Billing BootCamp 101[2]

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01

Medically Appropriate

Payor policy often dictates coverage of procedure-based services, and this must be identified through the documentation

02

Procedural Services

Defining the difference between minor and major procedures the variations in the rules and the required documentation

03

Global Care

Defining global services and addressing what is included as well as what is NOT included in the procedural reimbursement

04

Modifiers

Modifiers inform a payor that the service being billed does not represent the "typical" service defined by the CPT code

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Medically Appropriate

- The reason for the procedure should not be inferred. It should be plainly stated requiring no interpretation
- Insurance carriers have defined reasons why they are responsible for paying for services rendered to their beneficiaries
  - Payor policies vary
  - Most can be found on their website

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Medical Policies

- Medical policies define when a carrier will reimburse for certain services
- Not all carriers have policies for all services they reimburse for
- Typically included in a policy are:
  - Effective date
  - CPT codes covered (range)
  - ICD-10 codes covered
  - Specifications of intended work
  - Documentation requirements
  - Frequency limitations of coverage

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Procedural Services

- Minor procedures are typically performed in the office setting, but are traditionally defined as those service that have a 0-10 global coverage period
- Major procedures are standardly those that are performed in a surgical environment such as an ASC or OR, and these have a 90-day global coverage period

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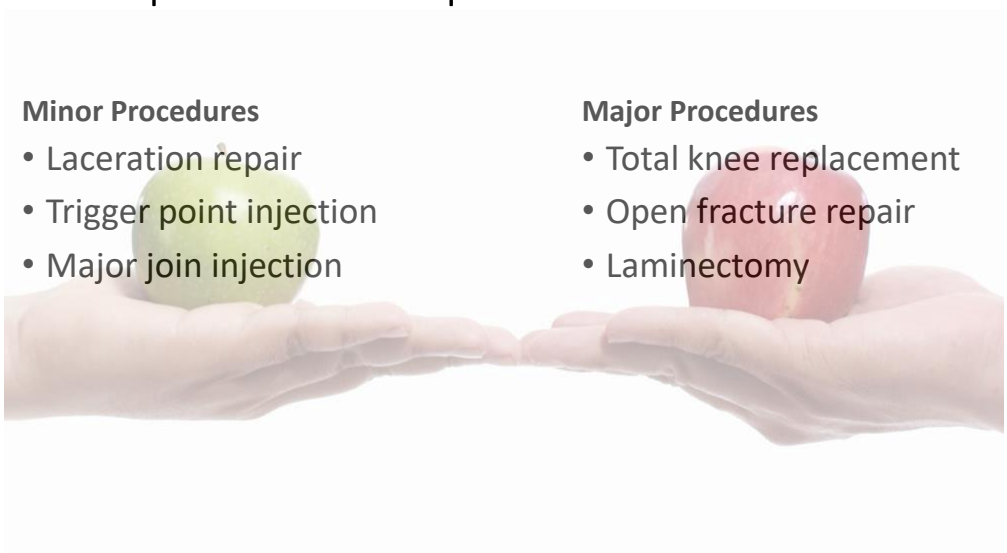
Examples for Comparison



Minor Procedures

- Laceration repair
- Trigger point injection
- Major join injection

Major Procedures

- Total knee replacement
- Open fracture repair
- Laminectomy

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Services NOT Included in These Categories

Office based radiology services

Lab services

Nursing services
- Vitals
- Administration of injection

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Global Care Services

- Global refers to “package” pricing of procedural services by a carrier
- Global payment is NOT optional- intentionally unbundling a service could be construed as fraud
- Exception- multiple providers involved with different portions of the total surgical care (noted below)
- Payment includes the following services:
  - Pre-operative work for major surgical services
  - Decision making service for minor procedures
  - The procedural work
  - Routine post-operative care
  - Usual aftercare complications

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The Math Behind the Global Package

EXAMPLE:
27447: Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing

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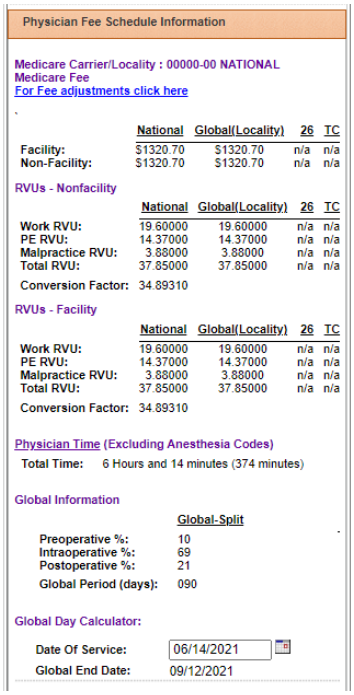

Physician Fee Schedule Information

Medicare Carrier/Locality : 00000-00 NATIONAL
Medicare Fee
For Fee adjustments click here

	National	Global(Locality)	26	TC
Facility:	$1320.70	$1320.70	n/a	n/a
Non-Facility:	$1320.70	$1320.70	n/a	n/a

RVUs - Nonfacility

	National	Global(Locality)	26	TC
Work RVU:	19.60000	19.60000	n/a	n/a
PE RVU:	14.37000	14.37000	n/a	n/a
Malpractice RVU:	3.88000	3.88000	n/a	n/a
Total RVU:	37.85000	37.85000	n/a	n/a
Conversion Factor:	34.89310			

RVUs - Facility

	National	Global(Locality)	26	TC
Work RVU:	19.60000	19.60000	n/a	n/a
PE RVU:	14.37000	14.37000	n/a	n/a
Malpractice RVU:	3.88000	3.88000	n/a	n/a
Total RVU:	37.85000	37.85000	n/a	n/a
Conversion Factor:	34.89310			

Physician Time (Excluding Anesthesia Codes)
Total Time: 6 Hours and 14 minutes (374 minutes)

Global Information

	Global-Split
Preoperative %:	10
Intraoperative %:	69
Postoperative %:	21
Global Period (days):	090

Global Day Calculator:

Date Of Service: 06/14/2021
Global End Date: 09/12/2021

Major Procedures: Pre-operative Care

- Global days are 90 days for major procedures
- Once the decision for surgery is made, the all-inclusive fee starts
  - If surgery is billed on the same day as an E&M service, the claim will be denied;
  - However, we can append a modifier and the carrier will pay for both
  - 57 modifier indicates that the decision for surgery was made on the same day as the surgical service was provided
  - Do NOT use this modifier if surgery is not performed the same day
- If the decision is made beyond 24 hours, no need for a modifier

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Modifier 24

- *Within the regulation, CMS has stated modifier 24 reports an unrelated evaluation and management service by the same physician during a postoperative period.*
- *This is for those situations where a physician performed surgery on a patient then needs to see them for some reason unrelated to the surgery they performed.*

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Modifier 24

- ***Services submitted with the "-24" modifier must be sufficiently documented to establish that the visit was unrelated to the surgery. A diagnosis code that clearly indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation.***
- Consider this: what is the global package of care?

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Modifier 24

- **What services are included in the global surgery payment?**
- When the physician who furnishes the surgery also furnishes the following services, Medicare includes them in the global surgery payment:
- Preoperative visits after the decision is made to operate. For major procedures, this includes preoperative visits the day before the day of surgery. For minor procedures, this includes preoperative visits the day of surgery;
- Intra-operative services that are normally a usual and necessary part of a surgical procedure;
- All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications, which do not require additional trips to the operating room;
- **Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;**
- **Post-surgical pain management by the surgeon;**
- Supplies, except for those identified as exclusions: and
- Miscellaneous services, such as dressing changes, local incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

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Modifier 24

What services are not included in the global surgery payment?

Services of other physicians related to the surgery, except where the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ASC record;

Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery;

Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery;

Diagnostic tests and procedures, including diagnostic radiological procedures;

Clearly distinct surgical procedures that occur during the postoperative period which are not reoperations or treatment for complications;

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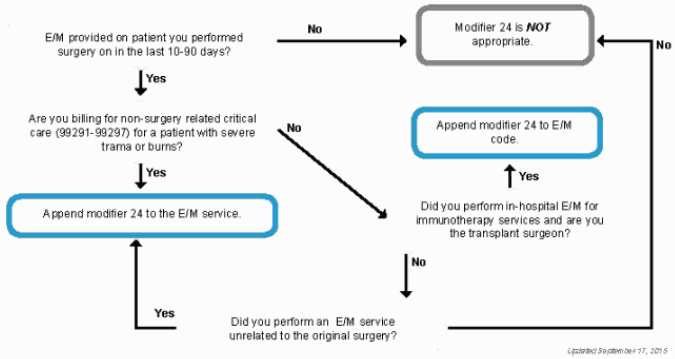
Modifier 24



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Examples to Help Us Learn

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Example:

In the Inpatient setting, the hospitalist requested an Ortho Consult for Jane. Upon evaluation, ortho makes the decision for surgical intervention.

Interactive response requested as yes or no in your questions/chat box

1. Can ortho bill for the consult and surgery?
2. Does the Ortho need a modifier?
3. What code set does the modifier append to?

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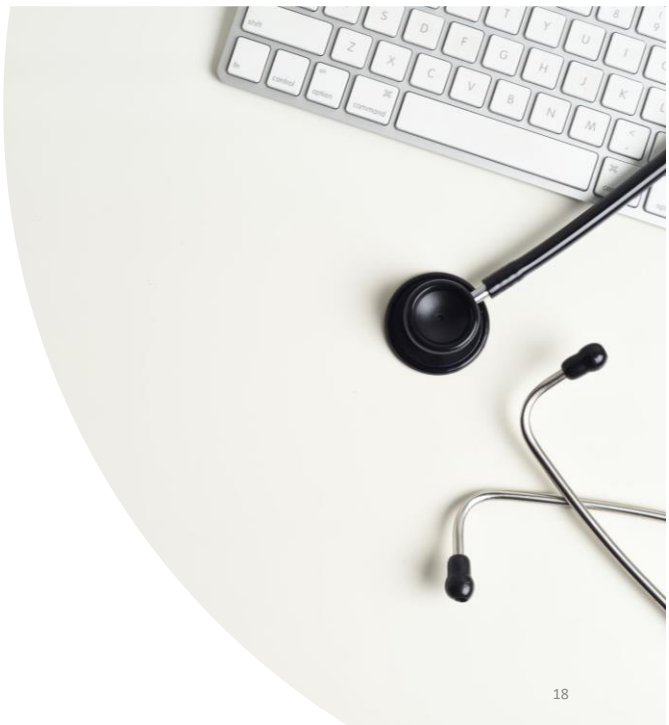
Change the Example:

Ortho sees Jane in their office and makes the decision to schedule surgery for next week

Same questions…

1. Can ortho bill for the E&M and surgery?
2. Does the ortho need a modifier?



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Intra-Procedural Services

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- Self explanatory except when it is not
- CPT descriptions provide specifics as to the work expectations for each reported service, and a "layman's description" of the service
- Example:

  42820: Tonsillectomy and Adenoidectomy under 12

  The physician removes the tonsils and adenoids. The physician accesses the tonsils and adenoids in an intraoral approach. First, the physician removes the tonsils by grasping the tonsil with a tonsil clamp and dissecting the capsule of the tonsil. The tonsil is removed. Bleeding vessels are clamped and tied. Bleeding may also be controlled using silver nitrate and gauze packing. Using a mirror or nasopharyngoscope for visualization, the physician uses an adenotome or a curette and basket punch to excise the adenoids. Alternate surgical techniques for a tonsillectomy and adenoidectomy include electrocautery, laser surgery, and cryogenic surgery. Report 42820 if the patient is under 12 years. For patients 12 years or older, report 42821.
- If the procedure varies from this, a modifier would be required on the surgical service

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Intraoperative Modifiers

- 22: Increased Procedural Services- when the work required to provide a service is substantially greater than typically required. Separate documentation should be found in the OP report for support
- 50: Bilateral Procedure- unless otherwise identified in the description, bilateral procedures that are performed at the same session
- 51: Multiple Procedures- multiple procedures performed at the same session by the same individual and are for like/similar reasons and sometimes include the same incision point
- 52: Reduced Services: under certain circumstances a procedure is partially reduced or eliminated at the discretion of the physician and therefore the service no longer meets the service description
- 59: Distinct Procedural Services: procedures that are distinct or independent of the other services. Documentation must support a different session, different procedures, different site/organ, separate incision/excision, separate lesion, or separate injury site

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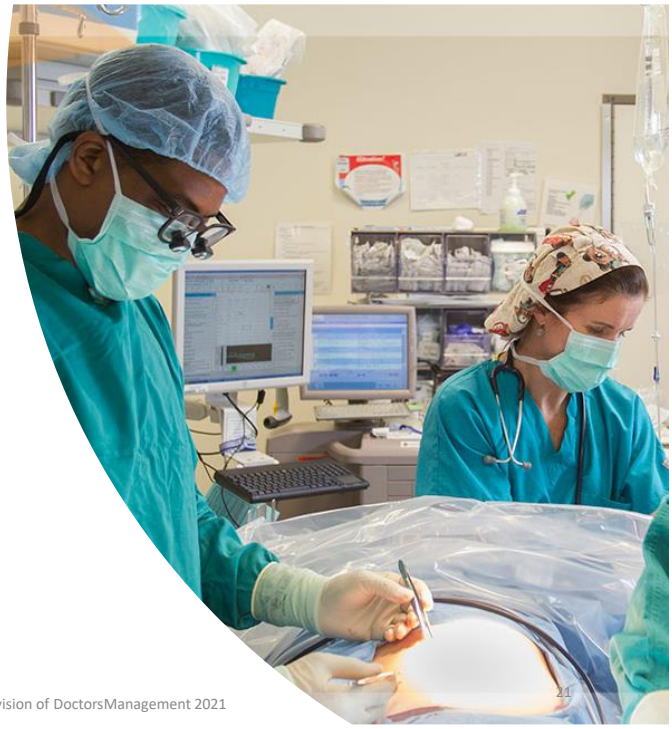
Modifiers to Identify Parties Involved:

- 62: Two Surgeons- 2 surgeons work together as primary surgeons performing distinct parts of a procedure
- 66: Surgical Team- highly complex procedures may be carried out under a team surgery concept.
- Assist-at-surgery:
  - Depends on who the assist is and who the carrier is:
    - AS modifier- use for PA, NP, or CNS assist
    - 80 modifier- use for MD assist
    - 82 modifier- used for MD assist in lieu of a resident



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Post-Operative Services

- Services rendered to the patient and type after the intra-operative services are complete
- Usual services are non-covered
  - Inpatient follow up
  - Office visit follow ups
  - Minor post-operative complications
- There will be cases in which services may be billable during the post-operative period

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Billable Post-Operative Services

- E&M services are only reimbursable during the global period if:
  - The visit is unrelated to the reason for the surgical service
    Example: The patient had surgery due to open fracture of the ankle and today they complain of wrist pain
  - The visit results in a treatment plan beyond that of routine post-operative care and/or minor complications
    Example: The patient has developed MRSA and will now require IV antibiotic therapy
  - This type of encounter could occur in the office setting or in the inpatient setting
    Example: Post-operatively the patient becomes anemic and in need of a blood transfusion
  - A modifier 24 is required on the E&M service

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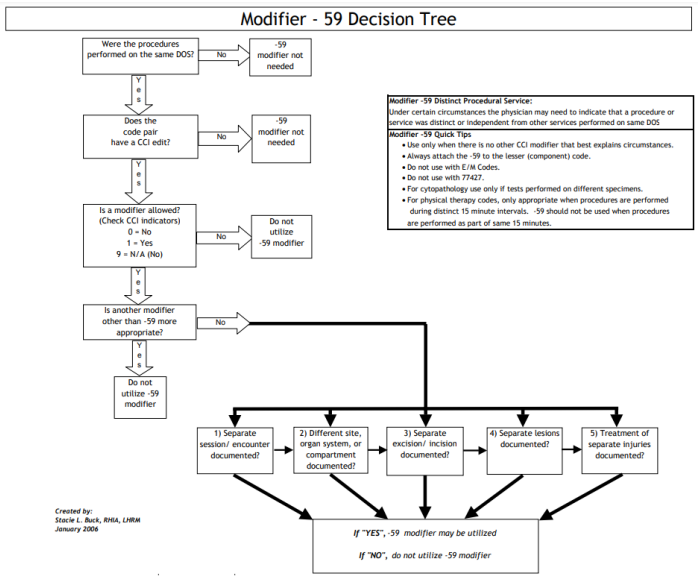

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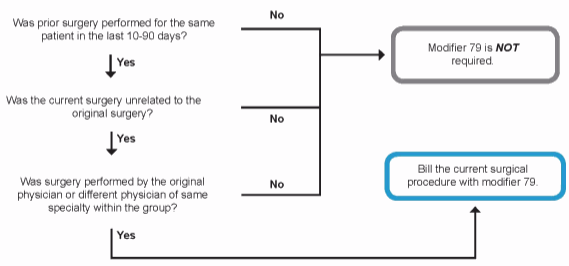
Modifier 79



Updated October 21, 2015

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Pre-procedural Work

- More commonly referred to as the decision-making process
- For years carriers have waffled back and forth as to whether this is included with the procedure or not
- THIS DECISION-MAKING PROCESS IS NOT REIMBURSED IN ADDITION TO THE PROCEDURE
- Exceptions do exist

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Exceptions to the Rule

- The E&M visit is reimbursable if the visit occurred for a problem other than the reason for the procedure
  - Example: Patient has a wart removed, but also has a sinus infection
- In these instances, the provider is reimbursed for the work related to the "other" problem and NOT the procedural diagnosis
- Therefore, in such encounters ensure your documentation appropriately address both presenting problems

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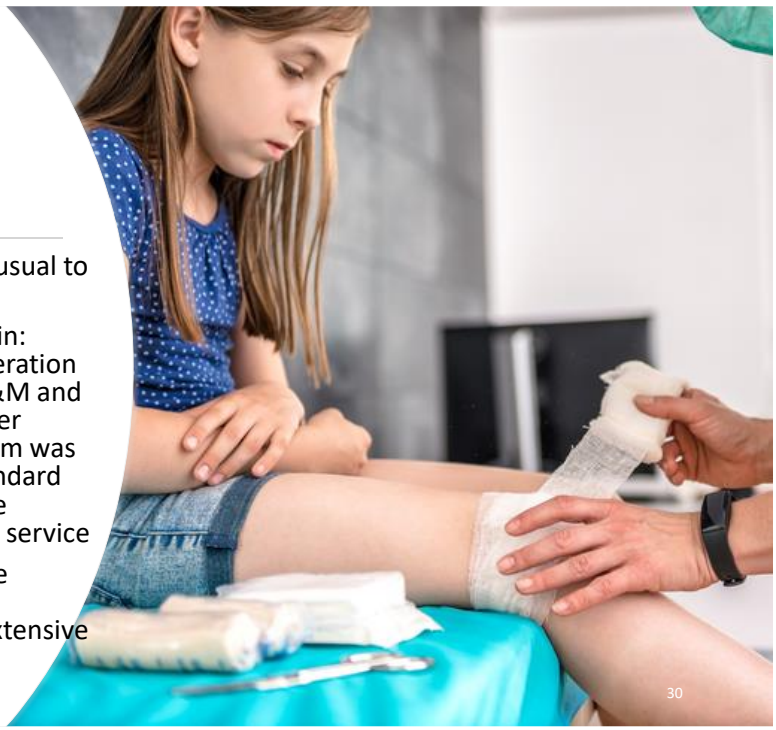
Exceptions to the Rule

- More extensive workup needed than usual to make the decision for the procedure.
- The example used by carriers to explain: Open wound to the head requires laceration repair. This would NOT allow for an E&M and laceration repair. However, the provider documented that a full neurologic exam was also required. Since this is not the standard workup for laceration repair, this more extensive eval could support the E&M service
- In these instances, we recommend the provider include a statement in their encounter to clearly state the more extensive work performed



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Modifier 25

National Government Services has identified problems common with claims submitted for evaluation and management (E&M) Services where modifier 25 was appended.

Use of modifier 25 indicates a "significant, separately identifiable E&M service by the same physician on the same day of the procedure or other therapeutic service."

Both services must be significant, separate and distinct. In general, Medicare considers E&M services provided on the day of a procedure to be part of the work of the procedure, and as such, does not make separate payment.

The exception to that rule is when the E&M documentation supports that there has been a significant amount of additional work above and beyond what the physician would normally provide, and when the visit can stand alone as a medically necessary billable service.

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Modifier 25

- *When billing an E&M service along with a procedure, your documentation must clearly demonstrate that:*
  - *the purpose of the evaluation and management service was to evaluate a specific complaint;*
  - *the complaint or problem addressed can stand alone as a billable service;*
  - *you performed extra work that went above and beyond the typical work associated with the procedure code;*
  - *the key components of the appropriately selected E&M service were actually performed and address the presenting complaint;*
  - *the purpose of the visit was other than evaluating and/or obtaining information needed to perform the procedure/service; and*
  - *both the medically necessary E&M service and the procedure are appropriately and sufficiently documented by the physician in the patient's medical record to support the claim for these services.*

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Medicare Modifier 25 Example

- *A patient comes to the office with complaints of right knee pain. The physician takes a history and does an exam. An X-ray of the knee is obtained and the physician writes an order for physical therapy. He determines that the patient would benefit from a cortisone injection to the affected knee. What do you think?*
- *In this case, a separate and significant E&M service was prompted by the knee pain for which the cortisone injection was given.*
- *We would expect that providers will use modifier 25* ***only when they can clearly substantiate that the visit was medically necessary, significant and distinctly separate from the procedure or therapeutic service they provided to the same patient on the same date of service.***

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NCCI Edits

Do you have all of the resources?

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NCCI Edits

- The most common issue is using modifiers to bypass the edits when a modifier is NOT warranted.
- Remember that unbundling modifiers are the most targeted sources for audits--- so what do you need to know?

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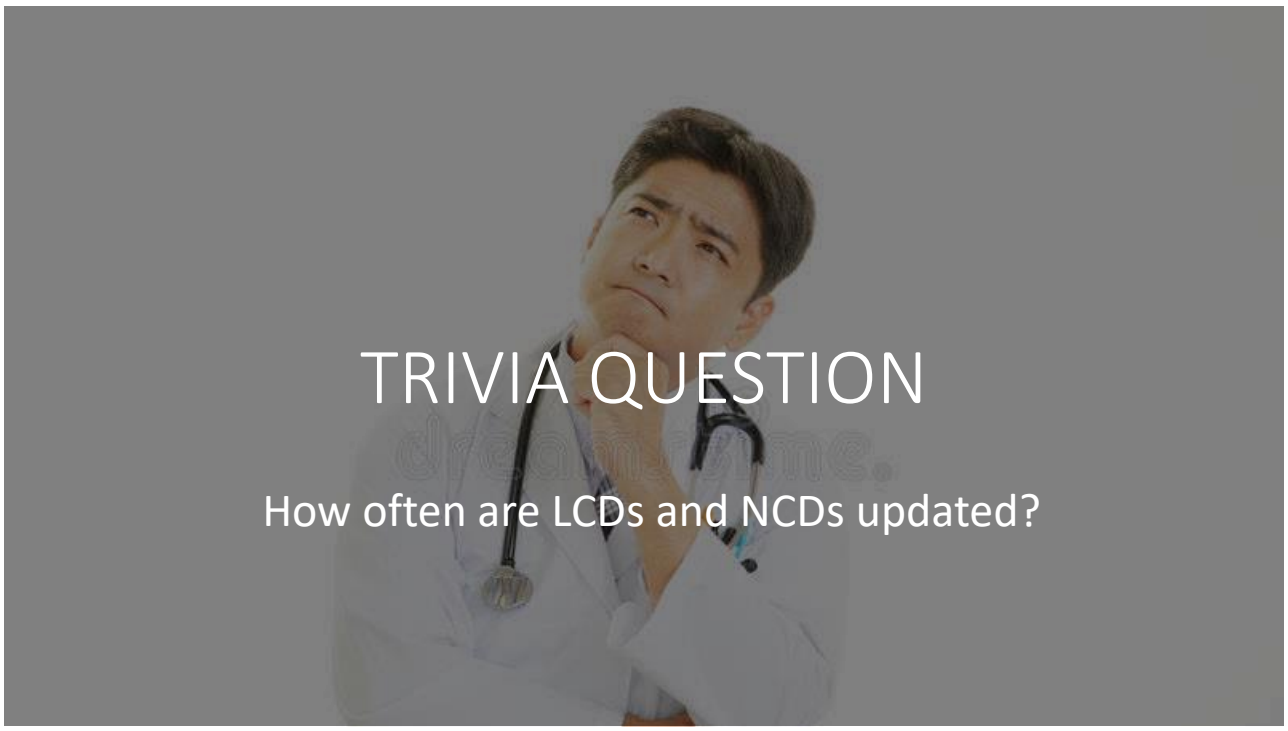

TRIVIA QUESTION

How often are LCDs and NCDs updated?

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National Coverage Determinations (NCD)

- Coverage policy that specifically includes information regarding frequency, coding, diagnoses that are applicable, and other specific information for when the service is covered
- Found on the CMS website:

  http://www.cms.hhs.gov/Coverage

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NCD Information

- May request a modification to an active NCD
- Formal request is required
- Visit the same website as listed previously for the NCD listings to find out the steps needed

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National Coverage Determination (NCD) for Lipid Testing (190.23)

Tracking Information

Publication Number	Manual Section Number	Manual Section Title
100-3	190.23	Lipid Testing

Version Number	Effective Date of this Version	Implementation Date
2	1/1/2005	3/11/2005

Description Information

Benefit Category
Diagnostic Laboratory Tests

Please Note: This may not be an exhaustive list of all applicable Medicare benefit categories for this item or service.

Item/Service Description

Lipoproteins are a class of heterogeneous particles of varying sizes and densities containing lipid and protein. These lipoproteins include cholesterol esters and free cholesterol, triglycerides, phospholipids and A, C, and E apoproteins. Total cholesterol comprises all the cholesterol found in various lipoproteins.

Factors that affect blood cholesterol levels include age, sex, body weight, diet, alcohol and tobacco use, exercise, genetic factors, family history, medications, menopausal status, the use of hormone replacement therapy, and chronic disorders such as hypothyroidism, obstructive liver disease, pancreatic disease (including diabetes), and kidney disease.

In many individuals, an elevated blood cholesterol level constitutes an increased risk of developing coronary artery disease. Blood levels of total cholesterol and various fractions of cholesterol, especially low density lipoprotein cholesterol (LDL-C) and high density lipoprotein cholesterol (HDL-C), are useful in assessing and monitoring treatment for that risk in patients with cardiovascular and related diseases. Blood levels of the above cholesterol components including triglyceride have been separated into desirable, borderline and high risk categories by the National Heart, Lung and Blood Institute in their report in 1993. These categories form a useful basis for evaluation and treatment of patients with hyperlipidemia. Therapy to reduce these risk parameters includes diet, exercise and medication, and fat weight loss, which is particularly powerful when combined with diet and exercise.

Indications and Limitations of Coverage

Indications

The medical community recognizes lipid testing as appropriate for evaluating atherosclerotic cardiovascular disease. Conditions in which lipid testing may be indicated include:

- Assessment of patients with atherosclerotic cardiovascular disease.
- Evaluation of primary dyslipidemia.
- Any form of atherosclerotic disease, or any disease leading to the formation of atherosclerotic disease.
- Diagnostic evaluation of diseases associated with altered lipid metabolism, such as: nephrotic syndrome, pancreatitis, hepatic disease, and hypo and hyperthyroidism.
- Secondary dyslipidemia, including diabetes mellitus, disorders of gastrointestinal absorption, chronic renal failure.
- Signs or symptoms of dyslipidemias, such as skin lesions.
- As follow-up to the initial screen for coronary heart disease (total cholesterol + HDL cholesterol) when total cholesterol is determined to be high (>240 mg/dL), or borderline-high (200-240 mg/dL) plus two or more coronary heart disease risk factors, or an HDL cholesterol, <35 mg/dl.

To monitor the progress of patients on anti-lipid dietary management and pharmacologic therapy for the treatment of elevated blood lipid disorders, total cholesterol, HDL cholesterol and LDL cholesterol may be used. Triglycerides may be obtained if this lipid fraction is also elevated or if the patient is put on drugs (for example, thiazide diuretics, beta blockers, estrogens, glucocorticoids, and tamoxifen) which may raise the triglyceride level.

When monitoring long term anti-lipid dietary or pharmacologic therapy and when following patients with borderline high total or LDL cholesterol levels, it may be reasonable to perform the lipid panel annually. A lipid panel at a yearly interval will usually be adequate while measurement of the serum total cholesterol or a measured LDL should suffice for interim visits if the patient does not have hypertriglyceridemia.

Any one component of the panel or a measured LDL may be reasonable and necessary up to six times the first year for monitoring dietary or pharmacologic therapy. More frequent total cholesterol HDL cholesterol, LDL cholesterol and triglyceride testing may be indicated for marked elevations or for changes to anti-lipid therapy due to inadequate initial patient response to dietary or pharmacologic therapy. The LDL cholesterol or total cholesterol may be measured three times yearly after treatment goals have been achieved.

Electrophoretic or other quantitation of lipoproteins may be indicated if the patient has a primary disorder of lipoid metabolism.

Effective January 1, 2005, the Medicare law expanded coverage to cardiovascular screening services. Several of the procedures included in this NCD may be covered for screening purposes subject to specified frequencies. See 42 CFR 410.17 and section 100, chapter 18, of the Claims Processing Manual, for a full description of this benefit.

Limitations

Lipid panel and hepatic panel testing may be used for patients with severe psoriasis which has not responded to conventional therapy and for which the retinoid etretinate has been prescribed and who have developed hyperlipidemia or hepatic toxicity. Specific examples include erythrodermia and generalized pustular type and psoriasis associated with arthritis.

Routine screening and prophylactic testing for lipid disorder are not covered by Medicare. While lipid screening may be medically appropriate, Medicare by statute does not pay for it. Lipid testing in asymptomatic individuals is considered to be screening regardless of the presence of other risk factors such as family history, tobacco use, etc.

Once a diagnosis is established, one or several specific tests are usually adequate for monitoring the course of the disease. Less specific diagnoses (for example, other chest pain) alone do not support medical necessity of these tests.

When monitoring long term anti-lipid dietary or pharmacologic therapy and when following patients with borderline high total or LDL cholesterol levels, it is reasonable to perform the lipid panel annually. A lipid panel at a yearly interval will usually be adequate while measurement of the serum total cholesterol or a measured LDL should suffice for interim visits if the patient does not have hypertriglyceridemia.

Any one component of the panel or a measured LDL may be medically necessary up to six times the first year for monitoring dietary or pharmacologic therapy. More frequent total cholesterol HDL cholesterol, LDL cholesterol and triglyceride testing may be indicated for marked elevations or for changes to anti-lipid therapy due to inadequate initial patient response to dietary or pharmacologic therapy. The LDL cholesterol or total cholesterol may be measured three times yearly after treatment goals have been achieved.

If no dietary or pharmacological therapy is advised, monitoring is not necessary.

When evaluating non-specific chronic abnormalities of the liver (for example, elevations of transaminase, alkaline phosphatase, abnormal imaging studies, etc.), a lipid panel would generally not be indicated more than twice per year.

Note: Scroll down for links to the quarterly Covered Code Lists (including narrative).

Cross Reference

Medicare Claims Processing Manual, Chapter 120, Clinical Laboratory Services Based on Negotiated Rulemaking.

Covered Code Lists (including narrative)

January 2018 (ICD-10)
October 2017 (ICD-10)
July 2017 (ICD-10)
April 2017 (ICD-10)
January 2017 (ICD-10)

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Incident-to

The do's and don'ts---- or maybe just the don'ts

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Incident-to

- What is it?
- Why do practices/physicians want to use incident-to?
- What are the rules?
- When do the rules apply?
- Who can provide Incident-to services?
- What about physical therapy?

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Billing Office

Know how to know what's going on in your office….

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Billing Office: CYA

Daily close	Monthly close
Direct each individual for a daily review of all services Balance each day practice wide	This is typically done Should balance to the overall daily

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Daily Close

- Every aspect of the billing practice should be balanced and closed
  - Charges
  - Payments
  - Adjustments
- Practice daily close
  - All payments
  - All charges
  - All adjustments
  - Balanced to the bank
- Consider deferring a cash option for payment

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Questions

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namas
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