Common Billing Mistakes

GARFUNKEL HEALTH ADVISORS, INC.

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Alicia has over 36 years of clinical and administrative healthcare experience, specializing in documentation and coding, revenue cycle integrity, and a strong background in both voluntary and mandatory compliance program development and implementation.

She frequently works with business litigation and health law practices on fraud and abuse intervention teams and providing litigation support.

Alicia has presented educational and training seminars nationally on compliance, documentation and coding, and practice management. She is also a frequent author for online physician blogs and journals.

She is an Accredited Health Care Fraud Investigator (AHFI), and is certified in Healthcare Compliance (CHC, CPCO). She is a Certified Professional Coder (CPC), Certified Professional Medical Auditor (CPMA), certified in Risk Adjustment Coding (CRC), and a Certified Professional Practice Manager (CPPM).

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Simon has extensive experience in business and health care administrative operations. His areas of expertise include revenue cycle integrity, documentation and coding, medical auditing, billing processes, payer policies, and compliance. He is a Certified Professional Coder (CPC) and a Certified Professional Medical Auditor (CPMA). Simon is an active member of the American Academy of Professional Coders (AAPC) – Manhattan Local Chapter.

Simon works closely with clients on revenue cycle integrity, routine and complex documentation and coding engagements. He provides in-depth analysis, and assists providers with understanding best practices, and how to identify opportunities while mitigating risk of improper payments.

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OBJECTIVE

Although ASC revenue cycle management is comprised of many complicated responsibilities, each function and duty plays a major role in the success of the facility. As healthcare technology continues to evolve, every function of the revenue cycle must thrive independently and collectively to achieve efficiency throughout the revenue cycle process.

The revenue cycle process begins when the patient or provider schedules the surgery and ends when payment has been received and the account is reconciled.

What are the common ASC pitfalls and solutions to achieving high-performing revenue cycle?

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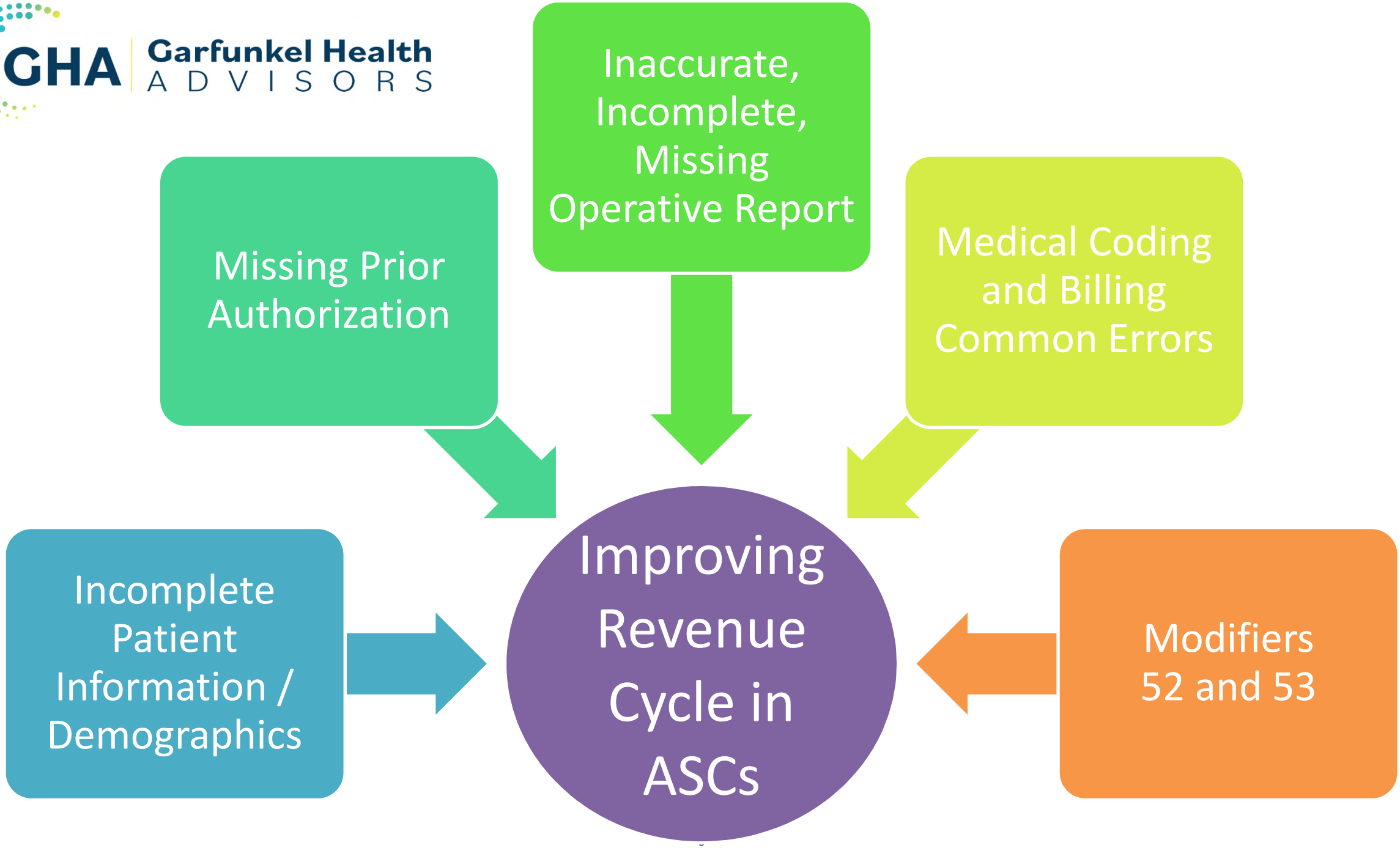

INCOMPLETE PATIENT INFORMATION/DEMOGRAPHICS

To ensure that the provider/facility produces a clean claim, it is imperative to assemble a comprehensive patient chart. The front-end should gather as much patient demographics, financial information, and socioeconomic information prior to the surgery date.

Patient Demographics/Information includes:

- ❑ Name, address, phone number
- ❑ Gender
- ❑ Date of birth
- ❑ Primary and secondary insurance information
- ❑ Policy holder's information (*if applicable*)
- ❑ Workers comp/work related injury (*if applicable*)
- ❑ Occupation and employer information
- ❑ Emergency contact name, address, phone number
- ❑ Reason for the surgery
- ❑ Referral and referring provider
- ❑ Test results or paperwork
- ❑ Authorization
- ❑ Diagnosis/CPT code(s)
- ❑ Consent forms (e.g. assignment of benefits, informed consent, etc.)
- ❑ Deductible/co-insurance/co-payment information

INCOMPLETE PATIENT INFORMATION/DEMOGRAPHICS

The most effective strategy for avoiding claims denials due to front-end issues is to ensure that your staff has proper tools, training and education in the collection of patient demographics and insurance verification.

Lack of front-end controls will result in:

- Insurance carrier rejecting a claim when it is missing key data needed to make an official determination on the claim
- Facility and/or staff do not have the ability to verify patient information for deductible, co-insurance, co-payment, and prior authorization
- Increased amount of claim denials and rejections due to incorrect patient demographics and insurance
- Old insurance cards and ID numbers submitted on an original claim are not recognized by an insurance company
- Errors in patient information are made when staff manually enters into the system. For instance, transposing numbers and letters in the insurance ID, patient date of birth, or zip code
- Increased staff members to chase after the patient for the correct information
- Patient is left in the dark regarding patient responsibility
- Potentially missed opportunities to collect deductible, co-insurance, and co-payment

MISSING PRIOR AUTHORIZATION

Prior authorization (precertification) – obtaining authorization from the health insurance company prior to the date of service allowing the medical treatment due to medical necessity.

It is the responsibility of the front end to ensure that staff verify the insurance and obtain prior authorization prior to the date the patient presents to the ambulatory surgical site.

Causes of not obtaining a prior authorization

- Lack of staff training
- EMR does not have capability to verify and see if an authorization is required
- Poor physician request (missing CPT code(s), ICD-10-CM, etc.)
- Decentralized system
- Not structured pre-registration team

Effects of not obtaining a prior authorization

- Claim denial
- Appealing the claim
- Loss of revenue/Decrease in cash flow
- Increased staff work for accounts receivables
- Authorization is invalid for the service date/procedure code billed

MISSING PRIOR AUTHORIZATION

The key to a successful revenue cycle is to ensure that the patient is pre-registered within 24 hours of their scheduled procedure and that their insurance verification is taken care of.

Failure to obtain a prior authorization request for service will result in the denial of the service, a drastic effect on the practice income, and increased financial risk.

Review all payer policies for all the services rendered at your ASC to see if authorization is required. Update quarterly your EMR systems with the policies and procedures of insurance payers.

Track and run reports to identify the problem for each payer and educate the front-end staff on how to reduce missing prior authorization denials.

INACCURATE, INCOMPLETE, MISSING OPERATIVE REPORT

The operative report is the number one important document that contains details of the surgical procedure(s), describes each part of the surgery, explains the medical necessity, and reveals the results of the surgery.

What should the operative report consist of?

Operative report is broken down into **four** parts: Heading, Indications for Surgery, Body, and Findings/Follow-Up

Heading	Indications for Surgery	Body of Surgery	Findings/Follow-Up
• Patient Information • Date of Service • Facility Information • Surgeon Information • Pre-operative Dx and Post-operative Dx • Procedure(s) Performed	• Patient History • Reason for the surgery • Family History • Pertinent Information • Illness or injury occurred	• Description of the Procedure(s) [prepping, closure, approach, implantation, removal of specimen, intraoperative findings, etc.] • If multiple surgeons, each surgeon should have their own operative report	• Summary of Findings • Complication (*if applicable)* • Follow-up Treatment

INACCURATE, INCOMPLETE, MISSING OPERATIVE REPORT

The operative report serves as proof of service(s) rendered to receive reimbursement for the facility, surgeon, and surgical team.

Poor documentation will result in:

- Increased A/R days
- Charges being posted after the bill has went out the door
- Unbillable procedure(s)
- Increased financial risk and account write-offs

Internal policies and procedures should address:

- Timely completion of the medical record
- Ensure that no charges are posted after the lag time
- Coders and billers have a QA process to ensure all components are complete and accurate. Coder must initiate a physician query to obtain the information
- Provide education to outliers
- Ensure adequate staffing, guidelines, procedures, and training

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INACCURATE, INCOMPLETE, MISSING OPERATIVE REPORT

It is the facilities responsibility to ensure that the medical record is timely, complete, and accurate

THE ASC MEDICAL RECORD			
Medical Record Content: - Assignment of benefits; - Informed Consent; - Release of information; Notice of Privacy Practices; - HIPAA Consent; - Etc.			
	Preoperative DX		Tissue/Organ Removal
	Patient Demographics		Materials Removed/Inserted
	Date of Surgery		Closure Information
	Preoperative Anesthesia		Blood Loss/Replacement
	Diagnostic Report(s)		Wound Status
	Indication for Procedure(s)		Drainage
	Intraoperative Information		Complication Noted
	Postoperative Dx		Postoperative Condition of Patient
	Surgeon/Asst Surgeon/Cosurgeon		IV Insertion/Infusion Record
	Procedure Name		Signature
	Findings		Legibility
	Procedure Details		Supports Procedure (CPT/HCPCS) and Medical Necessity
NOTE: NOT A COMPLETE CHECKLIST. EACH ASC MIGHT HAVE THEIR OWN STATE AND LOCAL REQUIREMENTS			

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MEDICAL CODING AND BILLING COMMON ERRORS

The medical coding and billing team (**aka** back end staff) helps the facility turn their services rendered into billable revenue. Incorrect medical coding of encounters will result in reimbursements being delayed, partially paid, inaccurately paid, or denied. Miscoding a procedure could result in a payment difference between $150 and $1500.

Common coding and billing errors:

- **Unbundling** - the use of separate codes for linked procedures when there is a single code for the entire group of procedures; this illegal act raises compliance and integrity issues of claim submission.
- **Undercoding/Upcoding** – undercoding is when the facility doesn't bill for all of the treatment or services provided while upcoding is billing code(s) for a more complicated or expensive service than what was actually done. While both will pose a compliance risk, undercoding will cause financial loss to the facility.
- **Modifier(s)** – incorrect modifiers used such as RT and LT instead of 50, usage of 26, TC, or global
- **Supplies** – not capturing all the supplies used by the ASC facility
- **Diagnosis Codes** – ICD-10-CM code(s) do not support medical necessity or was not addressed
- **Duplicate Billing** – multiple bills go out for the same patient, same date of service
- **Exceeded timely filing limit** - claims are filed outside the payer's required days of service
- **Missing or incorrect information** – incomplete or missing claim fields, technical issues, etc.

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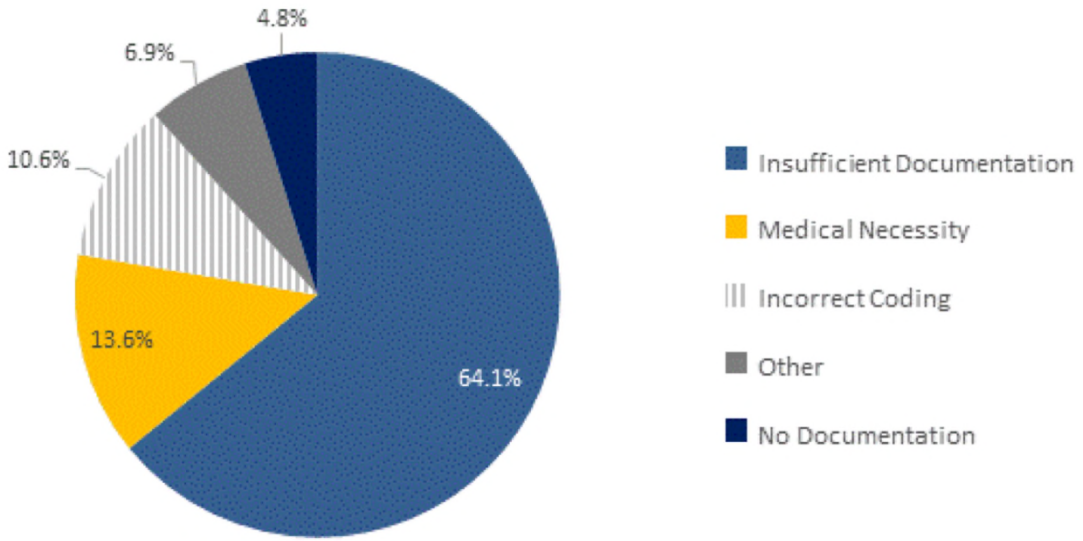
MEDICAL CODING AND BILLING APPROACH FOR SUCCESS

Identifying the problem to reduce financial risk:

- Run constant reports to keep track of front-end issues, provider documentation, and back-end issues.
- Have a strong QA process to ensure claims are going out “clean” on the first submission
- Develop an appropriate lag time for coders to receive complete medical records
- Track to see if claims are going out to the correct insurance carrier and that all secondary payer claims go out the door
- Track all noncovered procedures, items, and supplies
- Track all claims that were adjudicated
- Track any coding or billing denials



Improper Payment Rate Error Categories by Percentage of 2021 National Improper Payment

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MEDICAL CODING AND BILLING SOFTWARE AND EDITS

Many insurance carriers have software and edits in place to ensure that claims follow correct coding practices and basic rules and regulations.

A strong EMR/billing system will ensure that coders have access to:

- **NCCI (National Correct Coding Initiative) edits** – used to promote national correct coding methodology and to control improper coding that leads to inappropriate payment
- **MUE (Medically Unlikely Edits)** – used to prevent improper payments when services are reported with incorrect units of service
- **OCE (outpatient code editor)** – editing system developed by CMS to process outpatient facility claims; the OCE edits identify incorrect and improper coding of these claims
- **NDC/LCD (National/Local Coverage Determination)** –
  - NCD sets forth the extent to which Medicare will cover specific services, procedures, or technologies on a national basis
  - LCD is a decision by the Medicare Area Contractor or carrier whether to cover a particular service on an intermediary-wide or carrier-wide basis
- **Education and training** – ensure staff participate in webinars hosted by medical societies, coding/billing organizations, CMS, and other compliance programs

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REDUCED SERVICES VS DISCONTINUED PROCEDURE

For professional billing on a CMS-1500, there are times when the procedure does not go as planned. In these events, there are guidelines and modifiers that need to be used for these circumstances. A healthcare professional may choose to:

- Terminate the surgical or diagnostic procedure prior to the start of the service
- Unusual circumstances causing a reduction in services
- Discontinue the surgical or diagnostic procedure after the start of the service

For ASC facility billing on a UB-04, there are two possible scenarios for billing purposes.

- Discontinued outpatient/hospital ambulatory surgical center (ASC) procedure **prior to** the administration of anesthesia
- Discontinued out-patient hospital/ASC procedure **after** administration of anesthesia

PROFESSIONAL BILLING SCENARIOS

Terminate the surgical or diagnostic procedure prior to the start of the service

There may be times when the patient presents for surgery and while the patient is being prepped, the patient's blood pressure becomes uncontrolled. Due to uncontrolled blood pressure, the surgeon makes the decision to cancel the surgery due to poor management and reschedule it for a later date.

In this case, the surgeon is unable to bill for the surgical procedure due to the patient's underlying condition. If the surgeon has spent time with the patient and managed their blood pressure, the health care professional may in some cases bill for evaluation and management of the patient.

PROFESSIONAL BILLING SCENARIOS

Unusual circumstances causing a reduction in services

Modifier 52

Descriptor

- Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

Uses

- When procedure has not been completed fully due to unusual circumstances
- To indicate partial reduction of services for which anesthesia is not planned

Documentation

- State why the service was reduced
- Make sure that there is no other CPT code for the reduced service
- What portion of the procedure was not completed and why it was not

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PROFESSIONAL BILLING SCENARIOS

Discontinue the surgical or diagnostic procedure after the start of the service

Modifier 53

Descriptor

- Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure.

Uses

- Discontinued procedure after induction of anesthesia (to continue the surgery, patient will be at risk)
- Append to only one code per operative session

Documentation

- State when the procedure was started
- Reason for the procedure to be discontinued
- State what percentage of the procedure was performed

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COMMON BILLING MISTAKES FOR REDUCED AND/OR DISCONTINUED PROCEDURE

- Missing modifier on the claim form
- Incomplete operative report (does not state why the procedure was reduced or discontinued, etc.)
- Missing information in the narrative on the claim form to support the use of the modifier
- Facility only modifiers used for professional billing
- Applying modifier to non-surgical procedure (e.g., E/M)

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RECOMMENDATIONS AND TAKEAWAYS FOR SUCCESS

1. **Establish internal policies and processes** – clear and strong policies will be the outline for a successful revenue cycle; know all the steps of the revenue cycle
2. **Educate and train all staff** – the front-end, clinical staff, and back-end should all receive continuous education and feedback to ensure that all processes are followed correctly
3. **Monitor and audit performance** – each department in the ASC should be monitored and audited routinely to ensure proper payment. For example:
    i. **Front-End** = run continuous reports to ensure consent forms are complete, patient demographics are accurate, prior authorization is obtained, etc.
    ii. **Clinical staff** = documentation audit to ensure that operative report, nursing operative note, history & physical are all complete and up to date
    iii. **Back-End** = benchmark audit for each coder, continuous reports, and follow-up aging reports
    iv. **Monitor CMS, AMA, etc. for new updates on coding and payment methodologies**
4. **Benchmark results** – keep track of payer modifiers, perform clinical audits, monitor if procedures are paid properly, monitor reimbursement policies

RESOURCES

- **CY 2023 OPPS/ASC proposal rule:** https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center (*final rule expected in November/December of 2022*)
- **Ambulatory Surgical Centers (ASC) Center:** https://www.cms.gov/Center/Provider-Type/Ambulatory-Surgical-Centers-ASC-Center
  - Coding and Billing
  - ASC Payment Systems
  - ICD-10-CM
  - Educational Resources
  - CMS Manuals & Transmittals
  - Polices/Regulations
- **Ambulatory Surgical Centers (ASC) Center:** CMS Manual System, Medicare Claims Processing Manual, Chapter 14, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c14.pdf

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