REVENUE CYCLE INC SM

# Coding & Documentation Updates
# Part One

2016 Radiation Oncology Conference for Therapists & Dosimetrists

September 9, 2016

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Efforts have been made to ensure the information within this document was accurate on the date of presentation. Reimbursement policies vary from insurer to insurer and the policies of the same payer may vary within different U.S. regions. All policies should be verified to ensure compliance.

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# Objectives of this Presentation

- Present Attendees a Billing and Coding Overview
- Educate on Authoritative Guidance and Legislative Updates
- Provide Overview of Medicare Program
- Discuss Hot Topics
- Allow Interactive Discussion for Questions & Advice

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# Billing Scenarios

Hospital Outpatient

- Technical Services UB04
- Physician Services *(-26)* CMS 1500

Freestanding Facility

- Global Billing
  - Pro & Tech Services CMS1500
- Split Billing
  - Physician Services *(-26)* CMS 1500
  - Technical Services *(TC)* CMS 1500

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# Payment Systems

## MPFS

| CPT | Modifier | 2016 Payment |
|---|---|---|
| 77280 | Global | $276.05 |
| | TC | $239.53 |
| | 26 | $36.52 |
| 77290 | Global | $520.59 |
| | TC | $438.60 |
| | 26 | $81.99 |
| 77295 | Global | $495.89 |
| | TC | $271.75 |
| | 26 | $224.13 |
| 77301 | Global | $1,974.97 |
| | TC | $1557.13 |
| | 26 | $417.84 |

## HOPPS

| CPT | APC | 2016 Payment |
|---|---|---|
| 77280 | 5612 | $166.65 |
| 77290 | 5613 | $291.77 |
| 77295 | 5614 | $1,026.81 |
| 77301 | 5614 | $1,026.81 |

Services in the same APC group are paid at the same rate

In a hospital setting the physician is paid based on MPFS for the professional component

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# Claims Submission

## HOPPS on UB04

- Series or Recurring Accounts
- Physician = Attending MD
- Revenue Code

## MPFS on CMS1500

- Daily, weekly, etc.
- Physician = MD providing service/supervision
- Address should match the physical location services rendered
- Place of Service Code
- 26/TC modifiers
- Q6 Modifier for Locum Tenens

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# Authoritative Guidance

- Federal Register
- Centers for Medicare & Medicaid Services (CMS)
- American Medical Association & CPT® Manual
- OIG Compliance Standards
- Commercial Payor Policies

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# Federal Register

- Document actions of Federal agencies and forum for public review and comment
- Publications include:  Presidential Documents, Rule & Regulations, Proposed Rules and Notices

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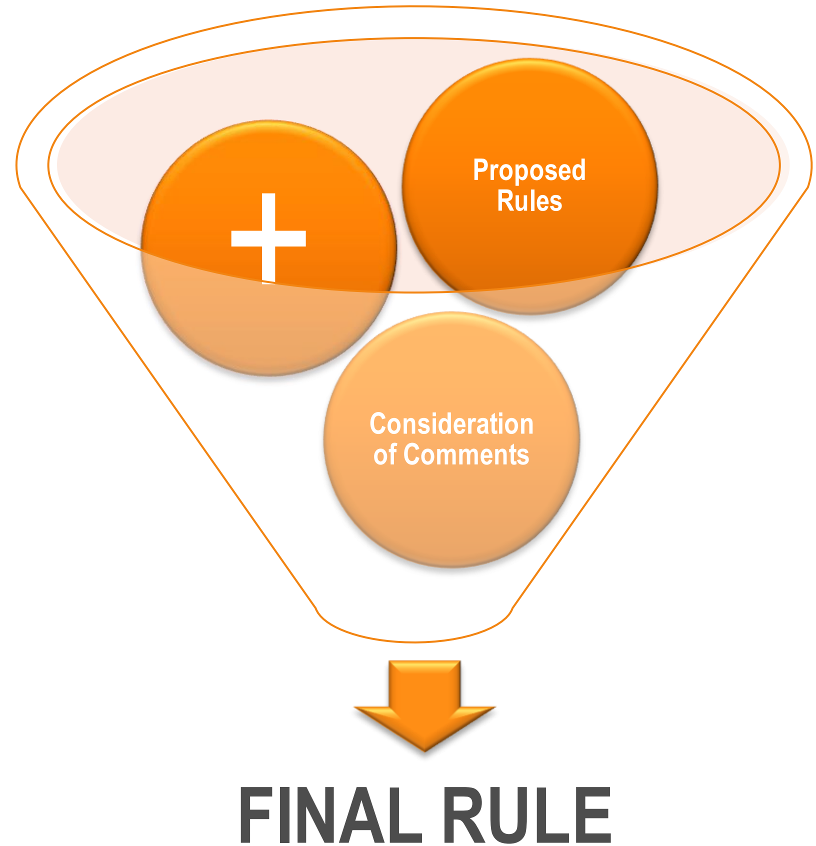
# Proposed vs. Final Rule

## Proposed Rule:

- CMS plans, goals, solutions to problems and proposed rulemaking
- Opportunity for public to make comments

## Final Rule:

- Final legal effect after consideration of comments



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# Medicare Program Overview

Health insurance managed by the Federal government

- Medicare Administrative Contractors (MACs)
- Claims Processing
- Rules & Regulations
- Program Integrity

*"The MACs serve more than 1.5 million health care providers enrolled in the Medicare FFS program. Collectively, the MACs processed more than 1.2 billion Medicare FFS claims annually, 210 million Part A claims and more than 1 billion Part B claims, and paid $367 billion in Medicare benefits."* Source: CMS.gov

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# Medicare Administrative Contractors

Companies awarded a bid to be the Medicare provider for a specific region of the country

- Enroll health care providers in the Medicare program and educate providers on Medicare billing requirements
- Answer provider and beneficiary inquiries
- Publish guidelines and coverage for services within Local Coverage Determinations (LCDs)
- Central point of claims processing for Part A and B
- 10 year term, then re-bid process begins

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| MAC | States Covered |
|---|---|
| Novitas-Solutions<br>www.novitas-solutions.com | Arkansas, Colorado, Delaware, DC, Louisiana, Maryland, Mississippi, New Jersey, New Mexico, Oklahoma, Pennsylvania, Texas, Virginia (counties of Arlington, Fairfax & City of Alexandria) |
| Cahaba GBA<br>www.cahabagba.com | Alabama, Georgia, Tennessee |
| Noridian Healthcare Solutions<br>www.noridianmedicare.com | Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming, American Samoa, California, Guam, Hawaii, Nevada, Northern Marianas Islands |
| Palmetto GBA<br>www.palmettogba.com | North Carolina, South Carolina, Virginia (except areas noted as Novitas), West Virginia |
| NGS<br>www.ngsmedicare.com | Connecticut, Illinois, Maine, Massachusetts, Minnesota, New Hampshire, New York, Rhode Island, Vermont, Wisconsin |
| First Coast Service Options<br>www.medicare.fcso.com | Florida, Puerto Rico, Virgin Islands |
| WPS Government Health Administrators<br>www.wpsmedicare.com | Indiana, Iowa, Kansas, Michigan, Missouri, Nebraska |
| CGS<br>www.cgsmedicare.com | Kentucky, Ohio |

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# CMS Publications

- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)
- Manuals & Transmittals
- National Correct Coding Initiative (NCCI)

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# National Coverage Determination (NCD)

- Determination by the Secretary of the Department of Health and Human Services whether or not an item or service is covered nationally
- Examples:
  - Hyperthermia for Treatment of Cancer (110.1)
  - Smoking and Tobacco-Use Cessation Counseling (210.4)
- In absence of an NCD, Medicare contractors may establish an LCD

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# Local Coverage Determination (LCD)

- Carrier, fiscal intermediary or MAC develop and/or adopt LCDs to define whether a particular service will be covered
- Developed when no NCD is published or in need of further definition
- May include:
  - CPT® and HCPCS coding instructions
  - ICD-10 codes
  - Documentation requirements
  - Associated articles with additional instructions

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# Retired LCDs

- Policies remain active when there is evidence of significant problems with performance, billing and/or coding
- Correct claims submission is expected with or without an active LCD

noridian
Healthcare Solutions

## Why are LCDs Retired?

LCDs are retired due to lack of evidence of current problems, or in some cases because the material is addressed by a National Coverage Determination (NCD), a coverage provision in a CMS interpretative manual or an article. Most LCDs are not retired because they are incorrect. The guidance in the retired LCD may be helpful in assessing medical necessity. Where providers have adjusted their billing and coding practices to correspond to the guidance in LCDs, they will want to be very careful in departing from these practices just because the LCD is retired.

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# Find Your Policies

https://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx

+ National Coverage

Back to Top

− Local Coverage

| Local Coverage Determinations (LCDs) | [1134 Records] |
|---|---|
| LCDs by Contractor | [1134 Records] |
| LCDs by State | [1134 Records] |
| LCDs Listed Alphabetically | [1134 Records] |
| **Articles** | **[873 Records]** |
| Articles by Contractor | [873 Records] |

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# Medicare Claims Processing Manual

- Numerous Internet-Only Manuals (IOMs) are published and provide additional guidance
  - Chapter 1 – General Billing Requirements
  - Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS)
  - Chapter 12 - Physicians/Nonphysician Practitioners
  - Chapter 13 – Radiology Services and Other Diagnostic Procedures
  - Chapter 17 – Drugs and Biologicals
  - Chapter 22 – Remittance Advice
  - Chapter 23 – Fee Schedule Administration and Coding Requirements

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912.html?DLPage=1&DLSort=0&DLSortDir=ascending

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# National Correct Coding Initiative (NCCI)

- Developed to promote correct coding and control improper coding resulting in inappropriate payments
- Based on coding conventions defined by the CPT® Manual
- Updated Quarterly
- Practitioner versus hospital outpatient publications
- Edits include:
  - Procedure to Procedure (PTP)
  - Medically Unlikely Edits (MUE)

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html?redirect=/NationalCorrectCodInitEd/

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# PTP Edits

- CPT® codes listed in either Column 1 or Column 2
- Indication:

  0 – Rule "zero chance of getting paid" = Modifier not allowed

  1 – Rule "one chance of getting paid" = Modifier allowed

  9 – Rule no longer applicable "typically in place originally in error"

| Column 1 | Column 2 | Effective Date | Deletion Date | Indication |
|---|---|---|---|---|
| 77290 | 77336 | 20031001 | | 1 |
| 77306 | 77300 | 20150101 | | 0 |
| 77295 | 77307 | 20150101 | | 0 |
| 77301 | 77290 | 20020101 | | 0 |

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# Modifiers

- Two digit designation added to the end of a CPT® code, provides additional information about the billed procedure
- Classified as either:
  - *Payment modifier*
  - *Information modifier*

- 24 – Unrelated E&M w/in global period
- 25 - E&M /procedure on same day
- 26 – Professional Component
- TC – Technical Component Only
- 58 – Staged or related procedure
- 59 – Distinct Procedural Service
- 76 – Repeat procedure or service

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# X Modifiers

**XE** Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter

**XS** Separate Structure, A Service That IS Distinct It Was Performed On A Separate Organ/Structure

**XP** Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner

**XU** Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

Developed to provide greater reporting specificity in lieu of modifier 59 when possible.

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# Medically Unlikely Edits (MUEs)

- Predetermined quantity allowed for a particular CPT® code on a date of service
- Most are published on Medicare Website
- Updated quarterly
- May be claim line or date of service edit

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# MUE Adjudication Indicator (MAI)

- Assigned to each published code
- MAI levels include:
  - “1” – Adjudicated as a claim line edit
  - “2” – Per day edits based on policy
  - “3” – Per day edits based on clinical benchmarks
- Denials for MAI “1” or “3” may be appealed and paid for correctly coded and medical necessary units in excess of MUE value

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# MAI of 2

MLN Matters Number: SE1422:

*“An MAI of 2 indicates an edit for which the MUE is based on regulation or subregulatory instruction (“policy”), including the instruction that is inherent in the code descriptor or its applicable anatomy…*

*…CMS expects all claims reporting services in excess of the MUE for edits with an MAI of 2 will represent either clerical errors or errors in the interpretation of instructions. CMS has not identified any instances in which a higher value would be correct and payable. MACs have therefore been instructed that this subregulatory instruction is binding on the MAC for both initial determinations and redeterminations, as is all subregulatory instruction.”*

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# MAI of 3

MLN Matters Number: SE1422:

*"An MAI of 3, the most common per day edit, indicates an edit for which the MUE is based on clinical information such as*

- *billing patterns;*
- *prescribing instructions; or*
- *other information…*

*…In the rare instance where the provider has verified all information, including the correct interpretation of coding instructions, and still believes that the correctly coded medically necessary service exceeds the MUE, the provider should submit a clearly supported appeal."*

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| HCPCS/ CPT Code | Outpatient Hospital Services MUE Values | MUE Adjudication Indicator | MUE Rationale |
|---|---|---|---|
| 77280 | 2 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |
| 77285 | 1 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |
| 77290 | 1 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |
| 77293 | 1 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |
| 77295 | 1 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |
| 77300 | 10 | 3 Date of Service Edit: Clinical | Clinical: Data |
| 77301 | 1 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |
| 77306 | 1 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |
| 77307 | 1 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |
| 77316 | 1 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |
| 77317 | 1 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |
| 77318 | 1 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |
| 77321 | 1 | 2 Date of Service Edit: Policy | Code Descriptor / CPT Instruction |
| 77331 | 3 | 3 Date of Service Edit: Clinical | Clinical: Data |
| 77332 | 4 | 3 Date of Service Edit: Clinical | Clinical: Data |
| 77333 | 2 | 3 Date of Service Edit: Clinical | Clinical: Data |
| 77334 | 10 | 3 Date of Service Edit: Clinical | Clinical: Data |
| 77336 | 1 | 2 Date of Service Edit: Policy | Code Descriptor / CPT Instruction |
| 77338 | 1 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |
| 77370 | 1 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |
| 77371 | 1 | 2 Date of Service Edit: Policy | Code Descriptor / CPT Instruction |
| 77372 | 1 | 2 Date of Service Edit: Policy | Code Descriptor / CPT Instruction |
| 77373 | 1 | 3 Date of Service Edit: Clinical | Clinical: Data |
| 77385 | 2 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |
| 77386 | 2 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |
| 77387 | 2 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |
| 77401 | 1 | 2 Date of Service Edit: Policy | Code Descriptor / CPT Instruction |
| 77402 | 2 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |
| 77407 | 2 | 3 Date of Service Edit: Clinical | Nature of Service/Procedure |

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# NCCI Policy Manual

- Published annually
- Divided into chapters by code range
- Provides additional instruction and guidance

c) **Modifier 58:** Modifier 58 is defined by the *CPT Manual* as a "staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period". It may be used to indicate that a procedure was followed by a second procedure during the post-operative period of the first procedure. This situation may occur because the second procedure was planned prospectively, was more extensive than the first procedure, or was therapy after a diagnostic surgical service. Use of modifier 58 will bypass NCCI PTP edits that allow use of NCCI-associated modifiers.

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# Center for Program Integrity (CPI)

- Promotes integrity of Medicare program
  - Audits
  - Policy Reviews
  - Monitoring of program vulnerabilities
- Utilize contractors to investigate potential fraud and abuse
  - Comprehensive Error Rate Testing (CERT)
  - Recovery Audit Program Recovery Auditors (RAC)
  - Zone Program Integrity Contractors (ZPICs)
  - Supplemental Medical Review Contractor (SMRC)…

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# Review Areas

- Provider-based status
- IMRT services
- Stereotactic radiation therapy and radiosurgery
- Prolonged services
- Imaging services
- Payment for drugs purchased under 340B Program
- NCCI edits

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# Provider-based

➢ **REVISED** Medicare oversight of provider-based status

We will determine the number of provider-based facilities that hospitals own and the extent to which CMS has methods to oversee provider-based billing. We will also determine the extent to which provider-based facilities meet requirements described in 42 CFR Sec. 413.65 and CMS Transmittal A-03-030, and whether there were any challenges associated with the provider-based attestation review process. Provider-based status allows facilities owned and operated by hospitals to bill as hospital outpatient departments. Provider-based status can result in higher Medicare payments for services furnished at provider-based facilities and may increase beneficiaries' coinsurance liabilities. The Medicare Payment Advisory Commission (MedPAC) has expressed concerns about the financial incentives presented by provider-based status and stated that Medicare should seek to pay similar amounts for similar services. (OEI; 04-12-00380; expected issue date: FY 2016)

OFFICE OF INSPECTOR GENERAL

U.S. Department of Health and Human Services

WORK PLAN

Fiscal Year 2016

➢ Comparison of provider-based and freestanding clinics

We will review and compare Medicare payments for physician office visits in provider-based clinics and freestanding clinics to determine the difference in payments made to the clinics for similar procedures and assess the potential impact on Medicare of hospitals' claiming provider-based status for such facilities. Provider-based facilities often receive higher payments for some services than do freestanding clinics. The requirements to be met for a facility to be treated as provider based are at 42 CFR § 413.65(d). (OAS; W-00-14-35724; W-00-15-35724; expected issue date: FY 2016)

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# IMRT (OIG)

➢ Intensity-modulated radiation therapy

We will review Medicare outpatient payments for intensity-modulated radiation therapy (IMRT) to determine whether the payments were made in accordance with Federal rules and regulations. IMRT is an advanced mode of high-precision radiotherapy that uses computer-controlled linear accelerators to deliver precise radiation doses to a malignant tumor or specific areas within the tumor. Prior OIG reviews have identified hospitals that have incorrectly billed for IMRT services. To be processed correctly and promptly, a bill must be completed accurately. (CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, Ch. 1, § 80.3.2.2.) In addition, certain services should not be billed when they are performed as part of developing an IMRT plan. (CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, Ch. 4, § 200.3.2) (OAS; W-00-15-35740; various reviews; expected issue date: FY 2016)

http://oig.hhs.gov/reports-and-publications/archives/workplan/2016/oig-work-plan-2016.pdf

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# IMRT (SMRC)

- Post payment medical record review of IMRT services
- Awarded to Strategic Health Solutions

**Action: Medical Records Required**

Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. **Providing medical records of Medicare patients to the SMRC does not violate the Health Insurance Portability and Accountability Act (HIPAA).** Patient authorization is not required to respond to this request.

Please submit the entire episode of care for each beneficiary requested, including the supporting information in the following sequence:

Clinical Treatment Plan:

- History and physical for the diagnosis being treated
- The prescription must define the goals and requirements of the treatment plan including the specific dose constraints for the target(s) and nearby critical structures
- A signed and dated IMRT inverse plan that meets prescribed dose constraints for the Planning Target Volume (PTV) and surrounding normal tissue using either Dynamic Multi-Leaf Collimator (DMLC) or Segmented Multi-Leaf Collimator (SMLC) or inverse planned IMRT solid compensators to achieve IMRT delivery

Computed Tomography (CT) & Simulation:

- The target verification methodology that includes the following:
  a. Documentation of the Clinical Treatment Volume (CTV) and the PTV
  b. Documentation of immobilization and patient positioning
  c. Means of dose verification and secondary means of verification
  d. Independent basic dose calculation of monitor units has been performed for each beam before the patient's first treatment
- Documentation of fluence distributions re-computed in a phantom is required, or an equivalent methodology consistent with Patient Specific IMRT Treatment Verification

Motor Units Check:

- The Monitor Units (MUs) generated by the IMRT treatment plan must be independently checked before the patient's first treatment

Other Documentation Needed:

- IMRT treatment plan report
- IMRT treatment delivery log for each fraction billed
- If image guidance is used prior to each fraction, the record must clearly document the medical necessity for pretreatment CT scans. Images should also be submitted to support each CT billed

EXAMPLE

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# Hot Topic

- Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)
  - Combines existing quality reporting programs into one – Merit- Based Incentive Payment System (MIPS)
    - Physician Quality Reporting System (PQRS)
    - Value Modifier (VM)
    - Medicare Electronic Health Record incentive program

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Draft-CMS-Quality-Measure-Development-Plan-MDP.pdf

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# Measure Development Timeline

**Figure 1: Key Dates in the Measure Development Plan**

- Jan. 2016 — Draft MDP Published for Comment
- Mar. 2016 — Comment period ends
- May 2016 — Final MDP published
- June 2016 — Call for measures ends
- Nov. 2016 — Final Rule no later than Nov. 1, 2016
- May 2017 — Annual Update to MDP
- June 2017 — Call for measures ends
- Nov. 2017 — Final Rule no later than Nov. 1, 2017
- May 2018 — Annual Update to MDP
- June 2018 — Call for measures ends
- Nov. 2018 — Final Rule no later than Nov. 1, 2018
- Jan. 2019 — MIPS Payment Adjustment Begins

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# QUESTIONS

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