

Documentation & Coding



What's the Deal?

Tammy W. Norville, RMC
Primary Care Systems Specialist
North Carolina DHHS - Office of Rural Health and Community Care
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NC Office of Rural Health & Community Care

The North Carolina Office of Rural Health and Community Care (ORHCC) helps communities get low-cost access to medical care. Since it was created in 1973, ORHCC has opened 86 rural health centers across the state. Currently, ORHCC supports 28 rural health centers with funding and technical support. ORHCC also helps to place medical, psychiatric, and dental providers in communities throughout the state. Rural hospitals, as well as many statewide medical facilities that treat poor and uninsured residents, may receive help through grant funds. Qualifying patients may take advantage of drug companies' free and low-cost drug programs through ORHCC's medication assistance program.



Road Map - 3 Part Series

Part 1 - The Basics

- Coding - CPT & ICD-9
- Documentation
- People to know & Compliance



Road Map (con't)

Part 2 - Next Steps

- Importance of Correct Coding
- Medicare Administrative Contractors
- RHC specifics
- RHC and IPPE

Part 3 - Bringing it all together

Part 1



The Basics



Part 1 - The Basics

- Types of Codes
- Coding Overview
- Documentation
- ICD-9 Use
- RAC



Types of Codes

- Level I - CPT - Procedures
- Level II - HCPCS - Healthcare Common Procedural Coding System - drugs, supplies, Prosthetics, vision
- ICD-9 - Diagnoses - Volumes 1 and 2
Volume 3 Hospital only
- RBRVS - Resource Based Relative Value Scale - Fee schedule broken down into parts
- CCI - Correct Coding Initiative - Updated quarterly



RAC Program Mission

"To reduce Medicare improper payments through efficient detection and collection of overpayments, the identification of underpayments, and the implementation of actions that will prevent future improper payments."

Part 2



Next Steps



Part 2 - Next Steps

- Importance of
Correct Coding
- Medicare Administrative
Contractors
- RHC Reimbursement Specifics
- RHC and IPPE



Correct Coding

What's the big deal about coding and making sure the coding is correct???



Correct Coding

Maximizing
Reimbursement



Correct Coding

Habitual incorrect coding
may "flag" the
organization



Correct Coding

Effect on future
reimbursement levels



Medicare Administrative Contractors



What's a MAC, anyway??

Medicare Contracting was reformed as outlined in section 911 of the Medicare Prescription Drug Improvement and Modernization Act of 2003.



Exploring MACs

CMS replaced its claims payment contractors - fiscal intermediaries and carriers - with new contract entities called Medicare Administrative Contractors (MACs). CMS will award a total of 19 MAC contracts through three procurement cycles.



Exploring MACs

CMS plans to replace the FIs and carriers with 23 MACs. These MACs will serve as the providers' primary point-of-contact for the receipt, processing and payment of claims. They will also perform all core claims processing operations for both Parts A and B. Section 1874A of the Social Security Act establishes the MAC authority.



Exploring MACs

These MACs will include:

Fifteen to process both Part A and Part B claims (A/B MACs)

Four to process DME claims (DME MACs)

Four to process Home Health & Hospice (HH) claims (HH MACs)



Exploring MACs

CMS designed the new MAC jurisdictions to balance the allocation of workloads and overlay the boundaries of the 4 DME and 4 HH MACs with the boundaries of the 15 A/B MACs.



MAC Benefits

Medicare Contracting Reform will benefit the FFS program by affecting the following changes to Medicare's administrative structure:



MAC Benefits

Competition

CMS will use full and open competition to select Medicare FFS contractors that represent the best value to the Government.



MAC Benefits

Beneficiary and provider-centered benefit administration

Medicare Parts A and B will be consolidated and administrative services standardized to provide beneficiaries and providers with a unified point-of-contact and improve their access to information.



MAC Benefits

Contract performance incentives

Incentives on contracts will allow contractors to earn profits for greater efficiency, innovation, and cost-effectiveness.



MAC Benefits

Improved contractor management

Competition will attract a broader range of private sector organizations, thereby strengthening the ability of CMS to manage contractors based on performance (e.g., terminating contracts for poor performance).



Provider Benefits

Improved Provider Services

A simplified interface with a single MAC for Part A and Part B processing and other services will benefit providers.



Provider Benefits

Competition will encourage MACs to deliver better service to providers.

Requiring MACs to focus on financial management will result in more accurate claims payments and greater consistency in payment decisions.



Beneficiary Benefits

Improved Beneficiary Services

Only one contractor will process claims for most beneficiaries, reducing the number of separate explanation of benefits statements a beneficiary will receive.



Beneficiary Benefits

A/B MACs will be required to develop and consistent an integrated approach to medical coverage across its service area, which benefits both beneficiaries and providers.



RHC Reimbursement Specifics



RHC Reimbursement

Applies to Medicare Patients
ONLY

Medicaid has its own coding and
billing rules.



RHC Reimbursement

Core Visits are paid as the **ALL INCLUSIVE RATE PER VISIT** created by dividing a practice's total allowable costs by it's total RHC visits.

In addition, other Medicaid RHC services are reimbursed on a fee-for-service basis and are reconciled to cost at the end of the year.



RHC Reimbursement

Under the RHC program, the practice is allowed to "break even" on the cost of providing RHC services to Medicare patients.

The RHC program does not affect reimbursement for private insurance and self-pay patients.



RHC Billing vs. "Normal" Billing

RHC

Co-pays are 20% of
charges

RHC visit & Hospital
visit may happen on
same day (in some
cases)

99211 Nurse Only visit
is not billable

Injection/allergy only is
not billable as stand
alone encounter

"Normal"

Medicare Allowables only

Visit & Hospital Admission
not allowed on same day

99211 Nurse Only visit is
billable

Injection/allergy only is
billable as stand alone



RHC Core Services

1. Physician services, including required physician supervision of NPs, PAs and Certified Mid-Wives (CMW)
2. Services of PAs, NPs and CMWs
3. Services of Clinical Psychologist (CP) and Clinical Social Workers (CSW)
4. Services provided "incident to" by any of the above mentioned providers



RHC Service Locations

1. Clinic/medical practice
2. Patient's place of residence
 - Home
 - Assisted Living
 - SNF (NOT Part A stay)
3. Other locations not specified as Non-RHC
 - Accident scene



Non-RHC Service Locations

Hospital Campus (reimbursed FFS)

Emergency Room

Inpatient

Observation

Skilled Nursing Facility (SNF) *IF* the patient is in a SNF Part A covered stay



Non-RHC Services

1. Durable Medical Equipment (DME)
2. Ambulance services
3. Diagnostic tests
X-Rays, EKGs, In-House Labs
4. Screening Mammography services
5. Prosthetic devices and braces for leg, arm, back and neck



NOTE!!!

On a visit-by-visit basis, the all-inclusive rate may be higher or lower than the actual charges for the day. It may appear the practice is either inappropriately receiving more or less than the day's charges. However, through the cost reporting and reconciliation process, the total cost of providing core RHC services to Medicare patients is reimbursed.



Diabetes Self-Management Training (DSMT) Services

Separate payment to RHCs for these practitioners/services continues to be precluded as **these services are not** within the scope of Medicare-covered RHC benefits.



Diabetes Self-Management Training (DSMT) Services

Note that the provision of the services by registered dietitians or nutritional professionals, might be considered incident to services in the RHC setting, provided all applicable conditions are met.



Diabetes Self-Management Training (DSMT) Services

However, they do not constitute an RHC visit, in and of themselves. All line items billed on TOB 71x with HCPCS code G0108 or G0109 will be denied.



Outpatient Mental Health *Treatment Limitation for CP Services*

Most covered services furnished by qualified CPs for the treatment of mental, psychoneurotic, and personality disorders are subject to the outpatient mental health treatment limitation (the limitation).

Certain diagnostic services are not subject to the limitation.



Outpatient Mental Health Treatment Limitation for CP Services

For detailed information on the application of the limitation please see the Medicare General Information, Eligibility, and Entitlement Manual, Publication 100-01, chapter 3, section 30 and the Medicare Claims Processing Manual, Publication 100-04, chapter 9, section 60.



CP Services at the Clinic or Center

The services of a CP performed at the clinic or center are RHC or FQHC services and are payable only to the clinic or center.



CP Services Away From the Clinic or Center

CPs who are employees of an RHC, or who are compensated by the clinic or center for providing services furnished to clinic or center patients in a location *other than* at the clinic/center facility, may furnish services to clinic/center patients at the clinic/center facility or in other locations, such as in a patient's home. These services are RHC services and are reimbursable only to the clinic or center.



CP Services Away From the Clinic or Center

A CP who is compensated by the clinic/center for services in locations other than the clinic/center, may not bill the Medicare program through the carrier for services furnished to Medicare beneficiaries who are clinic/center patients, regardless of place of service.



Clinical Social Worker (CSW) Services Away and at the RHC Clinic or Center

The RHC/FQHC services include the services provided by a clinical social worker (CSW).



Clinical Social Worker Services Defined

CSW services for the diagnosis and treatment of mental illnesses and services and supplies furnished incident to such services are covered as long as the *CSW* is legally authorized to perform them under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed.



Clinical Social Worker Services Defined

The services that are covered are those that are otherwise covered if furnished by a physician or as an incident to a physician's professional service. Services furnished to an inpatient or outpatient that a hospital is required to provide as a requirement for participation are not included.



Covered CSW Services

Clinical social worker services and supplies furnished incident to such services are covered as the services furnished by a physician or as incident to physician's services are covered. (See §60.)



Covered CSW Services

Coverage is limited to the services a CSW is legally authorized to perform in accordance with State law, including services and supplies furnished incident to such services and are those that are otherwise covered if furnished by a physician or incident to a physician's professional service.



Covered CSW Services

The services of a CSW may be covered in an RHC/FQHC if they are:

- The type of services that are otherwise covered if furnished by a physician, or incident to a physician's service
- Performed by a person who meets the above definition of a CSW



Covered CSW Services

- Not otherwise excluded from coverage

State law or regulatory mechanism governing a CSW's scope of practice in the service area must be considered. Development of a list of services within the scope of practice is encouraged.



Non-Covered CSW Services

CSW services are not covered if they are otherwise excluded from Medicare coverage even though a CSW is authorized by State law to perform them.

For example, the Medicare law excludes from coverage services that are not "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member."



Outpatient Mental Health *Treatment Limitation for CSW Services*

Most covered services furnished by qualified CSWs for the treatment of mental, psychoneurotic, and personality disorders are subject to the outpatient mental health treatment limitation (the limitation) in Section §1833 of the Act.

Certain diagnostic services are not subject to the limitation.



Outpatient Mental Health Treatment Limitation for CSW Services

For detailed information on the application of the limitation please see the Medicare General Information, Eligibility, and Entitlement Manual, Publication 100-01, chapter 3, section 30 and the Medicare Claims Processing Manual, Publication 100-04, chapter 9, section 60.



Services at the Clinic or Center

The services of CSW performed at the clinic or center are RHC services and are payable only to the clinic or center.



Services Away From the Clinic or Center

Clinical social workers who are employees of an RHC or FQHC, or who are compensated by the clinic or center for providing services furnished to clinic or center patients in a location other than at the clinic/center facility, may furnish services to clinic/center patients at the clinic/center facility or in other locations, such as in a patient's home.



Services Away From the Clinic or Center

These services are RHC/FQHC services and are reimbursable only to the clinic or center.



Services Away From the Clinic or Center

A clinical social worker that is compensated by the clinic/center for services in locations other than the clinic/center, may not bill the Medicare program through the carrier for services furnished to Medicare beneficiaries who are clinic/center patients, regardless of place of service.



RHC & Initial Preventive Physical Examination



Initial Preventive Physical Examination (IPPE)

Effective for services furnished on or after January 1, 2005, Section 611 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) provides for coverage under Part B of one initial preventive physical examination (IPPE) for new beneficiaries only, subject to certain eligibility and other limitations.



Initial Preventive Physical Examinations (IPPE)

Payment for IPPE professional services that meets all of the program requirements is made under the all-inclusive rate.

This is a once in a lifetime benefit.



Initial Preventive Physical Examinations (IPPE)

HCPCS coding is required to:

- adhere to the statutory limit
- to allow for the deductible to be waived when computing payment to RHCs for dates of service (DOS) on or after January 1, 2009



Initial Preventive Physical Examinations (IPPE)

- in rare circumstances depending on the clinical appropriateness of a separate visit, to allow RHCs/FQHCs to receive separate payment for an encounter in addition to the payment for IPPE encounter when they are performed on the same day.



Initial Preventive Physical Examinations (IPPE)

When the IPPE is provided, detailed HCPCS coding is required. For RHCs, the Part B deductible for IPPE is waived for DOS on or after January 1, 2009.

Coinsurance is applicable.

Questions/Comments??



Thank you for your
participation!!



Web Resources

<http://www.cms.hhs.gov/>

Centers for Medicare & Medicaid
Services

Coding/Documentation Requirements

RAC Audits/Requirements

HIPAA 5010 Implementation

ICD-10 Implementation



Web Resources (con't)

<http://www.mgma.com/>

Medical Group Management Association

<http://www.google.com/>

Google

*****When in doubt, Google it!!*****



Contact Info

Tammy W. Norville

Primary Care Systems Specialist

NC - DHHS Office of Rural Health &
Community Care

tammy.norville1@dhhs.nc.gov

Cell: (919) 215-0220

Office: (919) 733-2040 x 229