Coding for Improved Collections

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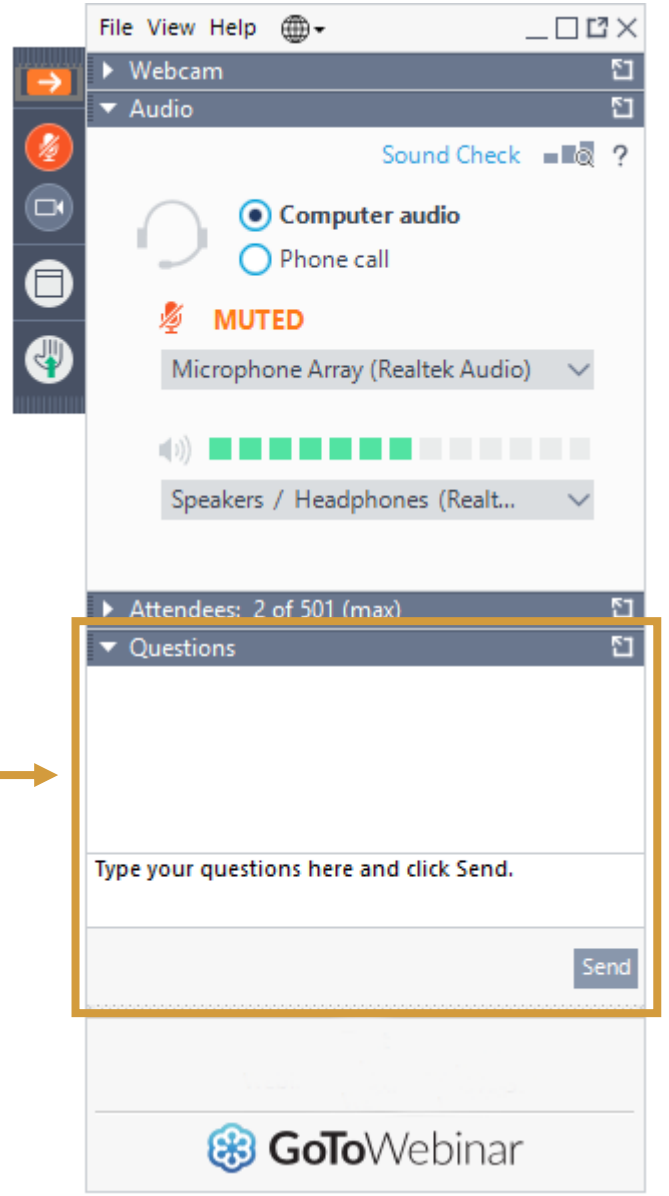
Submit your questions using the Questions window



Introduction

Discussion Topics

- Identify Common Areas for Coding to Support the Revenue Cycle
- How to Involve coders in a denial Management Strategy
- Learn strategies for writing effective appeals
- Understand Medical Necessity, Bundling and MUE edits
  - What to Review
  - How to Track
  - Modifiers


Revenue Cycle
Physician Order
Scheduling
Admin/ Registration
Insurance Verification
Patient Care
Charge Capturing
Procedure Coding
Discharge
Diagnosis Coding
Billing
Denials
Appeals
Patient Billing/ Collection
Collections
Payment Posting
End

HIM Support – Front End Touches

Claim Edit	# of Claims	$
Biosimilar HCPCS reported without biosimilar modifier.	6	$ 57,768.57
CCI edit	232	$ 1,437,658.89
Diagnosis cannot be primary and should be paired with another diagnosis.	6	$ 1,726.33
Diagnosis code reported is invalid for the statement date	173	$ 107,559.77
Diagnosis is not valid for patient age	1	$ 2,233.24
DX code is exempt from reporting POA according to the Code Table.	2	$ 148,847.60
DX V707 or Z006 being reported on claim. Condition Code 30 required for non-research services	2	$ 497.84
EKG or Chest X-ray billed with pre-op DX code as principal DX is not covered	25	$ 22,146.59
External Cause of Injury codes cannot be listed as primary.	15	$ 5,543.77
Functional G codes require appropriate pairing	9	$ 9,784.66
If vaccine charges are only services being billed, DX Z23 must be principal DX	6	$ 1,630.04
Medical Necessity	256	$ 821,143.47
Medical visit on the same day as a type T or S procedure without modifier 25	139	$ 422,103.73
Modifier 25 invalid with CPT being billed when no other charges are on claim	6	$ 917.16
Modifier 25 should not be billed for this CPT code	7	$ 15,079.71
Modifier 27 invalid on a professional claim.	1	$ 92.00
Modifier 50 not allowed with CPT being reported	2	$ 618.50
Modifier 50 should not be reported on the same line as RT/LT	2	$ 6,860.54
Modifier GO only allowed with Revenue Code 43x	3	$ 4,028.57
Modifier GZ and GY should not be reported on the same service line charge	4	$ 19,841.97
Multiple medical visits are present on the same day with the same revenue code without condition code G0	118	$ 133,338.45
Non-specific codes (NOC) require procedure description.	10	$ 55,656.40
Principal DX is not covered by Medicare and charges are not reflected in non-covered	3	$ 6,694.70
PT/OT evals to Medicare require functional G Code	13	$ 50,075.89
Screening DX primary; Possible coverage issue	89	$ 69,070.86
Screening pap charge requires screening DX code	4	$ 2,839.71
Speech therapy evals to Medicare require functional G Code	2	$ 1,700.78
Surgical code requires audit prior to release	2	$ 5,052.04
Surgical CPT units cannot be greater than 1.	12	$ 63,255.41
Units exceed allowable (MUE)	118	$ 858,499.40
Z00.00 billed with non-preventive EM code to Medicare.	13	$ 1,890.00
Total	**1281**	**$ 4,334,156.59**

Denials

1. Medical Necessity
2. MUEs
3. Inpatient vs Observation

Medical Necessity - NCD vs LCD

National Coverage Determinations—published by CMS

- NCD is defined by statute and means a determination by the Secretary of the DHHS with respect to whether or not a particular item or service is covered nationally under Title XVIII of the Act. [Federal Register, Vol. 78, No. 152, page 48165]
- An NCD indicates the Medicare coverage of specific services, procedures, or technologies on a national basis.
  - If a service/procedure/technology is not addressed by an NCD, there may be an LCD which provides coverage information.

Local Coverage Determinations—published by the MAC

- Different MACs have different coverage policies
- In addition to CPT/HCPCS codes and covered diagnoses, LCD may contain additional coverage limitations

Commercial Payer Policies

- Many commercial payers either follow CMS or create their own coverage policies
  - Search terms to help you find commercial payer coverage policies
    - Publications for healthcare providers
    - Provider manual
    - Medical coverage policy
  - Review your search results--pick a URL with "provider" in it
- Provider resources on payer websites typically do not require registration

Medical Necessity - Front End Fix

Work with Providers to gather more documentation

GZ Modifier – to use or not to use

Advanced Beneficiary Notice (ABN)

Appeals Process - Medicare

Medicare Appeals Process

APPEAL PROCESS SUMMARY

A summary of each appeal level is provided in Table 6.

Table 6. Appeal Process Summary

Level	Summary of review process	Who performs the review?	When must you request an appeal?	When should you get a decision?	AIC	Links to Forms
1st Level – Redetermination by a Medicare Administrative Contractor (MAC)	Document review of initial claim determination	MAC	Up to 120 days after you receive initial determination	60 days	No	CMS-20027 CMS-20031
2nd Level – Reconsideration by a Qualified Independent Contractor (QIC)	Document review of redetermination; submit any missing evidence or evidence relevant to the appeal	QIC	Up to 180 days after you receive MRN/RA	60 days	No	CMS-20033
3rd Level – Administrative Law Judge (ALJ) Hearing or Review by Office of Medicare Hearings and Appeals (OMHA)	May be an interactive hearing between parties or an on-the-record review	ALJ or attorney adjudicator	Up to 60 days after you receive notice of QIC decision or after expiration of the applicable QIC reconsideration timeframe if you do not receive a decision	May be delayed due to volume	Yes	OMHA-100 OMHA-100A OMHA-104
4th Level – Review by the Medicare Appeals Council (Council)	Document review of ALJ's decision (but you may request oral arguments)	Council	Up to 60 days after you receive notice of OMHA's decision or after expiration of the applicable OMHA decision timeframe if you do not receive a decision	90 days if appealing an OMHA decision or dismissal or 180 days if ALJ review time expired without an ALJ decision	No	DAB-101
5th Level – Judicial Review in U.S. District Court	Judicial review	U.S. District Court	Up to 60 days after you receive notice of Council decision or after expiration of the applicable Council review timeframe if you do not receive a decision	No statutory time limit	Yes	No HHS form available

Appeals Process - Commercial

UHC Appeals Process

Claim Reconsideration, Appeals Process and Resolving Disputes - Chapter 9, 2018 UnitedHealthcare Administrative Guide

Claim reconsideration does not apply to some states based on applicable state legislation. Refer to Provider Dispute Resolution (CA, OR, and WA Commercial Plans) section for more information.

Claim Reconsideration (step one of a two-step process)

A processed claim in which you do not agree with the outcome of the original claim payment, correction, or denial.

Timeframe

You must submit your Claim Reconsideration within 12 months (or as required by law or your participation agreement) from the date of the original EOB or PRA.

How to submit your Reconsideration:

If you believe we underpaid you, the first step in addressing your concern is to submit a Claim Reconsideration Request.

- **Online:** The claimsLink application. More information is available on UHCprovider.com/Claims > Submit a Claim Reconsideration.
- **Paper:** Use the Paper Claim Reconsideration Form on UHCprovider.com/Claims. Mail the form to the applicable address listed on the EOB or PRA. The address may differ based on product. Include a copy of the original EOB or PRA. Please see applicable benefit plan supplement for specific contact information.
- **Phone:** To request an adjustment for a claim that does not require written documentation call the number on the

Claim Appeal (step two of a two-step process post service)

If you do not agree with the outcome of the Claim Reconsideration decision in Step 1, you may use the following Claim Appeal process.

Timeframe

You must submit your appeal to us within 12 months (or as required by law or your participation agreement), from the date of the original EOB or PRA. The two-step process described in the Claim Reconsideration and Appeal Process allows for a total of 12 months for timely submission and not 12 months for step one and 12 months for step two.

Medical Records Request Submission Timeframe

If medical records are requested to process an appeal, the following timeframes are when the information is due:

- Expedited appeals – within two hours of receipt of the request
- Standard appeals – within 24 hours of receipt of the request.

This includes providing a copy of the denial notice. Timeframes may change based on applicable law or your participation agreement.

What to Submit

Attach all supporting materials, such as member-specific treatment plans or clinical records to the formal appeal request, based on the reason for the request. Include information which supplements your prior adjustment submission that you wish included in the appeal review.

We make our decision based on the materials available at the time of formal appeal review. If you are appealing a claim denied because filing was not timely:

Medically Unlikely Edits (MUEs)

- An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service
- Not all HCPCS/CPT codes have an MUE limit
- Medicare MUEs
  - Set as per line or per DOS limits
  - Medicare MUE files
- Medicaid MUEs
  - Set as per DOS limits
  - Medicaid MUE files
- Commercial payers may have a max frequency per day
  - UHC Maximum Frequency Per Day Policy

MUEs – Front End Fix

How to handle on the Front End

- Credit units that exceed the limit
- Keep units on the claim but report units that exceed the limit with a GZ modifier and report charge as non-covered
- Track by CPT code and Ordering Provider

How to appeal – if you want to

Inpatient vs Observation

How to Appeal

Get Case Management Involved

Medicare VS Medicare Advantage VS Commercial

Writing an Appeal

6. I do not agree with the determination decision on my claim because:

the billed service does meet medical necessity criteria outlined in LCD L33558 for complex cataract repair CPT 66982.

7. Additional information Medicare should consider:

Please review page two of the attached op report, where the pertinent findings to support CPT 66982 have been highlighted, and reprocess for payment.

Patient was brought to the operating room on the eye cart after pre-operative eye drops were placed in order to fully dilate the left eye. Pupillary response was less than expected. However, patient known to be on tamsulosin HCL. Capsule retractors were placed to stabilize the lens complex. The phacoemulsification unit was then placed into the eye. The nucleus was phacoemulsified using the phaco-chop technique.

CPT 66982 supported by documentation of additional work due to anomalous pupillary function

Record Requests

What to send for record requests:

- Read the request and provide only the requested information
- Is “everything” requested, or is it only for a specific denied charge or a specific date, etc.?
- Who is responsible for reviewing to assure that appropriate info is sent?
- More is not better!

Record Requests

- Medical necessity denial *(items in italics are additional resources that may better support medical necessity)*

- What not to send:
  - Discharge instructions for patient
  - Informational handouts on medical conditions
  - Referral recommendations
  - Preventive care reminders

- ER
  - Provider documentation
  - *Nursing triage note*
  - *Diagnostic testing results*
  - *Lab results*
- Surgery
  - Surgeon's note
  - *Intraoperative anesthesia documentation*
  - *H&P*
- Lab and/or diagnostic testing
  - Order
  - Result
  - Provider documentation from the time when the testing was ordered

Denial Management

- Tracking methods
  - Track by ANSI code and reason
  - Review high dollar and high frequency denials monthly as a department
- You can use this as part of your auditing as well

Denial Tracking

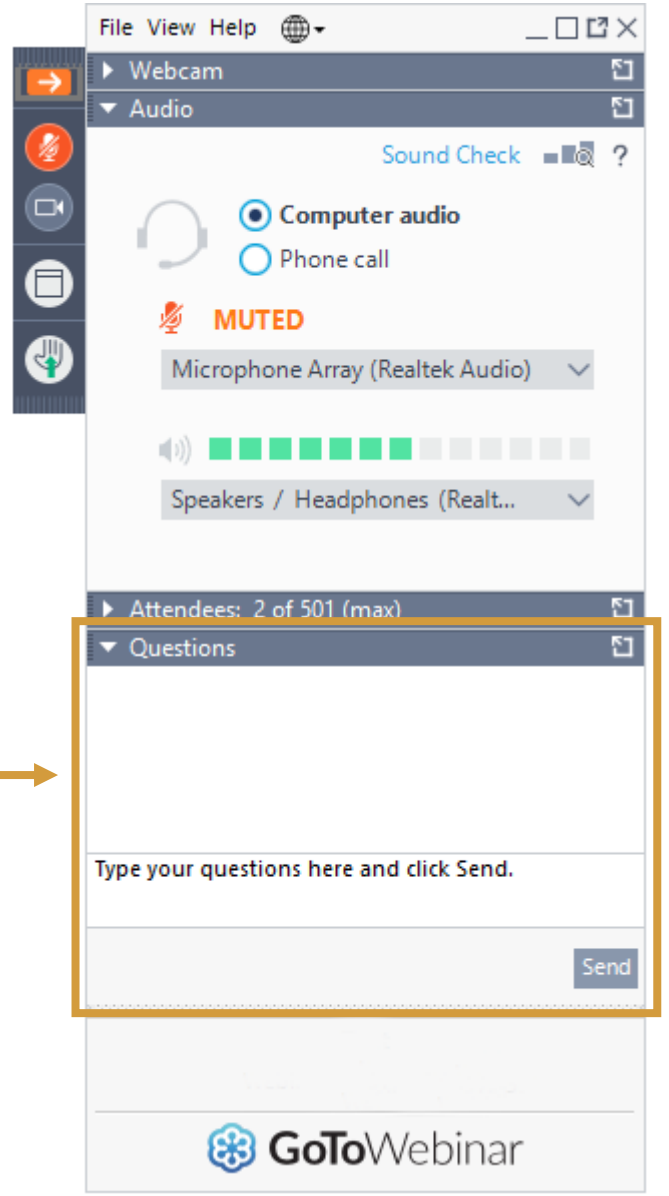
Category	Count of Category	Sum of Total Denied Charge	% of #	% of $
Additional info requested - Patient	18	$ 4,924.00	1.70%	0.80%
Additional info requested - Provider	4	$ 7,517.20	0.38%	1.20%
Authorization/Pre-Cert	6	$ 13,562.00	0.57%	2.20%
Benefits Exhausted	35	$ 6,502.90	3.31%	1.10%
Billing Related - Edit Review needed	35	$ 74,041.96	3.31%	12.10%
Bundling/CCI Edit	92	$ 66,348.00	8.71%	10.83%
COB Issue	81	$ 30,295.42	7.67%	4.90%
Coding	90	$ 4,999.42	8.52%	0.80%
Duplicate/Overlap	70	$ 51,911.81	6.63%	8.50%
Eligibility/Coverage	133	$ 126,515.50	12.59%	20.60%
Exceeds Frequency	23	$ 34,725.19	2.18%	5.70%
Medical Necessity	72	$ 49,278.50	6.82%	8.00%
Other	11	$ 21,495.91	1.04%	3.50%
Other Facility Overlap	20	$ 18,331.62	1.89%	3.00%
Provider Enrollment	360	$ 100,994.49	34.09%	16.48%
Timely Filing	6	$ 1,453.00	0.57%	0.20%
Grand Total	**1056**	**$ 612,896.92**		

Final Thoughts

Stickers & Glitter Won't Help get your Claims Paid but Coding Can

We will now take questions from the audience.

Submit your questions using the Questions window



Resources

- Medicare Coverage Database Quick Search
- Medicare Lab NCD alphabetical index
- Medicare Lab NCD zip files
- Medicare Preventive Services Quick Reference Guide

Thank you for attending!

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