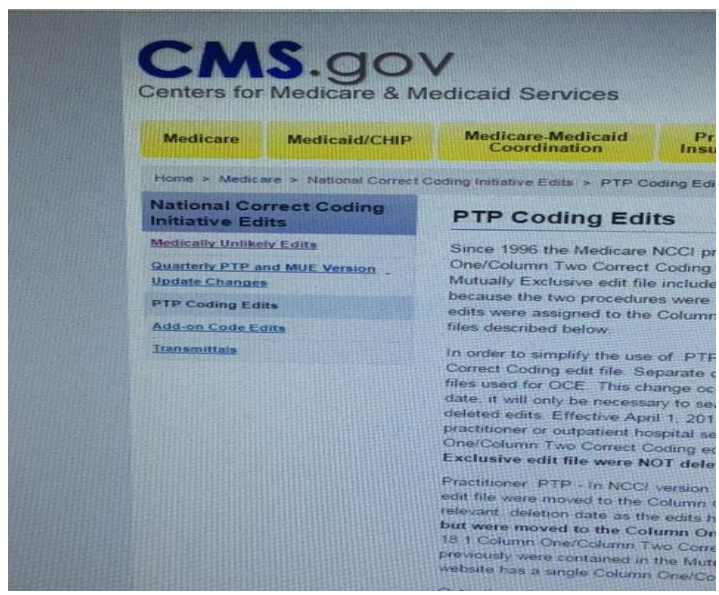
- CPT code 94640 should only be reported once during a*n episode of care* regardless of the number of separate inhalation treatments that are administered. If CPT code 94640 is used for treatment of acute airway obstruction, spirometry measurements before and/or after the treatment(s) should not be reported separately. It is a misuse of CPT code 94060 to report it in addition to CPT code 94640. The inhaled medication may be reported separately.
- *An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility.*
- *If a patient receives inhalation treatment during an episode of care and returns to the facility for a second episode of care that also includes inhalation treatment on the same date of service, the inhalation treatment during the second episode of care may be reported with modifier 76 appended to CPT code 94640.*

NCCI Guidelines

- Chapter 11 – Section V, Paragraph 18

"Some allergy testing CPT codes (e.g., 95004, 95017-95052) are reported based on the number of individual tests performed. CMS payment policy does not allow including testing of positive or negative controls in the number of tests reported. For example, if percutaneous testing (CPT code 95018) with penicillin allergens administering six allergens plus a positive and negative control is performed, only six tests may be reported for CPT code 95018. "

Medical Unlikely Edits



MUE Rationale – what do the numbers mean?

- 1. The first column entitled HCPCS/CPT Code contains codes with an MUE value.
- 2. The second column entitled Practitioner Services MUE Values represents the maximum UOS that a practitioner would report under most circumstances for a single beneficiary on a single date of service.
- 3. The third column entitled MUE Adjudication Indicator (MAI) describes the type of MUE.
  - MAI 1 indicates a value applied at the line level.
  - MAI 2 indicates a value that was determined based on absolute criteria, such as anatomic considerations, an intrinsic definition of the code, or published CMS policy.
  - MAI 3 indicates a value that is unlikely to appear on a correctly coded claim but could, in unusual circumstances, be payable.
- The fourth column entitled MUE Rationale provides the underlying basis for each MUE.

CPT Code	MUE Value	MUE adjudication indicator	MUE Rationale
95004	80	1 Line Edit	Clinical: Data
95012	2	3 Date of Service Edit: Clinical	Clinical: Data
95017	27	1 Line Edit	Clinical: Society Comment
95018	19	3 Date of Service Edit: Clinical	Clinical: CMS Workgroup
95024	40	1 Line Edit	Clinical: Data
95027	90	1 Line Edit	Clinical: Data
95028	30	1 Line Edit	Clinical: Data
95044	80	1 Line Edit	Clinical: Data
95052	20	1 Line Edit	Clinical: Data
95056	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
95060	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
95065	1	3 Date of Service Edit: Clinical	Clinical: Data
95070	1	3 Date of Service Edit: Clinical	Clinical: Data
95071	1	2 Date of Service Edit: Policy	Clinical: Data
95076	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
95079	2	3 Date of Service Edit: Clinical	Clinical: Society Comment

CPT Code	MUE Value	MUE adjudication indicator	MUE Rationale
95115	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
95117	1	2 Date of Service Edit: Policy	Code Descriptor / CPT Instruction
95144	30	3 Date of Service Edit: Clinical	Clinical: Data
95145	10	3 Date of Service Edit: Clinical	Clinical: Data
95146	10	3 Date of Service Edit: Clinical	Clinical: Data
95147	10	3 Date of Service Edit: Clinical	Clinical: Data
95148	10	3 Date of Service Edit: Clinical	Clinical: Data
95149	10	3 Date of Service Edit: Clinical	Clinical: Data
95165	30	3 Date of Service Edit: Clinical	Clinical: Data
95170	10	3 Date of Service Edit: Clinical	Clinical: Data
95180	6	3 Date of Service Edit: Clinical	Clinical: Data

Allergist Coding Curve (National)

99201	.20%	99211	3.0%
99202	2.1%	99212	4.8%
99203	32.7%	99213	51.9%
99204	56.8%	99214	37.7%
99205	8.3%	99215	2.6%

Questions

- Thank you