
University Healthcare Compliance Office

February 2008
Monthly Update



University Health Care

Agenda

10:45 - 10:55 - All Services

- Noridian versus National CMS Manuals
- Noridian Error Rate Calculation
- Timely Filing Requirements
- Educational Product – EduCode
- Medical Record vs. Charge Ticket
- Upcoming Training Sessions
- Useful Websites

10:55 - 11:10 - Physician Services

- Shared Review of Systems
- Billing Two Separate E/M Services
- Finding Diagnosis Codes
- Hospital Employees versus School of Medicine Employees

11:10 - 11:15 - Facility Services

- Billing Two Separate E/M Services – Modifier 27

Noridian versus National CMS Manuals

Example:

- Noridian ESRD Manual
 - Hospitals should be aware the ICD-9 code 585 (Chronic Renal Failure) **will no longer be acceptable without the fourth digit extension** for claims with dates of service on or after October 1, 2005.
- National CMS ESRD Manual
 - Hospital-based facility claims **must have** a principal diagnosis code and it should include a **diagnosis of end stage renal disease.**

Noridian Error Rate Calculation

Medicare Provider Error Rate

- For prepayment review, use the following formula to calculate the provider's service specific error rate:

$$\frac{\text{dollar amount of allowable** charges for services billed in error as determined by Medical Review***}}{\text{dollar amount of allowable** charges for services medically reviewed}}$$

- For post payment review, use the following formula to calculate the provider's service specific error rate:

$$\frac{\text{dollar amount of services paid in error as determined by Medical Review ***}}{\text{dollar amount of services medically reviewed}}$$

**If allowable charges are not available, submitted charges may be used until system changes are made.

***Net out (subtract) the dollar amount of charges under billed

<http://www.cms.hhs.gov/manuals/downloads/pim83c03.pdf>

Timely Filing Requirements

Medicare Usual Time Limit

Date of Service in:	January	February	March	April	May	June
Timely Filing Date	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year
Month to file*	23	22	21	20	19	18

Date of Service in:	July	August	September	October	November	December
Timely Filing Date	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year	Dec 31: Service year plus 1 year
Month to file*	17	16	15	26	25	24

* "Months to file" represent the number of full months plus the remainder of the service month.

Timely Re-Filing Requirements

- Reopening requests must be received within one year from the date the claim completed processing as determined by the date paid on the MSN, Electronic Remittance Advice (ERA) or the Standard Paper Remittance (SPR).
- Reopening requests received after the one year time limit will be dismissed as an untimely request.
- The carrier may, upon request by the party affected, extend the period for filing the request for reopening.
- Good cause for late filing is found in CMS's Internet Only Manual (IOM) Publication Number 100-4, Chapter 29, Section 90.7.
- Good cause for late filing will not be considered over the phone and is not applicable for telephone reopenings as described in CMS's IOM Publication Number 100-4, Chapter 29, Section 90.7

Timely Appeal Requirements

Appeal Level	Time Limit for Filing Request	Monetary Threshold to be Met
1. Redetermination	120 days from date of receipt of the notice initial determination	None
2. Reconsideration	180 days from date of receipt of the redetermination	None
3. Administrative Law Judge (ALJ) Hearing	60 days from the date of receipt of the reconsideration	For requests made before January 1, 2008 at least \$110 must remain in controversy. For requests made on or after January 1, 2008 at least \$120 must remain in controversy.
4. Departmental Appeals Board (DAB) Review	60 days from the date of receipt of the ALJ hearing decision	None
5. Federal Court Review	60 days from date of receipt of DAB decision or declination of review by DAB	For requests made on or before July 1, 2007 at least \$1,090 must remain in controversy. For requests made on or after July 2, 2007 at least \$1,130 must remain in controversy. For requests made on or after January 1, 2008 at least \$1,180 must remain in controversy.

Educational Product – EduCode

- University licensed on-line curriculum includes the following modules:
 - Billing
 - Inpatient Coding
 - HCPCS/CPT Coding
 - Interventional Radiology Coding
 - OPPS
 - Medical Terminology
 - HFMA Compliance
 - Research Curriculum
 - AHA Coding Clinic
 - JCAHO/OSHA Compliance

[MC Strategies EduCode](#)

Educational Product – EduCode

- If your Department is interested in using the on-line training curriculum, please contact:

Morgan Walker

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213-3967

Medical Record vs. Charge Ticket

- A medical record chronologically documents the care of the patient. The medical record facilitates:
 - the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time;
 - communication and continuity of care among physicians and other health care professionals involved in the patient's care;
 - accurate and timely claims review and payment;
 - appropriate utilization review and quality of care evaluations; and collection of data that may be useful for research and education.

Medical Record vs. Charge Ticket

- A charge ticket is:
 - a communication tool between the attending physician and billing office used to facilitate accurate coding/billing.
 - never part of the permanent medical record unless it contains specific clinician documentation that has been appropriately signed and dated.

Upcoming Training Sessions

Mandatory Compliance Training Session Advance Beneficiary Notice

An ABN is evidence of beneficiary knowledge about the likelihood of Medicare denial, for the purpose of determining financial liability for expenses incurred for services furnished to a beneficiary and for which Medicare does not pay. The ABN states “The purpose of this form is to help you make an informed choice about whether or not you want to receive these [items or services/laboratory tests], knowing that you might have to pay for them yourself.” and H§50.2.3H specifies that ABNs are to be given with respect to services furnished to a beneficiary for which denial is expected.

Useful Websites

- [Medicare General Billing Requirements](#)
- [Joint Commission Accreditation Resources](#)
- [University of Utah Health Sciences Center Policies and Procedures](#)
- [ICD-9 Official Guidelines](#)

Physician Services

Shared Review of Systems

- Question
 - I am writing to seek confirmation that where physicians who are part of an academic medical center based integrated health system, utilize a common electronic medical record for patients seen on an outpatient basis in Department offices, and all the physicians are employed by the University, even though the departmental groups have separate tax ID numbers all of which are the University's, that the use of a common record among all the physicians allows them to share a review of systems for E & M billing purposes.
- Answer
 - You are correct that we would allow a common record under the scenario you describe.

Billing Two Separate E/M Services

- It is possible to bill for more than one E/M services, by multiple physicians within a single group practice, on the same date-of-service
- Medicare Claims Processing Manual, 100-04, Chapter 12, 30.6.5, Physicians in a group practice; “If more than one evaluation and management (face-to-face) service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one evaluation and management service may be reported unless the evaluation and management services are for unrelated problems.”
- However, this should be an exception and not the norm (two separate E/M service classes).
- Remember that there are some E/M services where you can only bill for one E/M service per day (i.e. discharge services).

Billing Two Separate E/M Services

Preventive Medicine Service:

When a patient comes into the office for a routine preventive examination and also has significant new complaints the visit becomes a combination of preventive and problem-oriented care. As long as the problem-oriented service is clearly documented and distinct from the documentation of the preventive service, both the preventive medicine services code (99381-99397) for the routine exam and the appropriate office visit code (99201-99215) with modifier -25 can be billed.

Billing Two Separate E/M Services

Preventive Medicine Service:

When the physician or qualified NPP provide a medically necessary E/M service in addition to the “Welcome to Medicare Visit” , CPT codes 99201 – 99215 may be used depending on the clinical appropriateness of the circumstances. CPT Modifier –25 shall be appended to the medically necessary E/M service identifying this service as a separately identifiable service from the “Welcome to Medicare Visit” code G0344 reported.

Billing Two Separate E/M Services

Critical Care Services:

If there is a hospital or office/outpatient evaluation and management service furnished early in the day and at that time the patient does not require critical care, but the patient requires critical care later in the day, both critical care and the evaluation and management service may be paid.

Finding Diagnosis Codes

- ICD-9 official guidelines were been developed to assist both the healthcare provider and the coder in identifying those diagnoses and procedures that are to be reported.
- The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved.
- The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

Finding Diagnosis Codes

- The specific reason for the encounter and the conditions treated, that are documented in the patient's medical record, translate into the ICD-9 diagnosis codes.
- If the patient condition(s) are not listed or referenced in the patient's medical record for the given date-of-service, those ICD-9 codes should not be used.

Hospital Employees versus School of Medicine Employees

- Shared Service - SOS 22 - E/M Physician Services
- Medicare will pay for E/M services for specific non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS) and certified nurse midwife (CNM)) whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service, however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners.
- NPP is a direct employee of the physician, group practice, or have a clear leased agreement that represents an expense to the physician.

Shared Services Medicaid vs Medicare

Facility Services

Billing Two Separate E/M Services – Modifier 27

- Modifier 25 - Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
- Modifier 27 - Multiple Outpatient Hospital E/M Encounters on the Same Date
 - For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s).
 - This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (eg, hospital emergency department, clinic). **Note: This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date.**

Modifier 25 versus 27



Billing Two Separate E/M Services – Modifier 27

Clinical Example

- Medicare patient is seen in a hospital outpatient clinic in the morning and goes to the emergency room for an unrelated condition later in the day. Another example is when a patient presents to the emergency room twice on the same day for unrelated visits.
- If the services are billed on a single claim, the appropriate Emergency Department E/M code and the appropriate level outpatient E/M code should be reported with modifier -27 appended. The G0 condition code should also be used to indicate that the hospital is aware that it is **billing more than one clinic visit on the same day and that those visits are unrelated; and therefore, qualify for separate reimbursement for each visit.**
- For multiple claims, the hospital would bill the clinic services with the appropriate level outpatient E/M code with the modifier -27 appended, and the appropriate revenue and diagnosis code(s). Also, the hospital would bill the emergency room claim with the appropriate level emergency department E/M code, revenue code, diagnosis code(s), and other ancillary service(s) or procedure(s), as appropriate

CPT Assistant, December 2001