UPMC LIFE CHANGING MEDICINE

Best Practices in Billing

Tell the Story

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"Oh, me? Nothing much. I treated a dozen patients, did the charts, wrote new protocols, gave a seminar, fixed the computer and now it's lunchtime."

"Can I get continuing education credit for stories that never cease to amaze me?"

Disclosures

- Neither speaker has any conflicts of interest to report;
- This presentation is meant to provide best practices for wound care billing, but is not comprehensive, and does not include all aspects of wound care billing.
- Information provided does not constitute a guarantee of payment, or assurance or warranty that payment will be provided. Payment is subject to payor guidelines, including for example Medicare and Medicaid rules.

Assumptions

- Outpatient, licensed department of a hospital;
- Direct supervision is required for physician services;
- "Incident to" services are performed under the direct supervision of a physician.

Agenda

- Why?
- Best Practices
- Tell the Story
- Charting
- Episodic versus Series
- Best Process
- Insurance Benefit Verification/Authorization
- Physician Billing
- Possible Pitfalls

Why?

- By subscribing to these best practices and hardwiring these in our work, we were able to:
  - Increase the accuracy of physician billing, where all physicians achieve a 90-95% compliance in internal audits;
  - Increase billing accuracy on the facility side by 147% at the highest volume center in our portfolio.

Which should your chart look like?

MET

MOMA

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Why Tell a Story?

- Every patient encounter tells a story provided the documentation is descriptive and complete, in keeping with the guidelines and criteria necessary to bill for the encounter.

Tell the Patient's Wound Story!

Tell The Story

- History and Physical
- Progress Notes
- Wound Photography and Measurements (Every appointment!)
- Ask the patient when they first noticed the wound. What have they done for treatments in the past?
- Aways look at the patient's medication list and review it with them. (Immunosuppressants, autoimmune disease, etc.)
- Always order basic tests.
- Always make the appropriate referrals.
- Always practice evidence-based medicine.

Episodic versus Series Billing

- Wound Care is not intended to be billed in a "Series" method
  - Wound Care is episodic, meaning that each encounter should be billed for
  - The only Revenue codes that should be billed monthly are:
    - Durable Medical Equipment Rental
    - Therapy Codes
    - Skilled Nursing

Staying well informed is vital in all areas especially when it comes to documentation for claims submissions.
Insurance companies expect compliant claims with services and supporting codes reported accurately.
Pitfalls – incorrect coding are compliance issues.
Delay reimbursement which will ultimately affect your clinic.
Rules are handed down from government bodies, such as Medicare Administrative Contractors (MAC)
NCD- National Coverage Determination
LCD – Local Coverage Determinations
CMS – Center for Medicare and Medicaid
Clinics job to ensure that your documentation complies with the necessary regulations

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Best Process

- Obtain as much information as possible from the referral;
- Connect with the patient when scheduling; is there any additional information that you need?
- When patient presents for their appointment, ensure that their registration includes all the components necessary;
- Providers: Tell the Story within the chart during their Appointment;
- Schedule follow up appointments at the appropriate interval.


Referral


Scheduling


Registration


Appointment


Follow Up Appointments

Tools

- Coding Resources
- National Correct Coding Initiative (NCCI) Edits
- Your Medicare Administrative Contractor (MAC)
- Payer Contracts
- Your Electronic Medical Record (EMR)
- Your Charge Description Master (CDM)

Coding Resources

Your Medicare Administrative Contractor (MAC)

- Code Books
- Your Coding Department
- Your Local and National Coverage Determinations

National Correct Coding Initiative (NCCI)

- Edits and resources can be obtained at www.cms.gov
- This is a great tool to understand what codes can be billed, specifically related to procedures and what combinations are or are not acceptable.
- Purpose of HCPCS coding – ensure orderly and consistent claims processing.
- Prices and fees are NOT a part of coding.
- HCPCS codes describe the product, not the price.

Payor Contracts

- Your Payor Contracts will vary depending upon your service area
- Clinical setting of use/provider type
- Payer specifics
- Payer coverage policy
- Payer medical necessity requirements
- Codes
- Payment
- Utilization parameters

Primary Insurance Verification

Traditional Medicare

- Make Sure the patient is active and eligible with traditional Medicare.
- Medicare Deductible: $233
- Medicare advantage plan? Y/N
  - If the Patient has a Medicare Advantage Plan you will need to contact the plan for eligibility and coverage (see below)
  - Is it very important to review the LCD to ensure the patient meets for all the criteria and the it is documented in the patient notes
  - For traditional Medicare, coinsurance will be 20%. This will then go to either the patient (self-pay), Supplement, Medicaid, or assistance program (PAN). (See secondary insurance verification.)

Medicare Advantage/Replacement

For all Health Plans verify the following codes are valid and billable.

- 15271: Application of trunk, arms, legs
- 15275: Application of face, scalp. Eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, multiple digits
- Q4131: Q code/procedure code, per sq cm
  - Make sure the patient is active and eligible
  - It is very Important to review the LCD to ensure the patient meets for all the criteria and that it is documented in the patient notes. Advantages plans follow Medicare guidelines.

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Medicare Advantage/Replacement Cont.

Prior Authorization required? Y/N

- Ask If prior authorization is required for both the application and the product. If it is required, make sure you request several applications and based on the wound size units per sq cm.
- **Example:** if a wound on the foot is approximately 5 sq cm you may want to request 5 applications of 15257 and 30 units of Q4131 (5 application x 6 sq cm of product). **Request the units by the total product size not wound size.**

Medicare Advantage/ Replacement Cont.

Most Medicare Advantage plans follow the Medicare payment methodology and package the product in the application payment.

Benefits:

Deductible Amount: _____ Ded Met:_____ Ded included in OOP? _____

Co-Pay:_____ Co-Insurance:_____

Out of Pocket (OOP):_____ OOP Met:_____

Is co-pay waived if OOP met? Y/N or NA

Commercial Health Plans

- For all health plans verify the following codes are valid and billable.
- 15271: Application of trunk, arms, legs
- 15275: Application of face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, multiple digits
- Q4131: Q code/procedure code, per sq cm

For all cases, make sure the patient is active and eligible with the plan.

Commercial Health Plans Cont.

- Is there a clinical policy on skin substitutes? Y/N
- What type of benefits does Q4131 fall under? DME, Surgical, Outpatient, Supplies
  - Sometimes the product will fall under a different benefit than the application which is typically under surgical. If this occurs the benefits may be different for each code.

  Is the provider in network? Y/N
  - If the Provider is out of network the benefits are less or they may not cover them all.

Commercial Health Plans Cont.

Benefits:

Deductible Amount: _____ Ded Met: _____

Ded included in OOP?_____

Co-Pay: _____ Co-insurance:_____

Out of Pocket (OOP):_____ OOP Met:_____

Is co-pay waived if OOP met? Y/N or NA

Secondary Insurance Verification

Medicare Supplement

- When secondary to Medicare, verify whether the plan is a supplement or an independent commercial. Supplements are obligated to cover after Medicare does. There are many different types of supplements--
- **Note** that supplement Plan F can have a patient responsibility. The other should pick up the 20% co-insurance.

If a secondary plan is commercial, it can operate independently. See next slide

Secondary Insurance Verification Cont.

Medicaid/Managed Medicaid

Prior Auth Required? Y/N

- Confirm that the Medicaid plan type will reimburse the Medicare deductible and full 20% co-insurance.
- Some state Medicaid plans will only reimburse up to their allowed amount which may be less than Medicare. Please review your state Medicaid fee schedule.

Secondary Insurance Verification Cont.

Commercial Health Plans

If the secondary plan is commercial (and not a supplement) it will typically follow their own guidelines and clinical policy. Refer to the primary COMMERCIAL section above.

Your Electronic Medical Record

If the documentation box or area exists, use it;

Ensure that you photograph and document measurements for the wound at each appointment;

Cellular Based Tissue Products require the documentation of wastage and the reason for wastage (the reason is a new requirement)

Chargemaster

Every entity has a charge description master that captures the different charge codes and CPT®codes that are used at your facility;

Chargemasters are generally updated annually, on July 1st

These can be obtained from your Revenue Cycle Department

Insurance Benefit Verification/Authorization

- Consider authorizing your "Top 10" CPT® codes
- Always authorize Cellular Based Tissue Products
- Always document the reference # for the call; if authorization is obtained in that manner

Physician Billing

- If the physician did not perform the service, the physician should not bill for the service
- Do not cherry-pick CPT® codes – follow the NCCI edits and if you performed a procedure, you must use the procedure code, not an E/M code

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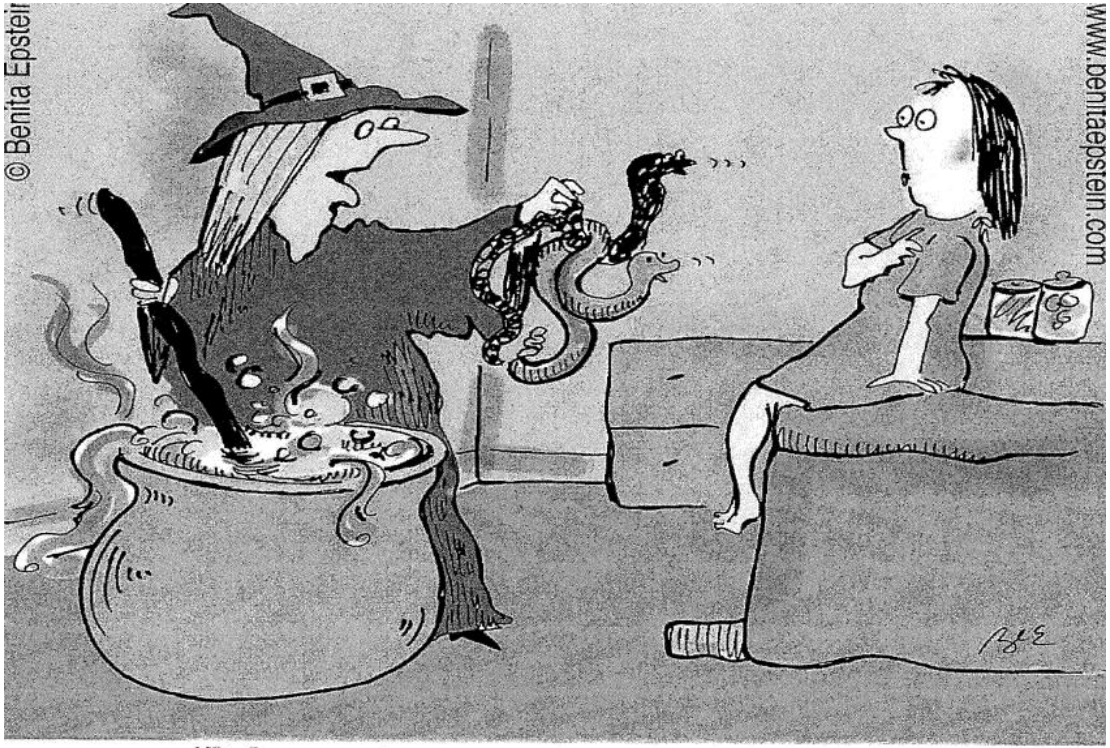
Possible Pitfalls

- Surgical Global Periods
  - Transfer of Care During a Global Period
    - Surgeon appends modifier 54 to the surgical code
    - Physician or qualified healthcare professional appends modifier 55 to the same surgical procedure code including the date of surgery as the date of service or the date care is assumed
    - Surgeon specifically states that they are "transferring care" and explains why they are doing so

"Charts should look like they belong in the MET, not at MOMA."



"Your insurance company said this is all they're gonna pay for."

Sources

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- "Global Surgery Booklet", www.cms.gov, pp. 1-19
- www.wound source.com
- www.flickr.com/photos/wallg/246896968