Addressing Payment Delays and Barriers to Organizational Cash Flow for Fiscal Sustainability

PRIMARY CARE DEVELOPMENT CORPORATION

Today's Presenter

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AHIMA Approved ICD-10-CM
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Exam Prep Facilitator

With over 25 years of experience, Ms. Murphy currently works for JMS Billing Solutions, LLC as a Healthcare consultant providing an array of services ranging from revenue cycle management to medical record documentation and coding, and chart auditing.

She is responsible for many of JMS' health care clients providing expertise in revenue cycle management, coding education and has supported capacity building technical assistance training initiatives.

Acronyms Used

- AMA: American Medical Association
- CARC: Claim Adjustment Reason Code
- CMS: Centers for Medicare and Medicaid Services
- CPT: Current Procedural Terminology
- EDI: Electronic Data Interchange
- EOB: Explanation of Benefits
- ERA/RA: Electronic Remittance Advance

Acronyms Used

- HCPCS: Healthcare Common Procedure Coding System
- HIPAA: Health Insurance Portability and Accountability Act
- ICD-10-CM: International Classification of Diseases, 10th Revision Clinical Modification
- NPDB: National Practitioner Data Bank NPDB
- NPI: National Provider Identifier
- NPPES: National Plan and Provider Enumeration System
- RARC: Remittance Advice Remark Code

Agenda

- Recalibration of matching provider licenses to grant requirements
- Guidance on checking NPI status and diversifying funding
- Preparing, addressing and vigilance around clean claims
- The role of medical necessity and proper documentation in coding and accurate billing
- Billing and Coding Scenarios
- Q&A

Poll

What role do you play at your health care center or facility:

1. Clinical staff (MD's, NP's, PA's, RN's, etc)
2. Office Manager/ Supervisor
3. Biller, Coder, Insurance Follow up specialist
4. Front desk/Patient registration
5. Other (C-suite, etc)

Approved Healthcare Providers

Providers must:

- be board certified physicians or certified nurses (M.D.'s, N.P's, P.A.'s, etc
- Possess valid license, NPI number and/or participating provider ID number

Ancillary health care professionals:

- perform services based on requesting physician's orders documented
- not designated as providers that qualify for reimbursement

Examples:

- Phlebotomists
- Medical office assistants
- LPN's

Approved Healthcare Providers

Approved Primary Care Specialties:

- Family Practice/Family Medicine
- Internal Medicine/Adult Medicine
- OB/GYN
- Pediatrics
- Pathology & Laboratory

Sub-specialties (list is not extensive):

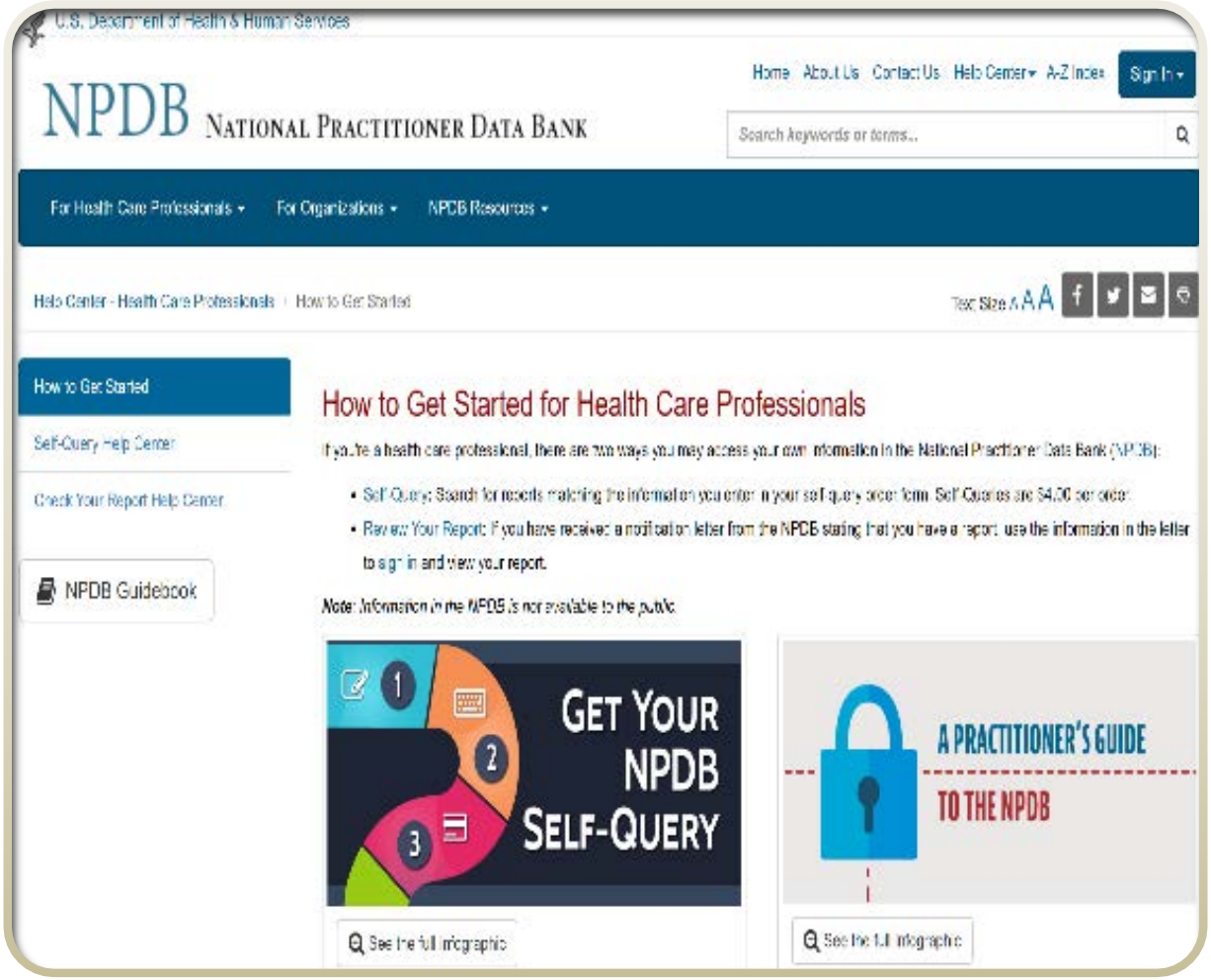
- Allergy/Immunology
- Behavioral Health
- Cardiology
- Clinical Neurophysiology
- Critical Care
- Emergency Medicine
- Geriatrics
- Hematology
- Infectious Disease

Provider Data Requirements

National Practitioner Data Bank (NPDB) query

- Web based repository with provider medical malpractice and adverse events
- Promotes quality healthcare
- Fraud and abuse deterrent

https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp

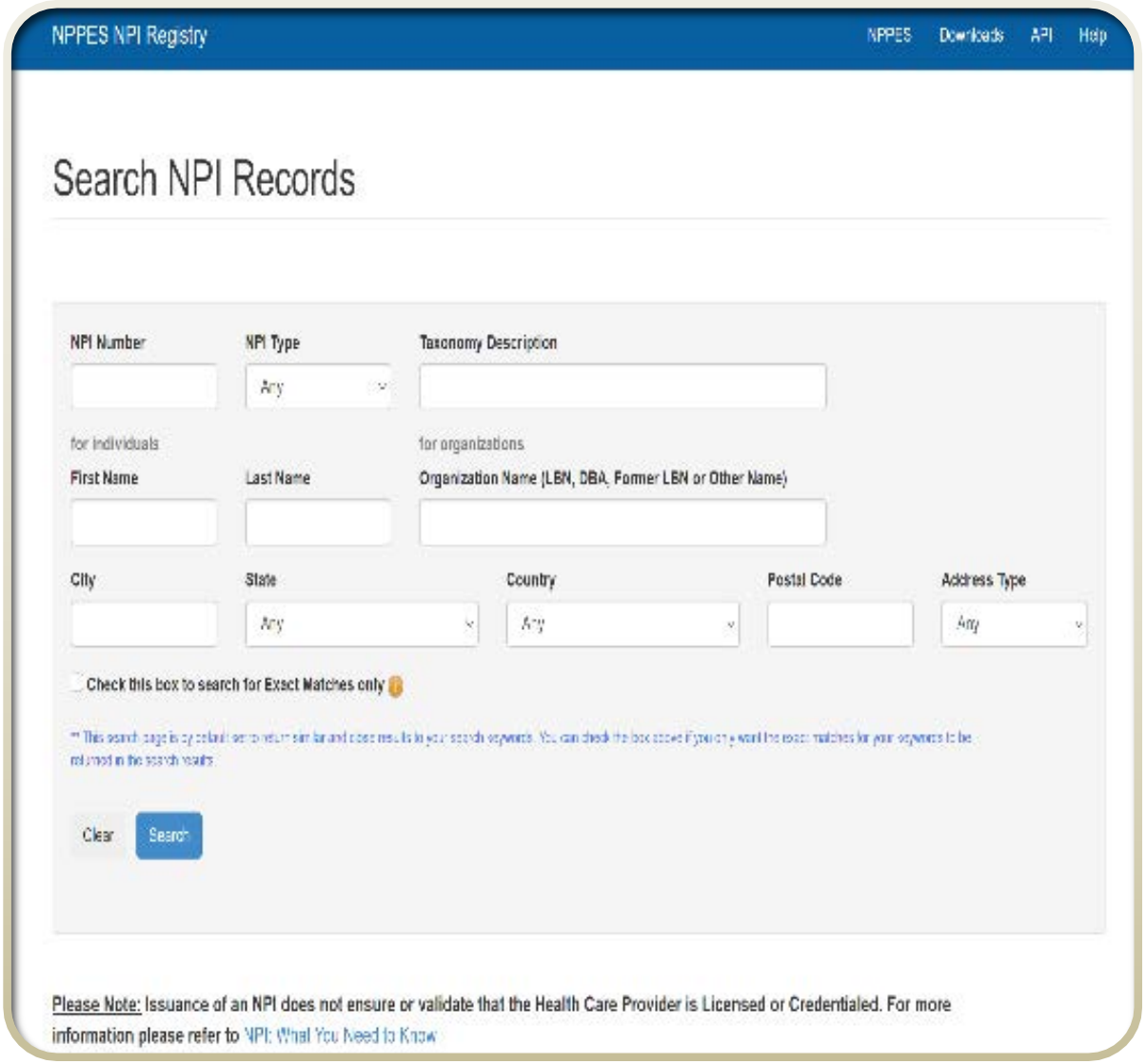


Provider Data Requirements

National Plan and Provider Enumeration System (NPPES) NPI (National Provider Identifier) Registry

- Located on CMS's website
- A unique 10-digit number assigned to every health care entity and health practitioners
- Reported on all HIPAA transactions (to submit claims to insurance carriers

https://npiregistry.cms.hhs.gov/
https://nppes.cms.hhs.gov/#/

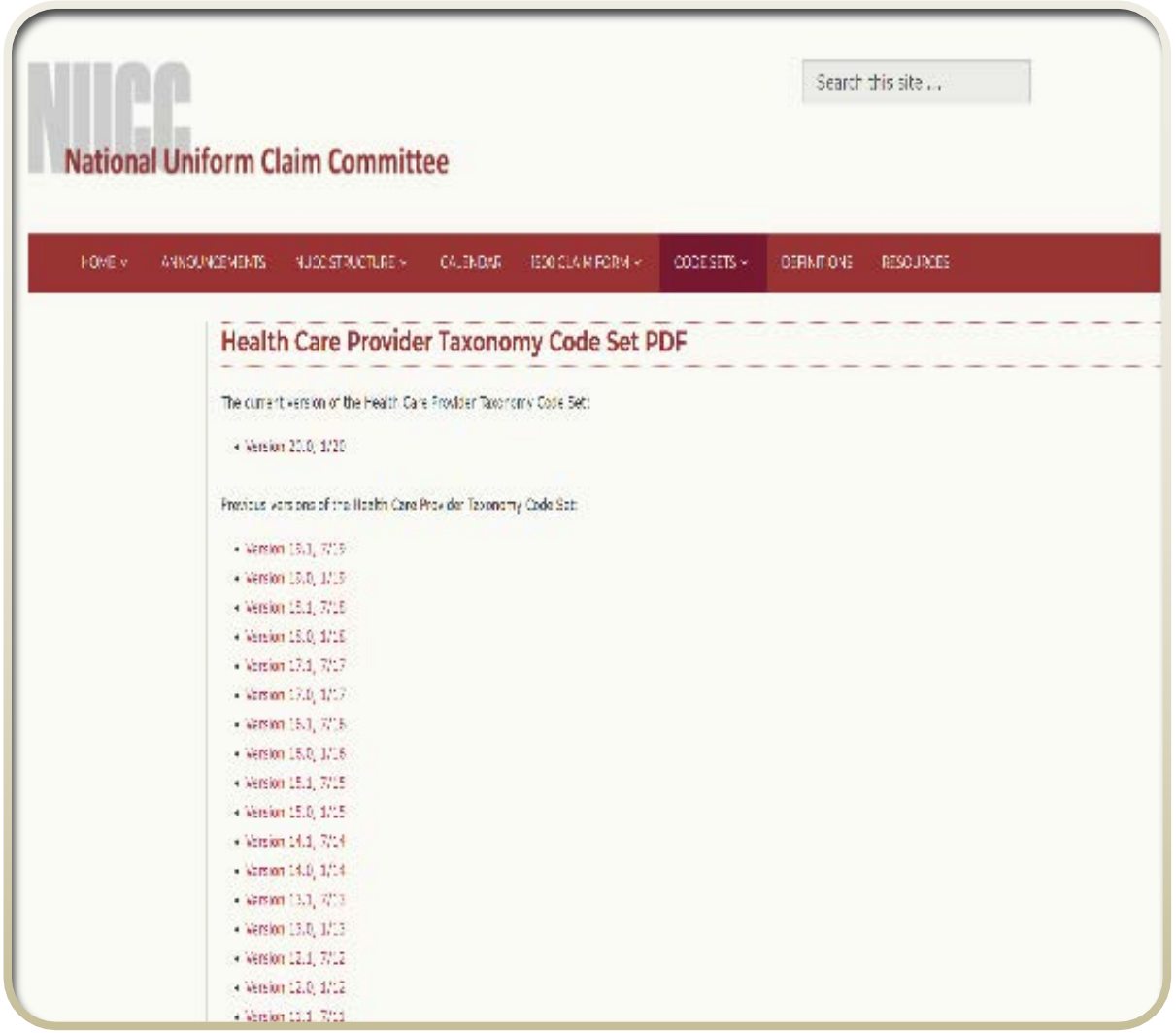


Provider Data Requirements

Healthcare Provider Taxonomy

- Categorizes provider type, classification and health care specialty
- Two sections; individuals and groups
- Must be reported on the NPI application

http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40



Provider Data Requirements

Provider Taxonomy: Group vs Individual

Group

A business entity under which one or more individuals practice. A group does not require multiple professional providers. A single provider group is a valid group and would be identified by the business entity name, for instance- John Doe, PC.

193200000x Multi-specialty
A business group of one or more individual practitioners who practice with different areas of specialization.

193400000x Single specialty
A business group of one or more individual practitioners, all of who practice with the same area of specialization.

207 Q00000x Family Medicine
Family medicine is the medical specialty which is concerned with the total health care of the individual and the family. It is the specialty in breadth which integrates the biological, clinical, and behavioral sciences. The scope of family medicine is not limited by age, sex, organ system, or disease entity.

207QA0401x Addiction Medicine
A family medicine physician who specializes in the diagnosis and treatment of addictions.

207QA0000x Adolescent Medicine
A family medicine physician with multidisciplinary training in the unique physical, psychological and social characteristics or adolescents and their health care problems and needs.

Provider Data Requirements

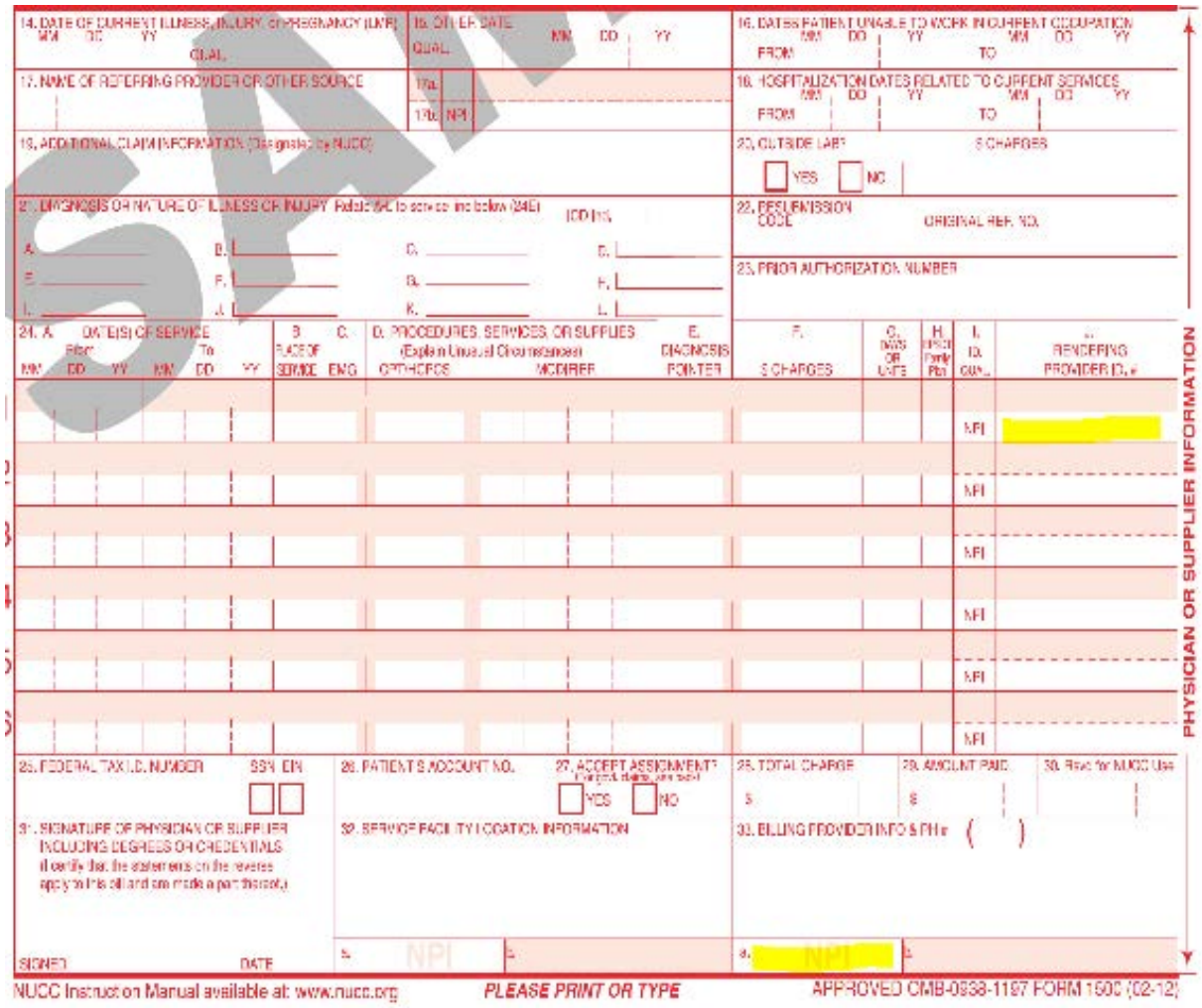
Electronic Claim 837P/837I

- 2010A/A NM1 Segment

Manual Paper Claim

- Item#24J – rendering provider NPI number (group practice)
- Item#32A – NPI# for facility/location where service was rendered
- Item#33A – NPI number for billing provider

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/NPI-What-You-Need-To-Know.pdf



Poll

TRUE/FALSE:

Services performed by ancillary providers such as LPN's, medical office assistants, phlebotomists, etc. can be submitted/billed to insurance carriers?

Payor Reimbursement Guidelines vs Coding Guidelines

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What is a "Clean Claim"?

- A claim that:
  - Has no defect or impropriety
  - Includes the proper documentation
  - Submitted timely
  - Submitted to the correct health insurance payor
  - Is adjudicated and paid by health insurance payor without resubmitting the claim

What is a "Clean Claim"?

CMS' definition:

A claim that has no defect impropriety or special circumstance including incomplete documentation that delays timely payment

- A complete and accurate claim form contains all pertinent:
  - Provider information
  - Guarantor/patient information
  - HIPAA compliant code sets (CPT, HCPCS and ICD-10)

Elements of a "Clean Claim"

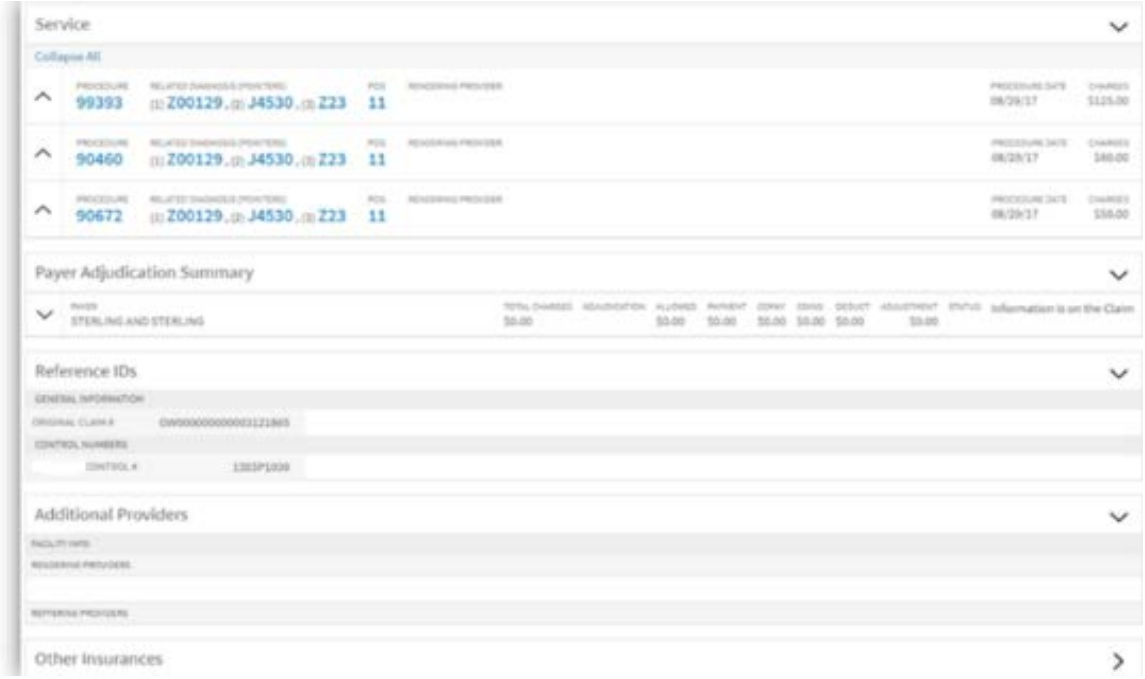
- Guarantor/Patient's insurance ID number
- Guarantor/Patient's name
- Guarantor/Patient's date of birth and gender
- Guarantor/Patient's address (street, city, state, zip)
- Patient's relationship to guarantor
- Whether patient's condition is related to employment, auto accident, or other accident
- Guarantor's insurance ID number
- Guarantor's date of birth and gender
- Insurance health plan name
- Disclosure of any other health insurance coverage
- Patient/authorized person's signature or notation that the signature is on file with the health care provider (consent for treatment)
- Guarantor/Authorized person's signature or notation that the signature is on file with the health care provider (consent to pay)

Claim Scrubber

- Claim editing software that reviews each claim line to verify that HIPAA compliant code combinations are valid and support medical necessity
- Generates report which details accepted and rejected claims
- Some claim scrubbers also check the accuracy of claim charges based upon the contracted rate allowing optimization of claim charges and minimizing revenue loss

Claim Management Additional Fields

View additional details, such as service lines with procedure and diagnosis codes, the adjudication summary, and referring and rendering providers.



Claim Types

Rejected

- Claim does not meet minimum data requirements established by the clearinghouse
- Claim not transmitted to payer
- Clearinghouse generates edit report which details accepted and “rejected” claims
- Rejected claims must be corrected and resubmitted

Duplicate

- Claim matches previously submitted claim

Denied

- Claim meets the minimum requirements for submission to health insurance plan
- Claim submitted, accepted, adjudicated then denied by payer
- Denied claims can be appealed

Suspended

- Claim submitted, accepted and placed in suspended status
- Payer requests additional information to adjudicate

Rejected

- Missing or invalid provider NPI/ID number
- Guarantor/Patient eligibility
- Provider not on file
- Guarantor/Patient not on file
- Guarantor/Patient ID number not on file
- Missing/incorrect HIPAA compliant code sets
- Missing/incorrect modifiers

Denied

- Bundled service
  - Service is considered part of another service
- Non covered service
- Service does not support medical necessity
- Missing/incorrect modifiers
- Guarantor/member has other insurance as primary
- Timely filing
- Previously paid/duplicate claim
- No Authorization/ precertification
- Frequency limits
- Missing/incorrect units
- Procedure code not valid for patient's age

Suspended/Pending

- Certain claims will trigger request for additional information (copy of the medical note/operative report, etc)
  - Submit copy of medical note/operative report for further consideration
  - Claims with modifiers
  - Diagnoses codes that describe injury and poisoning(S00-T88)
  - Random retrospective claim review
    - High dollar claims

Duplicate

- Top denial reason by most health insurance plans:
  - Unnecessary duplicate filing costs health facilities, providers and health plans time and resources
- Duplicate claims leads to:
  - Delays in adjudication and payment of “clean claims”
  - Health insurance plan increased monitoring to minimize fraud and abuse activity

Remittance Advice (RA)

- Statement from payer detailing procedures/services processed on the claim
  - Also referred to as:
    - Explanation of Benefits (EOB)
    - Electronic Remittance Advice (ERA)

Elements

- Guarantor/Patient name
- Guarantor/Patient ID number
- Provider name
- Provider ID/NPI number
- Claim Charge

- Amount paid/Zero paid
- Services covered/not covered
- Amount guarantor/patient responsible to pay (if any)
- HIPAA compliant code sets (CPT, HCPCS, ICD-10

Reading your Explanation of Benefits (EOB)
After you visit your provider, you may receive an Explanations of Benefits (EOB) from your insurer. This is an overview of the total charges for your visit and how much you and your health plan will have to pay. An EOB is NOT A BILL and helps to make sure that only you and your family are using your coverage. You may get a bill separately from the provider.

Here's an example of an Explanation of Benefits
Your insurance plan's or Medicaid or CHIP agency's **Customer Service Number** may be near the plan's logo or on the back of your EOB .

Explanation of Benefits (EOB)

Customer service: 1-800-123-4567

Statement date: XXXXXX
Document number: XXXXXXXXXXXXXXXXX
THIS IS NOT A BILL

Member name:
Address:
City, State, Zip:

Subscriber number: XXXXXXXXX ID: XXXXXXXXX Group: ABCDE Group number: XXXXXX

Patient name:
Date received:
Provider:
5 Payee:
Claim number: XXXXXXXXX
Date paid: XXXXXXXX

	Claim Detail			What your provider can charge you		Your responsibility			Total Claim Cost		
Line No.	Date of Service	1 Service Description	Claim Status	2 Provider Charges	3 Allowed Charges	Co-Pay	Deductible	Co-Insurance	4 Paid by Insurer	6 What You Owe	7 Remark Code
1	3/29/14–3/29/14	Medical care	Paid	$371.68	$12.15	$10.00	$10.00	$0.00	$12.15	$20.00	PDC
2	3/29/14–3/29/14	Medical care	Paid	$375.00	$118.12	$25.00	$10.00	$0.00	$82.12	$25.00	PDC
			Total	$406.68	$130.27	$35.00	$10.00	$0.00	$95.27	$25.00	

Remark Code: PDC—Billed amount is higher than the maximum payment insurance allows. The payment is for the allowed amount.

Pay your bills and keep any paperwork. Some providers will not see you if you have unpaid medical bills. You may be able to go online to look up your own health information, such as screening and test results or prescribed medications. This can help you take charge of managing your health.

APPEALS AND GRIEVANCES
If you have a complaint or are dissatisfied with a denial of coverage for claims under your health plan, you may be able to appeal or file a grievance. For questions about your rights, or assistance, you can contact your insurance plan or state Medicaid or CHIP program. If you think you were charged for tests or services your coverage is supposed to pay for, keep the bill and call the phone number on your insurance card or plan documentation right away. Insurance companies have call and support centers to help plan members.

1. **Service Description** is a description of the health care services you received, like a medical visit, lab tests, or screenings.
2. **Provider Charges** is the amount your provider bills for your visit.
3. **Allowed Charges** is the amount your provider will be reimbursed; this may not be the same as the Provider Charges.
4. **Paid by Insurer** is the amount your insurance plan will pay to your provider.
5. **Payee** is the person who will receive any reimbursement for over-paying the claim.
6. **What You Owe** is the amount the patient or insurance plan member owes after your insurer has paid everything else. You may have already paid a portion of this amount, and payments made directly to your provider may not be subtracted from this amount.
7. **Remark Code** is a note from the insurance plan that explains more about the costs, charges, and paid amounts for your visit.

Contact your health plan if you have questions about your EOB.

CMS Product No.
11499 June 2014

Group, Reason and Remark Codes

- Data elements used on remittance advices:
  - Claim Adjustment Group Codes
  - Reason Codes
  - Remark Codes and messages
- Washington Publishing Company

  www.wpc-edi.com/reference.com

Claim Adjustment Group Codes

- EDI standards that generally describe adjustment amounts
  - Typically begin with two alpha characters
    - Contractual Obligations (CO)
    - Corrections and Reversals (CR)
    - Other Adjustments (OA)
    - Payor Initiated Reductions (PI)
    - Patient Responsibility (PR)

Claim Adjustment Group Codes

- Contractual Obligation: describes joint contractual agreement
  - Regulatory requirement that denote write offs
    - Cannot bill guarantor/patient
- Corrections and Reversals:
- Other Adjustments: typically used when no other group code is applicable
- Payor Initiated Reductions: typically used for providers without carrier contracts
  - Cannot bill guarantor/patient
- Patient Responsibility: describes balances that are guarantor/patient responsibility
  - Deductibles, copayments, coinsurances

Reason and Remark Codes

Every claim assigned a claim adjudication status

- Reason Code/Claim Adjustment Reason Code (CARC)
- Explains why claim was paid/unpaid
- Shows reason for denial, payment reduction or increased payment

Remark Code/Remittance Advice Remark Code (RARC)

- Two Types
  - Supplemental: further explains claim adjudication status
  - Informational: non-financial information typically referred to as an “ALERT”
    - Alert N185: Do not resubmit this claim/service

Some reason codes are payor specific

Common Reason and Remark Codes

- CO4: Procedure inconsistent with modifier
- CO6: Procedure inconsistent with patient age
- CO9: Diagnosis inconsistent with patient age
- CO10: Diagnosis inconsistent with patient gender
- CO11: Diagnosis inconsistent with procedures
- CO16: Claim lacks information or has submission/billing errors which is needed for adjudication
- CO-18: Duplicate Services
- CO50: These are non-covered services because this is NOT deemed "medically necessity" by the payer

Common Reason and Remark Codes

- CO96: Non covered service
- CO97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- M20: Missing/incomplete/invalid HCPCS
- N115: This decision was based on Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered by the payer
- CO-147: Provider contracted rate expired/not on file
- CO181: Procedure code invalid on date of service

New York Medicaid

Edit ID: **00901**

Updated: 10/23/2017

Claim Type Unknown

Claim Adjustment Reason Code: **16**
CLAIM / SERVICE LACKS INFORMATION OR HAS SUBMISSION / BILLING ERROR(S).

Healthcare Claim Status Code: **145**
ENTITY'S SPECIALTY / TAXONOMY CODE.

Remark Code: **N34**
INCORRECT CLAIM FORM / FORMAT FOR THIS SERVICE.

Entity Identifier Code: **1P**
PROVIDER

CAUSE:
The eMedNY processing system could not determine the type of claim submitted. All claims are processed according to the regulations and policies for the type of claim, such as Practitioner, Hospital Inpatient, etc... For Clinic claims the system may not have derived the correct internal Category of Service. If a claim type cannot be determined, the claim cannot be processed and will fail edit 00901.

SOLUTION:
For Institutional (Rate-based) claims, verify the rate code, revenue code and bill type are correct for the claim. Check to ensure the date of service is correct for the revenue code/rate code combination.

For professional (procedure based) claims (physician etc), check to ensure the procedure code is correct and active. Check to ensure the date of service is after the start date for the billing provider.

If further assistance is necessary, Call the eMedNY Call Center at 1-800-343-9000.

Poll

When an insurance claim is missing the provider information, how will this claim be handled?

1. Denied
2. Rejected
3. Suspended
4. Duplicate

Poll

TRUE/FALSE: ERA's and EOB's are sent to patients only.

Poll

TRUE/FALSE: The acronym ERA stands for Electronic Rejection Advice.

Medical Necessity

The American Medical Association (AMA) policy H-320.953[3] defines medical necessity as:

Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is:

(a) in accordance with generally accepted standards of medical practice;

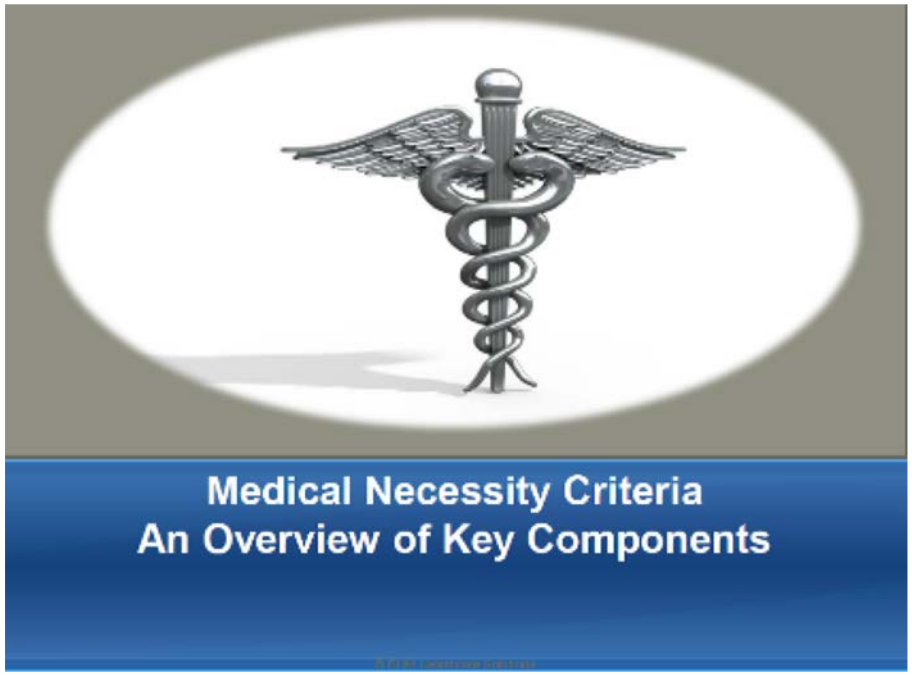
(b) clinically appropriate in terms of type, frequency, extent, site and duration; and

(c) not primarily for the convenience of the patient, physician, or other health care provider.

Medical Necessity

CMS Benefit Policy Manual, chapter 16, section 20, similarly defines medical necessity as, "services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member and not excluded under another provision of the Medicare Program."

In other words: Medical necessity means the services provided were appropriate based on the reason the patient was seen.



Medical Necessity

According to CMS' Claims Processing Manual, chapter 12, section 30.6.1:

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.

That is, a provider should not perform or order work (or bill a higher level of service) if it's not "necessary," based on the nature of the presenting problem.

Documentation Tips

"If it isn't documented, it hasn't been done" is an adage that is frequently heard in the health care setting.

Documentation Quality vs Quantity

More documentation does not mean better documentation!!

General Documentation Tips

- Medical record should be complete and legible
- Documentation of each patient encounter should include
  - Reason for encounter and relevant history
  - Physical examination findings
  - Prior diagnostic test results
  - Assessment, clinical impression or diagnosis
  - Plan for care
  - Date and legible identity of observer

General Documentation Tips

- If not documented, rationale for ordering diagnostic and other ancillary services should be easily inferred
- Past and present diagnoses should be accessible to treating and/or consulting physician
- Appropriate health risk factors should be identified
- Patient's progress, response to and changes in treatment, and revision of diagnosis should be documented
- Codes should be supported by the documentation in the medical record

Claim Examples

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EOB Example#1 – Paid Claim

48-year-old female patient presents with complaints of painful urination and fever. HPI denotes condomless sex with a new male partner. The physician performs chlamydia screening, HIV screening and counseling during this encounter and documents the final diagnoses as mild dysuria, fever. This is an established patient.

DOS	Proc Code/Mod	PDx	Billed amt	Paid amt	Remark Codes
07-15-2018	99213-25: E&M est pt, level 3	R30.0	$300.00	$160.60	CO-45
07-15-2018	86701-QW: HIV screen	Z11.4	$60.00	$18.67	CO-45, N115
07-15-2018	87810-QW,59: Chlamydia screen	Z11.8	$60.00	$16.33	CO-45, N115

EOB Example#1 – Rationale

- CO-45: Billed amount exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement

- N115: This decision was based on Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered by the payer

EOB Example#2 – Denied Claim (FQHC)

DOS	Proc Code/Mod	PDx	Billed amt	Paid amt	Remark Codes
07-15-2018	G0467: FQHC, est	R30.0	$300.00	$160.60	CO-45
07-15-2018	99213-25: E&M est pt, level 3	R30.0	$300.00	$0	CO-97
07-15-2018	86701-QW: HIV screen	Z71.89	$60.00	$0	CO-50
07-15-2018	87810-QW,59: Chlamydia screen	Z71.89	$60.00	$0	CO-50

Rationale

CO-50: These are non-covered services because this is NOT deemed "medically necessity" by the payer

EOB Example#3 – Paid Claim (FQHC)

DOS	Proc Code/Mod	PDx	Billed amt	Paid amt	Remark Codes
07-15-2018	G0467: FQHC, est pt	R30.0	$300.00	$160.60	CO-45
07-15-2018	99213-25: E&M est pt, level 3	R30.0	$300.00	$0	CO-97
07-15-2018	86701-QW: HIV screen	Z11.4	$60.00	$18.67	CO-45, N115
07-15-2018	87810-QW,59: Chlamydia screen	Z11.8	$60.00	$16.33	CO-45, N115

Rationale

CO-97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

EOB Example#4 – Paid Claim

54-year-old male patient presents for annual well visit. Physician performs HIV screening with counseling and also Flu vaccine (Afluria). Final diagnoses are: well visit, HIV screening with counseling and Flu vaccine. This is a new patient

DOS	Proc Code/Mod	PDx	Billed amt	Paid amt	Remark Codes
07-15-2018	99386-25: Well visit, est pt	Z00.00	$300.00	$160.60	CO-45
07-15-2018	86701-QW: HIV screen	Z11.4	$60.00	$16.33	CO-45, N115
07-15-2018	90658-SL, 59: Flu vaccine	Z23	$0.00	$0.00	CO-97
07-15-2018	90471: Vaccine adm	Z23	$60.00	$25.42	CO-45, N115

EOB Example#5 – Paid Claim (FQHC)

39 year-old male patient presents for annual well visit. Physician administers yearly HIV screening with counseling and also Flu vaccine (Afluria). Final diagnoses are: well visit, HIV screening with counseling and Flu vaccine. This is an established patient.

DOS	Proc Code/Mod	PDx	Billed amt	Paid amt	Remark Codes
07-15-2018	G0467 - FQHC, est pt	Z00.00	$300.00	$160.60	CO-45
07-15-2018	99395-25: Well visit, est pt	Z00.00	$300.00	$0	CO-97
07-15-2018	86701-QW: HIV screen	Z11.4	$60.00	$16.33	CO-45, N115
07-15-2018	90658-59: Flu vaccine	Z23	$60.00	$18.67	CO-45, N115
07-15-2018	90471: Vaccine adm	Z23	$60.00	$25.42	CO-45, N115

EOB Example#6 – Denied Claim (FQHC)

47-year-old female patient presents for annual well visit.

DOS	Proc Code/Mod	PDx	Billed amt	Paid amt	Remark Codes
07-15-2018	G0467 - FQHC, est pt	Z00.00	$300.00	$0	CO-6
07-15-2018	99397-25: Well visit, est pt	Z00.00	$300.00	$0	CO-6
07-15-2018	86701-QW: HIV screen	Z11.4	$60.00	$16.33	CO-45, N115
07-15-2018	90658-59: Flu vaccine	Z23	$60.00	$18.67	CO-45, N115
07-15-2018	90471: Vaccine adm	Z23	$60.00	$25.42	CO-45, N115

Rationale

CO-6: Procedure inconsistent with patient age

EOB Example#7 – Denied Claim Clover Health

55 year-old female patient presents for annual well visit and HIV screening.

DOS	Proc Code/Mod	PDx	Billed amt	Paid amt	Remark Codes
07-15-2018	99396-25: Well visit, est pt	E11.9	$300.00	$0	CO-147
07-15-2018	86701-QW: HIV screen	Z11.4	$60.00	$0	CO-147

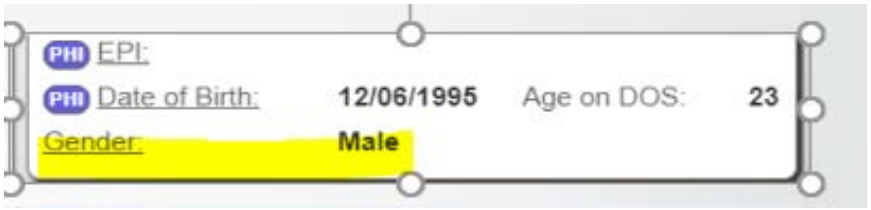
Rationale

CO-147: Provider contracted rate expired/not on file

EOB Example#8 – Denied Claim Amerigroup

23-year-old male patient presents for annual well visit and HIV screening. This is an established patient.

DOS	Proc Code/Mod	PDx	Billed amt	Paid amt	Remark Codes
07-15-2018	99394-25: Well visit, est pt	Z01.00	$300.00	$0	CO-06, CO-10
07-15-2018	86701-QW: HIV screen	Z11.4	$60.00	$16.33	CO-45, N115



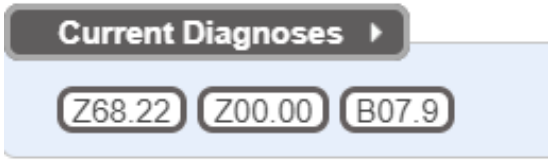
Rationale

CO-06: Procedure inconsistent with patient gender

CO-10: Diagnosis inconsistent with patient gender

EOB Example#9 – Denied Claim United Healthcare UHCCP

43-year-old female patient presents for annual well visit and HIV screening.



DOS	Proc Code/Mod	PDx	Billed amt	Paid amt	Remark Codes
07-15-2018	99397-25: Well visit, est pt	Z68.22	$300.00	$0	CO-11
07-15-2018	86701-QW: HIV screen	Z11.4	$60.00	$16.33	CO-45

Rationale

PR-3: Co-payment Amount

CO-45: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. This must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication.

CO-11: The diagnosis is inconsistent with the procedure.

CO-16: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation.

EOB Example#10 – Denied Claim Cigna Health

53-year-old male patient presents for an HIV screening visit.

This is a new visit.

DOS	Proc Code/Mod	PDx	Billed amt	Paid amt	Remark Codes
07-15-2018	99386-25: Well visit, est pt	Z71.89	$300.00	$0	CO-50
07-15-2018	86701-QW: HIV screen	Z11.4	$60.00	$16.33	CO-45

Rationale

CO-45: Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. This must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication.

CO-50: These are non-covered services because this is not deemed a 'medical necessity' by the payer

EOB Example#11 – Denied Claim Clover Health

52-year-old male patient presents for annual well visit and HIV testing.

DOS	Proc Code/Mod	PDx	Billed amt	Paid amt	Remark Codes
07-15-2018	99397-25: Well visit, est pt	N18.5	$300.00	$0	cl222
07-15-2018	86701-QW: HIV screen	Z11.4	$60.00	$16.33	CO-45, N115

Rationale

cl222 - Diagnosis Code Validation
Reason for Denial: Invalid and/or non-payable principal/primary diagnosis code used.
CMS website, Medicare Coverage Database (MCD); CMS website, Definitions of Medicare Code Edits

EOB Example#12 – Denied Claim Clover Health

62-year-old male patient presents for annual well visit and HIV screening.

I25.82	Chronic total occlusion of coronary artery
R94.30	Abnormal result of cardiovascular function study,
E11.65	Type 2 diabetes mellitus with hyperglycemia
E78.5	Hyperlipidemia, unspecified

DOS	Proc Code/Mod	PDx	Billed amt	Paid amt	Remark Codes
07-15-2018	99397-25: Well visit, est pt	I25.82	$300.00	$0	cl222
07-15-2018	86701-QW: HIV screen	Z11.4	$60.00	$16.33	CO-45, N115

Rationale

cl222 - Diagnosis Code Validation
Reason for Denial: Invalid and/or non-payable principal/primary diagnosis code used.
CMS website, Medicare Coverage Database (MCD); CMS website, Definitions of Medicare Code Edits

Poll

TRUE/FALSE: According to the ICD-10-CM Official Coding Guidelines, all diagnoses codes are acceptable as principal/primary diagnosis codes.

In Conclusion!

How to address payment delays and barriers to organizational cash flow?

Closing Comments

- Documentation and coding extremely important
  - Drives reimbursement
  - Provide documentation and coding training to clinical and non-clinical staff
  - All visits must be signed/completed by physicians within 24 hours
- Ensure code assignment is consistent with documentation
- Ensure all elements necessary for “clean claim” submission
- Submit claims timely
- Review claim submission/clearinghouse reports to identify and correct rejected claims

Closing Comments

- Report all diagnoses that reflect the care rendered
  - Principal diagnosis should always reflect reason why patient presented for medical care
  - Ensure proper sequencing of all diagnosis codes; especially for procedures & diagnostic tests
  - Codes reported on health care claims should match information documented in the health record
  - All chronic conditions noted in medical record should be coded accordingly
    - Greatly impacts reimbursement and Quality Measures (QARR, HEDIS and HCC risk adjustment)

Closing Comments

- When reporting diagnosis code for prescriptions, be sure to report the diagnosis code for the medical condition that establishes the reason for the prescription
- Codes reported on health care claims should match information documented in the health record
- Use current coding resources
  - CPT
  - ICD-10-CM
  - HCPCS

Closing Comments

- Check claim status for claims pending 15+ days
- Periodically review adjudicated/paid claims to ensure that payments are accurate and post them to accounts timely
- Review EOB's/ERA's to identify and correct denied claims
  - Review denials to determine if claims need correction (resubmission) or appeals
  - Do not resubmit denied claims!!!
    - Follow established payer instructions for submitting corrected claims/appeals process
  - Do not resubmit entire claim when partial payments rendered
    - Check with payor first!

Resources

- American Medical Association (AMA) –
  https://www.ama-assn.org/practice-management/cpt/covid-19-coding-and-guidance
- Centers for Medicare and Medicaid Services (CMS)
  https://www.cms.gov/Medicare/Coding/ICD10/ICD-10Resources
- New York State Medicaid Program (eMedNY)
  http://www.emedny.org/ProviderManuals/index.aspx
- National Center for Health Statistics (NCHS)
  https://www.cdc.gov/nchs/icd/icd10cm.htm
- The American Academy of Family Physicians (AAFP)
  https://www.aafp.org/practice-management/payment/payer.html

Resources

- National Practitioner Data Bank (NPDB) query

  https://www.npdb.hrsa.gov/topNavigation/aboutUs.jsp
- National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI) Registry

  https://npiregistry.cms.hhs.gov/

  https://nppes.cms.hhs.gov/#/
- Healthcare Provider Taxonomy

  http://www.nucc.org/index.php/code-sets-mainmenu-41/provider-taxonomy-mainmenu-40
- Washington Publishing Company

  www.wpc-edi.com/reference.com

Coding Resources

- CPT® 2020 Professional Edition. Publisher: American Medical Association.
- HCPCS Level II 2020. Publisher: Optum 360
- Pocket Guide to E&M Coding and Documentation. Publisher: Healthcare Quality Consultants.
- ICD-10-CM Physician 2020. Publisher: Optum 360.
- American Academy of Professional Coders (AAPC)
  https://www.aapc.com/icd-10/icd-10-documentation-example.aspx
- American Hospital Association (AHA)
  https://www.aha.org/issue-landing-page/2020-03-24-coronavirus-covid-19-telehealth-and-virtual-care
- American Health Information Management Association (AHIMA)
  http://www.ahima.org/topics/covid-19