DIVISION OF COMPLIANCE AND PAYMENT ADVOCACY

• Yolanda Doss, MJ, RHIA, Director, Compliance and Payment Advocacy

• Kavin Williams, CPC, Senior Manager of Public and Private Payment Advocacy
Yolanda Doss, MJ, RHIA, CHPS

Responsibilities include:

– Helping to secure reimbursement for osteopathic services
– Securing the acceptance of osteopathic credentials
– Addressing Medicare issues
– HIPAA compliance
– Fraud and Abuse
Kavin T. Williams, CPC, CCP

Responsibilities include:

– Assists AOA members with reimbursement and health payment policies
– Oversees and assists AOA members with coding and payment disputes with carriers
– Oversees the AOA Coding and Reimbursement Advisory Panel
– Represents the AOA at national reimbursement policy meetings
Quick and Easy Billing for OMT

Objective:

• To provide information related to the documentation and coding for E/M and OMT services
• To clear up confusion about the reporting of these two services on the same date
• To encourage regular internal review of documentation and coding
Maintain Current Resource Materials

- The most current CPT and ICD-9CM coding manuals

- Copies of the latest carrier manuals and updated bulletins

- Easy access to frequently used resources (website addresses, contact names and telephone numbers, etc.)
Why Evaluation and Management (E/M) Coding?

- The E/M codes represent 46% of all Medicare physician reimbursements
E/M Services

- New Patient 99201-99205
- Established Patient 99210-99215
- All of these services are rendered face-to-face.
- The patient is an established patient if they have been seen by the physician, or a physician of the same specialty within that group, within the last three years.
Documentation Guidelines for E/M Services

• Your documentation should support the level of code selected

• There are five levels of services for these codes

• There are three **key** components for determining the level of the E/M code, History (Chief Complaint), Exam, and Medical Decision Making.
Documentation Guidelines for E/M Services

The medical record should be complete and legible.

The documentation of each patient encounter should include:

- reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
- assessment, clinical impression or diagnosis;
- plan for care; and
- date and legible identity of the observer
Documentation Guidelines for E/M Services

If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.

- Past and present diagnoses should be accessible to the treating and/or consulting physician.

- Appropriate health risk factors should be identified.
Documentation Guidelines for E/M Services

The patient’s progress, response to and changes in treatment, and revisions of diagnosis should be documented.

The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
Time as the Key or Controlling Factor

• When is it appropriate to code for time?

• What is the auditor looking for when they review a chart that was billed as time being the controlling factor?
Narrative to Include when Billing for Time

Example of correct documentation of time:
• “I spent 45 minutes with the patient and over 50% of that time was spent discussing …

Example of incorrect documentation of time:
• “I spent 45 minutes with the patient, discussed surgical options versus medical management.”
Osteopathic Manipulative Treatment (OMT)

• Evaluation & Management (E/M) and Modifier-25

• ICD-9 Diagnosis code(s)

• CPT code

• Documentation
Osteopathic Manipulative Treatment (OMT)

• 5 codes for reporting the number of regions treated:
  – 98925 for 1-2 body regions
  – 98926 for 3-4 body regions
  – 98927 for 5-6 body regions
  – 98928 for 7-8 body regions
  – 98929 for 9-10 body regions
Osteopathic Diagnosis codes

- 739 Nonallopathic lesions, not elsewhere classified Includes: segmental dysfunction somatic dysfunction
- 739.1 Head region
  - Occipitocervical region
- 739.2 Cervical region
  - Cervicothoracic region
- 739.3 Thoracic region
Osteopathic Diagnosis codes

- 739.4 Lumbar region
- 739.5 Pelvic region
- 739.6 Lower extremities
- 739.7 Upper extremities
- 739.8 Rib cage
- 739. Abdomen
- Others as appropriate
Coding for OMT

• E/M coding guidelines require that in order to bill any procedure, you must have a procedure note. That note must include the site, the technique utilized and the outcomes for the patient.
Clearing up the confusion

• Per the guidelines in CPT (Current Procedural Terminology) regarding coding for Osteopathic Manipulative Treatment, Evaluation and Management services may be reported separately, using the modifier -25, if the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual pre-service and post-service work associated with the procedure.
Clearing up the confusion, cont’d

• The E/M may be caused or prompted by the same symptoms or condition for which the OMT service was provided. As such, different diagnoses are not required for the reporting of the OMT and E/M service on the same date.
Pre-service...Clearing up the confusion...

E/M Pre-service Work:
- Set the appointment
- Pull the chart
- Identify the patient
- Update demographic information
- Review Chart
- Prepare patient for examination

Osteopathic Manipulative Treatment
- If the evaluation indicates the best intervention on this day, for this patient, is Osteopathic Manipulation, then, and only then, is it necessary to perform the "pre-service" and "post-service" work associated with the procedure.
Documentation is Vital

• An established patient presents for back pain that was treated last week with OMT. The patient was feeling fine after that treatment; however, they are having an exacerbation of back pain post lifting a couch. The patient tried over the counter meds and a heating pad without relief.

• Upon physical exam the physician states the patient is alert and oriented x's three.
Documentation is Vital, cont’d

He/she reviews the musculoskeletal system and diagnoses somatic dysfunction of the cervical region, the thoracic region, and the lumbar region. He/she decides to perform OMT on these three regions. This is the point that the physical exam ends and the OMT procedure begins. At this point he/she should document the note describing the technique (ex, counter strain, muscle energy, etc.) utilized for treatment, and how well the patient tolerated the procedure.
Documentation is Vital, cont’d

Documenting the above scenario would support coding/billing a 99213 E/M code with a -25 modifier and 98926 OMT code. Physical findings must be very clear; it must be evident to any reviewer what documentation is related to the E/M and what documentation is related to the OMT
E/M Claims Scrutiny Continues

• May 2012 OIG Report-Coding Trends of E/M Services:
Medicare payments for E/M services increased by 48% from 2001 to 2010
Spending went from $22.7 billion to $33.5 billion
The Bell Curve of 2001
The Bell Curve of 2011

![Bar chart showing the distribution of new and established patients]

- **New**
  - 1
  - 2
  - 3
  - 4
  - 5

- **Estab.**
  - 1
  - 2
  - 3
  - 4
  - 5
Findings were that physicians increased their reporting of higher level E/M codes in all visit types. (e.g. established, subsequent hospital, emergency department etc.)
2012 OIG Report

Three Recommendations:

• Continue to educate physicians on proper billing for E/M services

• Encourage Its Contractors To Review Physicians’ Billing for E/M Services

• Review Physicians Who Bill Higher Level E/M Codes for Appropriate Action

Regularly perform you own internal auditing of
Medical Necessity

• This area is not black and white
• There are numerous definitions of medical necessity
• Linking the appropriate diagnosis to the appropriate procedure to support the necessity of the procedure performed is critical.
• Medicare defines medical necessity as services or items reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member.
OMT Code Reporting

• Regularly perform your own internal auditing
• Cross-reference the E/M service with the OMT codes. Is there documentation of your review of systems and physical findings documented to support the number of regions treated and billed?
• This is what supports medical necessity of the OMT treatment
Practice Management Website What is There for You

- Billing and Coding
- E/M documentation
- ICD-9-CM code updates
- ICD-10-CM Resource Center
- OMT information
- Health Information Technology; Quality Initiatives, EMR, eRx

CMS/Medicare
- Links to local carrier information
- Information on CPT codes
- CMS Enrollment information
- CMS Medlearn
- CCI link
- Fee schedules, new and prior
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