Medicare Reimbursement Challenges

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Financial Interest

E. Ann Rose is President of Rose & Associates and acknowledges a financial interest in this subject matter.

Current Issues
CCI Edits

- Last year CCI bundled office visits with all surgical procedures (0/10/90 day global)
  - Exams have always been considered global
  - They were just never bundled in CCI before
  - In order to be paid, providers use modifiers to let Medicare know special circumstance occurred
    - e.g., modifier -25 with minor surgery to indicate exam was more than just normal pre- and post-operative workup of procedure

CCI Edits

- CMS forgot ophthalmology had two sets of exam codes they use (E&M and eye codes)
  - Did not include edit to permit eye codes to be paid when modifiers -24, -25, or -57 was used
    - Particularly effected was modifier -25 with retina injections, code 67028
  - Effective July 1, 2014, CCI will reinstate modifier bundling edits

CCI Edits

- Pay close attention to the appropriateness of using these modifiers
  - Modifier -24 is appended to office visit in global fee period
    - Indicates service is unrelated to the surgical episode
    - Cannot append -24 modifier to post-op visits
    - Cannot use with known complications of surgery
  - Tip: Would patient have needed to be seen had surgery not been performed?
    » If answer is no, then don’t append -24 modifier
CCI Edits

- Modifier -25 is used when exam is a significantly, separately identifiable service from the procedure performed
  - If exam is only to determine need for injection in eye scheduled for treatment, visit should not be billed
- Modifier -25 cannot be used as the “initial evaluation for surgery” like the -57 modifier
  - This is a big misconception among physicians
- Modifier -25 is on OIG radar
  - According to OIG 35% of claims allowed did not meet modifier -25 requirements
  - Resulted in $538M overpayment

CCI Edits

- Make sure you know modifier -25 is being used correctly
- Tip: Take exam for minor surgery out of mix for a minute
  - Do you have anything left in exam?
  - If answer is no, then don’t append -25 modifier
- Modifier -57 is to be appended the day before or day of a major surgery (90 day global)
  - Indicates initial evaluation to determine need for surgery

CCI Edits

- Modifier -59 is used to identify distinct procedure on same day as another procedure
  - Must be performed at different session or in different segment of eye
  - Even if “different procedure,” must still be performed in different segment or at different session
- Modifier -59 is still on OIG radar
  - Use only when no other modifier applies
  - Use very rarely to avoid audit
MUEs

- There were changes to the Medically Unlikely Edits (MUE) in 2013
  - Caused claim denials
    - Procedures billed on two lines with -RT and -LT modifiers
    - Procedures billed with repeat or distinct modifier and one line without
  - When service only allows 1 unit per day, only one is paid

MUEs

- When procedures or services are performed on both eyes at the same session physicians should:
  - Append the -50 modifier on one line only
  - Bill "1" unit
  - Increase your charge
- ASCs still required to bill bilateral services on two lines
  - Using the -RT and -LT modifiers

New Patient

- CPT definition of new patient
  - "A new patient is one who has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years."
  - Note: Medicare does not recognize sub-specialties in ophthalmology for reimbursement purposes
New Patient Billing

- CMS previously edited new patient exams based solely on Tax ID # of practice
  - Recent changes to CMS Common Working File (CWF) changed this
    - CMS now edits new patient exams by NPI number not just Tax ID #
    - Exam will be denied if provider saw that patient anywhere during the past 3 years regardless of where he/she worked

New Patient Billing

- If new physician joins practice and sees his/her patients in new practice, should not bill new patient exam
  - Medicare will deny claim
- Patient sent to you for test because referring doctor did not have equipment
  - No face-to-face exam conducted
  - If patient returns to you for exam within 3 years, must bill as established patient because professional service previously provided

CMS-1500 Claim Form

- CMS revised CMS-1500 claim form
  - Effective 4/1/14 paper claims must be submitted on new form
    - Version 02-12 – located in lower right-hand corner of form
  - Most notable changes for filing Medicare claims include:
    - New indicators to differentiate between ICD-9 and ICD-10 codes on claims
CMS-1500 Claim Form

• Qualifiers to identify if provider has ordering, referring, or supervising role in furnishing services
• Use of letters instead of numbers as diagnosis code pointers
• Expands number of possible diagnosis codes on a claim to 12

CMS-1500 Claim Form

• Item 17 – Name of referring provider or rendering source
  – A qualifier must be added to the left of the dotted vertical line on item 17
    » DN – Referring Provider
    » DK – Ordering Provider
    » DQ – Supervising Provider
  – If claim requires multiple referring/ordering physicians, use separate CMS-1500 claim form for each doctor
• Item 17b – NPI
  – Enter NPI of provider performing service (referring, ordering, supervising physician, or non-physician practitioner)

CMS-1500 Claim Form

Referring Provider or Rendering Source

<table>
<thead>
<tr>
<th>17. Name of Referring Provider or Other Source</th>
<th>17a.</th>
</tr>
</thead>
<tbody>
<tr>
<td>DN</td>
<td>John Jones, MD</td>
</tr>
</tbody>
</table>

** DK – Indicates Ordering Provider
This doctor “ordered” and rendered the service
CMS-1500 Claim Form

* Item 21 – diagnosis code field expanded to accept more diagnosis codes and ICD-10 (7-digit) diagnosis codes
  - Now includes an ICD Ind (Indicator) field
  - Enter "9" when using ICD-9 codes
  - Enter "0" when you begin using ICD-10 codes
  - Enter between the vertical, dotted lines
* Item 21 - Uses letters A-L instead of 1, 2, 3, etc.
  - Must enter the diagnoses in priority order
    - From left to right
  - DO NOT insert a period in the diagnosis codes

CMS-1500 Claim Form

* Item 24E – Diagnosis Pointer
  - This is a required field
  - Enter diagnosis code “letter” as shown in item 21 (A-L)
  - Enter only one reference letter per line item for Medicare claims
    - Commercial payers may permit more than one
  - When multiple services are shown, enter the primary reference letter for each service

A. 36616 B. 37033 C. 37924 D. __________
E. _________ F. _________ G. __________ H. __________
I. __________ J. _________ K. __________ L. __________

24. A. Dates of Service  B. Place of Service  C. EMG  D. Procedures, Services or Supplies  E. Diagnosis Pointer

<table>
<thead>
<tr>
<th>M. A. Dates of Service</th>
<th>N. Place of Service</th>
<th>O. EMG</th>
<th>P. Procedures, Services or Supplies</th>
<th>Q. Diagnosis Pointer</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/01/2014</td>
<td>90014</td>
<td>C</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Patient here for annual cataract check. Also complained of dry eyes and floaters in fellow eye.**
CMS-1500 Claim Form

- Can do internet search for CMS-1500 instructions
  - Medicare
    - Make sure the document comes from CMS
    - Look for CMS Transmittal or CMS Claims Processing Internet Only Manual
  - Commercial payers
    - Look for NUCC instructions
    - NUCC is the National Uniform Claim Committee responsible for maintenance of 1500 claim form

Consolidated Billing

- Consolidated billing continues to be a problem
  - What is consolidated billing?
    - Medicare Part A covers skilled nursing home stays for patients for a period of time if they were in the hospital for at least 3 days
    - The SNF must bill Medicare for all services SNF patients receive during their Part A stay
      - With some exceptions

Consolidated Billing

- Services excluded include
  - A physician’s professional service (e.g., exam)
  - Professional component of any diagnostic test performed on the SNF patient
    - Test must be billed to Medicare with -26 modifier only
  - Technical component of test is included in the SNF’s reimbursement
    - Practices should work with SNFs to invoice the SNF directly for the technical component of the test
Consolidated Billing

- Some injectables are included in consolidated billing as well
  - The physician should not bill Medicare for medications administered to SNF patients such as:
    - Avastin
    - Celestone
    - Depo-Medrol
    - Dexamethasone
    - Fluorouracil
    - Garamycin

- Kenalog
- Lucentis
- Solu-Medrol
- Vancomycin
- Verteporfin

- SNF can purchase drugs
  - Not likely to happen
- Physician should purchase drugs and invoice SNF
  - Even when injection is performed in physician’s office

Consolidated Billing

- SNF also responsible for DME services furnished to their patients
  - Optical shops should invoice SNF for glasses provided to patients in a Part A stay
    - Do not bill DME MAC
  - If glasses provided outside the 100-day SNF covered Part A stay
    - Okay to bill DME MAC

Consolidated Billing

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Place of Service

- Normally POS code reflects actual setting where beneficiary receives face-to-face service
  - There are a few exceptions:
    - Inpatient
      - If inpatient seen in your office must bill place of service as hospital (21), not office
    - Outpatient or Rehab Patient
      - If patient seen in your office must bill place of service as outpatient or rehab (22), not office

Femtosecond Laser

- CMS FS laser guidance
  - Refractive imaging component of FS laser performed on premium AC-IOL and PC-IOL cataract patients before surgery has begun is non-covered service
  - Can bill premium IOL patients for OCT imaging
  - Fee usually included in premium IOL charge
  - Cannot charge fee for Femtosecond laser used intraoperatively (during surgery) such as:
    - Phaco incision, capsulotomy, lens fragmentation

Femtosecond Laser

- Cannot bill patient Femtosecond OCT imaging performed on conventional IOL patients
  - CMS expects FS laser on these patients to be rare
    - Even if no charge
  - Will negate argument that only premium IOL patients need this special imaging
- LRI/CRI performed with FS laser at same time as conventional IOL surgery
  - Is billable to patient separately
  - If performed on premium IOL patients fee usually included in premium IOL charge
Documentation Issues

Cloned Documentation

- Cloned Documentation big issue in EHR
  - EHR must follow same documentation requirements as paper chart
    - Progress note must accurately reflect what occurred at current visit
  - Chief complaint
    - Must be pertinent to today’s visit only
      - Can be a new or continued complaint or previously diagnosed condition
    » May be found in Plan of previous visit
  - CC also drives level of service for E&M (99) codes

- Even when information is “somewhere” else in EHR
  - Cannot be counted for documentation for any and all dates of service
  - Notes must reflect “today’s” service in order to get credit for that information
  - For example, if PFISH not documented in today’s record
    - Medicare auditor would not know there was PFISH in a previous record or even if provider reviewed it
Cloned Documentation

– If HPI obtained by allied staff
  • Must be repeated by physician and either re-recorded or annotated with specific comments, additions, and/or corrections and notation of elements of work personally performed by physician
– Old adage still applies to EHRs
  • If it isn’t documented, it wasn’t done!

Cloned Documentation

– Templates can be beneficial but can also create problems
  • Sometimes ROS and Exam templates are pulled into every exam to save time
  • If additions and/or deletions to the template are not made at every visit, the documentation begins to look the same for each patient
  • Thus the OIG’s issue with “cloned documentation”
  • According to OIG, cloned documentation does not meet medical necessity requirements for coverage

Cloned Documentation

– How do you combat this problem?
  • Print out a few progress notes from your EHR as though you were going to send them in for audit
    – In many cases, print out is different than what you see when working in EHR
    – Remember, this is what an auditor will be looking at
  • Look for contradictory information not supported in the documentation on that date of service
  • Work with physicians and allied staff to see how this documentation problem can be remedied
Late Entries

- Medicare expects documentation to be generated at time of service or shortly thereafter
  - Delayed entries (24-48 hours) are acceptable for purposes of:
    - Clarification
    - Error correction
    - Addition of information not initially available
    - Unusual circumstances prevented medical records entry at time of service

Source: First Coast – Florida Medicare contractor

Late Entries

- Entries beyond 48 hours could be considered unreasonable
  - Providers should comply and complete timely documentation in a timely manner
  - Coders and billers need to be aware of timeliness of medical record completion
    - It's unreasonable to expect a provider to recall the specifics of a service two weeks after the service was rendered
    - Nor should an entry ever be made in advance

Diagnostic Tests
Visual Fields

- Visual Fields – MN for eyelid surgery
  - Once with lids taped, and
  - Once with lids not taped
- According to CPT Assistant, this is a single isopter test
  - Code 92081 is correct code
  - Some payers may permit different codes or the use of -76 modifier on second line item
    - Check with your MAC for specific instructions

Bilateral/Unilateral

- Most diagnostic tests are considered bilateral
  - Payment includes both eyes
    - If CPT description indicates “unilateral or bilateral,” Medicare inherently pays as a bilateral service
    - -52 modifier not required
    - If CPT description does not indicate unilateral or unilateral/bilateral (e.g., 92020, 92060)
      - Append -52 modifier to indicate only one eye tested

Bilateral/Unilateral

- Some tests are unilateral and can be billed to Medicare “per eye”
  - 76512 – Contact B-scan
  - 92071 – Fitting of contact lens, ocular disease
  - 92225 – Extended ophthalmoscopy, initial
  - 92226 – Extended ophthalmoscopy, subsequent
Bilateral/Unilateral

- 92230 – Fluorescein angioscopy
- 92235 – Fluorescein angiography
- 92240 – ICG

• Diagnostic tests are payable during the global fee period
  • No modifier required
  • Do not use -25 modifier with diagnostic tests – may cause audit
  • Chart must be clear as to who ordered test and who performed the service

Test Results

• All test results must be readily available
  - In some instances, photos and results of tests may not be in the paper chart or the EMR
    - Sometimes stored digitally
  - The medical record must document the location of the diagnostic test in this case
    - Disc C, dated 4/1/13, etc., or
    - Notation as to where test result can be found

Interpretation & Report

• There appears to be an increasing lack of compliance with Interpretation & Report requirements
• An “interpretation and report” should address the findings, relevant clinical issues, and comparative data (when available)
  • Source: Medicare Claims Processing Manual, 100-4, 13.§100
Interpretation & Report

• At minimum MD should address:
  – What was seen or not seen but anticipated
    • Glaucoma
  – What findings suggest as to status of illness
    • Stable, worsening, improving
  – What impact the test results have on treatment
    • Continue present meds, surgery as indicated, see Plan, etc.
• Physician must also sign and date I&R

COMPLIANCE

Non-compliance Can Affect Reimbursement

SMRC Auditor

• Supplemental Medical Review Contractor
  – The newest contractor auditor
    • These audits triggered when volume is an outlier
    • When any service is billed at greater percentage than his/her peers could receive SMRC audit
      – Exams
      – Tests
      – Surgeries
      – Modifiers
### SMRC Auditor

- Will receive request for records
  - Typically 10 – 35 charts
- If 50% or more of the chart don’t meet criteria below, may take more punitive action in recoupment
  - Match level of exam billed;
  - Meet criteria for test performed;
  - Comply with documentation requirements for surgery performed, or
  - Apply to modifier appended

### SMRC Auditor

- Need to take pro-active approach to avoid adverse audit results from SMRC
  - Conduct internal and external audits regularly
  - Be aware of Local Coverage Determinations (LCDs) and monitor regularly for revised LCDs

### Comparative Billing Report

- Comparative Billing Report (CBR)
  - Tool used by CMS to educate providers about individual billing practices
    - Includes summary of individual provider’s utilization by procedure code
    - Also notifies provider of areas of billing that may vary from peers
    - Compares each procedure code billed to other provider’s billing in same specialty
Comparative Billing Report

– Usually done for the most current six-month reporting period
  • January through June
  • July through December

• If you receive CBR
  – Pay close attention to chart and graphs showing your utilization
  • If you appear as outlier consider recommendations in CBR to correct issue

Comparative Billing Report

– Consider external audit to correct issues and develop compliance plan
  • Recommend external audit be conducted under attorney-client privilege

– Should also conduct internal audits on a regular basis
  • Refund any overpayments to Medicare identified in audits

Comparative Billing Report

• Providers can also request CBR
  – Request must be in writing
    • Request must be made and signed by physician or practitioner requesting CBR
      – Cannot be requested by office manager, administrator, or other staff member
  – Information on how to request CBR should be available on Medicare contractor website
    • Usually provides CBR form to be completed
### Compliance Plan

- Implementing reimbursement compliance plan does not have to be difficult
  - Per OIG, compliance plan should contain the following 7 core elements
    - Implement written policies
    - Designate compliance officer
    - Conduct comprehensive training and compliance
      - On documentation and billing
    - Develop accessible lines of communication

- Conduct internal monitoring and auditing
  - May consider conducting annual external audits to use as guide for internal audits
  - Enforce standards through well-publicized disciplinary guidelines
    - Respond promptly to detected offenses and take corrective actions
  - Any or all of the above will put you one step ahead of most practices with regard to compliance
  - [www.oig.hhs.gov](http://www.oig.hhs.gov)

### ICD-10
Ready or Not – Here I Come

• So Congress voted on one-year delay of ICD-10
  • It only affects CMS patients
  • Some payers may be moving forward with ICD-10
  – Basic training now will help identify areas of weakness
  • Will provide more time for additional training
  – Delaying training will just put you in the same boat this time next year
  • Be proactive and be prepared

Questions