THINGS TO TALK ABOUT OTHER THAN THE PRICE OF GAS

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AGENDA

UNDERSTANDING "MEDICAL NECESSITY" BASED ON RULES &DOCUMENTATION

I didn't say it would be fun!

HOW DID IT ALL BEGIN & WHERE ARE WE?

- September 1994 - President Clinton's Health Security Act entitles individuals not to unlimited health care, but to a package of defined insurance benefits with specific exclusions and limitations. Like virtually all reform proposals, it would limit covered benefits to services that are medically necessary. If health reform is to control costs, not all medically necessary care can be covered.
- Who decides what is medically necessary in US healthcare?
- Without a federal definition of medical necessity or regulations listing covered services, health insurance plans will retain the primary authority to decide what is medically necessary for their patient subscribers.

WHERE ARE WE NOW?
FROM THE PERSPECTIVE OF THE PHYSICIAN / CLINICIAN

FROM THE PERSPECTIVE OF THE PHYSICIAN / CLINICIAN

- "Medically Necessary" or "Medical Necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient. The service must be:
  1. For the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms
  2. In accordance with the generally accepted standards of medical practice
  3. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease
  4. Not primarily for the convenience of the patient, health care provider, or other physicians or health care providers
  5. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.
- ***Does This Sound Like a Physician/Clinician?***

FROM THE PERSPECTIVE OF THE PHYSICIAN / CLINICIAN

WHERE ARE WE NOW?

FROM THE PERSPECTIVE OF THE AMERICAN MEDICAL ASSOCIATION “AMA”

&

COMMERCIAL CARRIERS

FROM THE PERSPECTIVE OF THE AMERICAN MEDICAL ASSOCIATION "AMA"

- Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
- "Medically Necessary" or "Medical Necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient.
- According to the AMA:

1. Medical necessity mandates the provision of health-care services that a physician or other health-care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are
2. In accordance with generally accepted standards of medical practice (based on credible scientific evidence published in peer-reviewed literature)
3. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
4. Not primarily for the convenience of the patient, physician or other health-care provider, and not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease
5. In all cases, documentation in the patient's medical record must be consistent with and support the reason that the procedures were performed.

FROM THE PERSPECTIVE OF THE COMMERCIAL CARIERS
Blue Cross & Blue Shield of Oklahoma

Medically Necessary or Medical Necessity shall mean health care services that a physician, hospital or other provider, exercising prudent clinical judgment, would provide to a Member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Member's illness, injury or disease; and
3. Not primarily for the convenience of the Member, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Member's illness, injury or disease.
4. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

FROM THE PERSPECTIVE OF THE COMMERCIAL CARIERS

Cigna of Oklahoma

- Cigna's "Medically Necessary" or "Medical Necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient. The service must be:
  1. For the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms
  2. In accordance with the generally accepted standards of medical practice
  3. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease
  4. Not primarily for the convenience of the patient, health care provider, or other physicians or health care providers
  5. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease
- For these purposes, "generally accepted standards of medical practice" means:
  1. Standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community
  2. Physician Specialty Society recommendations
  3. The views of physicians practicing in the relevant clinical area
  4. Any other relevant factors

WHERE ARE WE NOW?

FROM THE STANDPOINT OF THE GOVERNMENT

HOW DOES THE GOVERNMENT DETERMINE MEDICAL NECESSITY - *SOUND FAMILIAR*

1. "Medical necessity mandates the provision of health-care services that a physician or other health-care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are in accordance with generally accepted standards of medical practice (based on credible scientific evidence published in peer-reviewed literature)
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
3. Not primarily for the convenience of the patient, physician or other health-care provider, and not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease
4. In all cases, documentation in the patient's medical record must be consistent with and support the reason that the procedures were performed."
5. #1 - #4 matches the American Medical Associations

FROM THE STANDPOINT OF THE GOVERNMENT

- "Medicare, for example, defines *medically necessary* as: "Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice."
- "Medicare and private insurers have varying criteria for determining whether a given procedure is medically necessary based on the patient's circumstances. Medicare uses National Coverage Determinations and private Medicare plans (i.e., Medicare Advantage) use Local Coverage Determinations in order to ensure that the criteria for medical necessity are met."
- Medicare Glossary states medically necessary refers to:

1. Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.
2. Anything deemed "medically necessary" is vital to the Medicare process and coverage because Medicare only helps pay for what is absolutely needed to help treat an injury, illness, or other medical condition.

FROM THE STANDPOINT OF THE GOVERNMENT

- "It is critically important that we get fraudsters off the streets, protect patients from harm, find misspent funds, reduce improper payments, and ferret out mismanagement."

Christi A. Grimm, Inspector General

WHY IS THIS IMPORTANT?

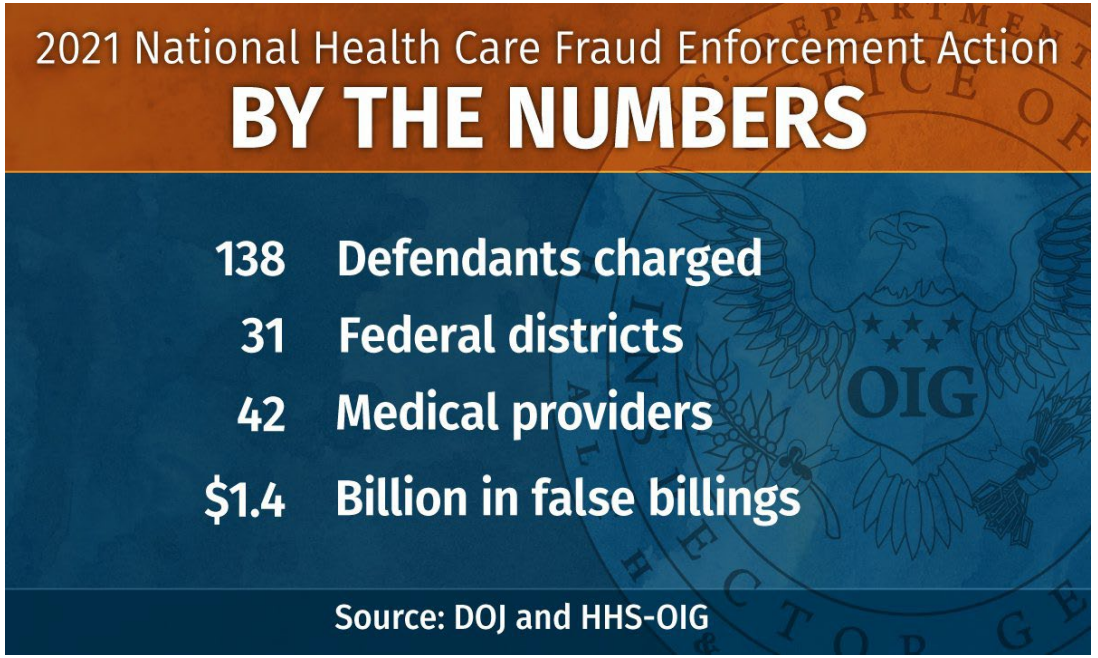
The government has stated: "When you submit a claim for services performed for a Medicare patient, you are filing a bill with the Federal Government and certifying that you have earned the payment requested and complied with the billing requirements."

WHY IS THIS IMPORTANT?

1. Social Security Act (SSA) issues approximately $1 trillion in benefit payments annually.
2. In its financial report, SSA estimated it made approximately $7.9 billion in improper payments in FY 2019.
3. Of those, $6.6 billion were overpayments
4. $1.3 billion were underpayments.
5. OIG believes the Agency needs to prevent improper payments
   a) through automation and data analytics that identify changes that affect benefit payments;
   b) expand efforts to collect data from reliable third-party sources;
   c) do more to address the root causes of improper payments;
   d) ensure staff have adequate training and technology;
   e) And periodically review manual processes to determine whether they can be automated to reduce computation errors.

DEPARTMENT OF JUSTICE - UPDATE

- A psychiatrist was fined $400,000 and permanently excluded from participating in the Federal health care programs for misrepresenting that he provided therapy sessions requiring 30 or 60 minutes of face-to-face time with the patient, when he had provided only medication checks for 15 minutes or less. The psychiatrist also misrepresented that he provided therapy sessions when in fact a non-licensed individual conducted the sessions.
- A dermatologist was sentenced to 2 years of probation and 6 months of home confinement and ordered to pay $2.9 million after he pled guilty to one count of obstruction of a criminal health care fraud investigation. The dermatologist admitted to falsifying lab tests and backdating letters to referring physicians to substantiate false diagnoses to make the documentation appear that his patients had Medicare covered conditions when they did not.
- An endocrinologist billed routine blood draws as critical care blood draws. He paid $447,000 to settle allegations of upcoding and other billing violations.



DIFFICULTIES IN DEFINING MEDICAL NECESSITY

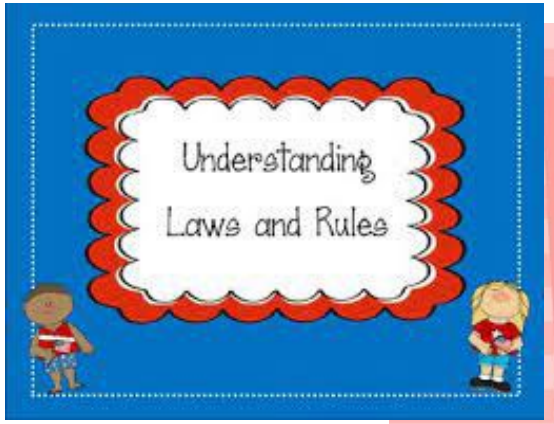
1. "Access to health services in both managed care plans and in government health care programs can depend in part on the *medical necessity* of a service provided.
2. The definition of the term *medical necessity* varies depending upon whether the term is being used by providers, physicians, courts, government insurers, private insurers, or consumers.
3. From the providers' point of view, *medical necessity* is used by managed care plans as a rationing tool to deny access to necessary care, especially to those patients with special health care needs.
4. From the federal government's point of view, the Medicare and Medicaid statutes authorize payment only for *medically necessary* care and impose criminal and civil liability for filing claims that are "medically unnecessary."

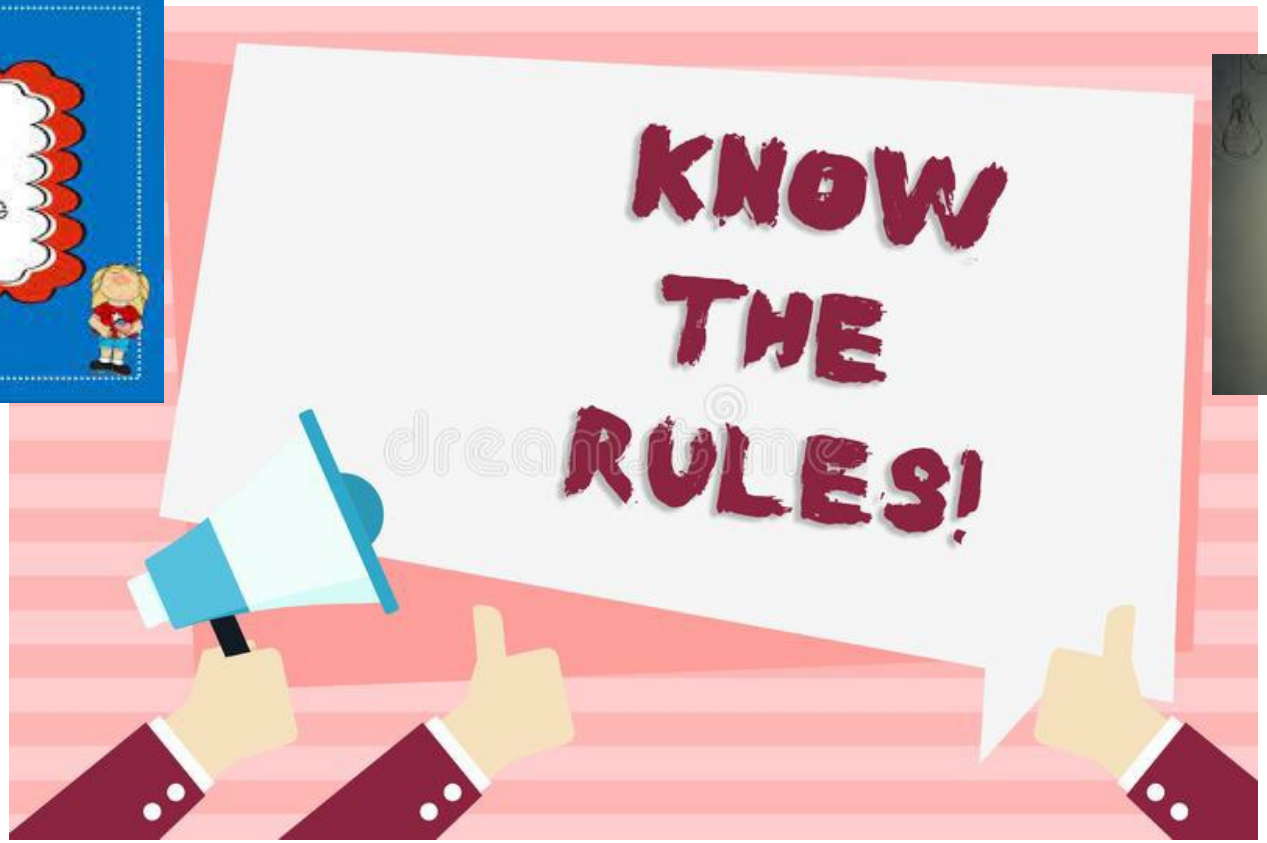
By Morris A. Landau, J.D., M.H.A., LL.M. Candidate January 29, 2000

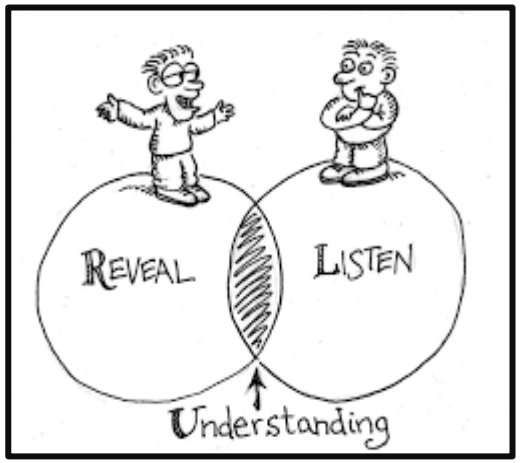
WHAT DOES THE FUTURE HOLD?

An increase in Audits…. *The CMS budget for fraud, waste and abuse has doubled in size from 2021 to 2022.*

WE KNOW WHAT THEY WANT
BUT HOW DO WE PROVE IT







UNDERSTAND THE SOCIAL SECURITY ACT (SSA) GOVERNMENT AS WELL AS OTHER PAYERS - RULES TO FOLLOW
REASONABLE & NECESSARY GUIDELINES

- Section 1862(a) (1) (A) of the Social Security Act directs the following:

  "No payment may be made under Part A or Part B for any expenses incurred for items or services not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

REASONABLE & NECESSARY GUIDELINES: UNDERSTAND THE SOCIAL SECURITY ACT RULES TO FOLLOW

- Section 1862(a) (1) (A) states the service must be:
  1. Safe and effective.
  2. Not experimental or investigational; and
  3. Appropriate, including the duration and frequency in terms of whether the service or item is needed.
  4. Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary's condition or to improve the function of a malformed body member.
  5. Furnished in a setting appropriate to the beneficiary's medical needs and condition.
  6. Ordered and furnished by qualified personnel.
  7. One that meets, but does not exceed, the beneficiary's medical need.
  8. For any service reported to Medicare, it is expected that the medical documentation clearly demonstrates that the service meets all of the above criteria. All documentation must be maintained in the patient's medical record and be available to the contractor upon request.

#1 – SAFE AND EFFECTIVE

- Section 1862(a) (1) (A) states the service must be established as safe and effective. The treatment must be consistent with:

1. The symptoms or diagnosis of the illness or injury;

   Example: The patient has no symptoms related to their cardiovascular system but has a Great Aunt that died from a heart attack. The patient is demanding a stress test just in case.

2. Generally accepted professional medical standards;

   Example: The patient has a mother who died from colon cancer at the age of 52. She has no symptoms and is under the age of 50. Her physician has agreed to scheduling a colonoscopy.

3. Not furnished primarily for the convenience of the patient, or physician;

   Example: The patient wants the physician to schedule an MRI because she is worried about brain cancer after watching a movie. The physician scheduled the MRI.

4. At the most appropriate level that can be provided safely and effectively to the patient.

   Example: The patient presents to the office with a complex medical condition. The very busy provider charges a 99215 for this patient, completes the medical record two months after the date of service. The signature was performed by the nursing staff before the claim was sent. The claim is billed to Medicare the next day processed as a clean claim. A few months later the record is selected for review by Medicare. The medical record clearly supports a level 5. However, the record was not signed in a timely manner and an audit trail identifies that the signature was not the provider but a staff member.

- Questions to Ask Yourself - A) Was the medical record documented in a reasonable time? B) Who signed the record? C) What does the audit trail say? D) Does the insurance have a policy that determines timelines for procedures to be performed? E) What is illness or injury for each example?

#2 – NOT EXPERIMENTAL OR INVESTIGATIVE

- Section 1862(a) (1) (A) –
  - "Not experimental or investigational…."
    - Example: Sixteen devices were cleared or approved by FDA in 2022. That is a start, but it doesn't mean there is a code that will support it. Is there a new LCD (Local Coverage Determination) or NCD (National Coverage Determination) to review? Chances are good that if there is a code there is an LCD or NCD. Remember if the government is going to pay for the item and/or service, it must be medically necessary and meet all of the requirements.
  - Questions to Ask Yourself:
    - Is there a current CPT code for the year the service was performed?
    - Does your staff have a current CPT code book?
    - Has the code changed in any way when compared to previous year? Don't assume it hasn't.
    - Is it a Category III Code (temporary code)? These codes do not get paid
    - Is it an S Code (HCPCS S codes report **drugs, services, and supplies for which national codes do not exist but are needed to implement policies, programs, or support claims processing**. They are not payable by Medicare.)
    - Can I use a modifier and bill the patient?
    - Is there an LCD or NCD that needs to be taken into consideration?
      - AND THIS IS ONLY THE BEGINNING!

#3 – APPROPRIATE CARE FOR SERVICE & ITEM

- Section 1862(a) (1) (A) –
  - "Appropriate, including the duration and frequency in terms of whether the service or item is needed."
    - Example: The patient wants to get a covid test at the doctor's office just to make sure they don't have covid. After the Medical Assistant discussed the situation with the provider, the test was performed.
    - Questions to Ask Yourself:
      - When was the last covid test given to this patient?
      - Why do they want it?
      - Are they asymptomatic?
      - Who saw the patient?
      - Who order the test?
      - Is there an LCD "Local Coverage Determination" or an NCD "National Coverage Determination" that would limit the number of times this can be performed on the date of service the patient was seen?
      - Has there been any changes in the guidelines as it relates to the date of service the patient was seen?

#4 – FURNISHED IN ACCORDANCE WITH ACCEPTED STANDS OF MEDICAL PRACTICE

- Section 1862(a) (1) (A) –
  - "Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary's condition or to improve the function of a malformed body member."
    - Example: The patient presented to the clinic with complaints of pain in his right leg after falling. A bilateral x-ray was ordered and performed. It was determined that the patient needed a cast which was performed in the office after the initial examination.
    - Questions to Ask Yourself:
      - Does the medical record support the need for a bilateral x-ray? Based on the example would a bilateral x-ray be medically necessary?
      - Who ordered the x-ray?
      - Who signed the order?
      - When was the order signed? Was it a verbal order?
      - Was the personal performing the x-ray qualified to do so?
      - Was the personal putting a cast on qualified?

#5 – FURNISHED IN AN APPROPRIATE SETTING

- Section 1862(a) (1) (A) –
  - "Furnished in a setting appropriate to the beneficiary's medical needs and condition."
    - Example: The patient came into his oncologist office two weeks ahead of time with complaints of exhaustion. The patient's doctor was unavailable so the patient was seen by the Nurse Practitioner. After evaluating the patient, it was determined that due to his medical history, the patient needed a CDC. Since he was scheduled to come back and see the oncologist, she also ordered a urine test with additional labs that were standard for the patients care when he returns in two weeks. The order was explained to the Medical Assistant who called the lab with the instruction.
    - Question to Ask Yourself–
      - Is the setting appropriate to the patient medical needs and their condition?

#6 – QUALIFIED PERSONNEL

- Section 1862(a) (1) (A) –
  - "Ordered and furnished by qualified personnel."
    - Same Example from #5 but Different Question: The patient came into his oncologist office two weeks ahead of time with complaints of exhaustion. The patient's doctor was unavailable so the patient was seen by the Nurse Practitioner. After evaluating the patient, it was determined that due to his medical history, the patient needed a CDC. Since he was scheduled to come back and see the oncologist, she also ordered a urine test with additional labs that were standard for the patient care when he returns in two weeks. The order was explained to the Medical Assistant who called the lab with the instruction.
    - Question to Ask Yourself–
      - Is a Nurse Practitioner allowed to see this patient?
      - Does it matter what insurance policy the patient has?
      - Does the Nurse Practitioner have a current license, not been excluded from Medicare, has a contract with the payer in question, has a current NPI number, and does not require supervision?
      - Who should be listed as the performing provider?
      - Who should be listed as the ordering provider?

#7 – MEETS, BUT DOES NOT EXCEED, MEDICAL NEED

- Section 1862(a) (1) (A) –
  - "One that meets, but does not exceed, the beneficiary's medical need."
    - Example: Same Example from #5 but Different Question: The patient came into his oncologist office two weeks ahead of time with complaints of exhaustion. The patient's doctor was unavailable, so the patient was seen by the Nurse Practitioner. After evaluating the patient, it was determined that due to his medical history, the patient needed a CDC. Since he was scheduled to come back and see the oncologist, she also ordered a urine test with additional labs that were standard for the patient care when he returns in two weeks. The order was explained to the Medical Assistant who called the lab with the instruction.
    - Questions To Ask Yourself –
      - Did the patient need a full panel CDC?
      - What was the justification in the urine test?
      - Why were additional labs ordered?
      - Was this for the convenience of the patient and/or the physician in two weeks?
      - Did it meet the beneficiary's medical need?
      - Were there any written orders?
      - Were there any signed orders? If yes, who signed them?
      - Are verbal orders acceptable? What are the rules?

8 – MEETS ALL THE CRITERIA

- Section 1862(a) (1) (A) –
- "For any service reported to Medicare, it is expected that the medical documentation clearly demonstrates that the service meets all of the above criteria. All documentation must be maintained in the patient's medical record and be available to the contractor upon request."

ALL OF THE ABOVE CRITERIA - means for this presentation all seven preceding elements listed.

A MORE EVEN PLAYING FIELD – LET'S LEARN

- Proper Signatures
- Correct Dates of Services Billed
- Orders Properly Documented
- Billing Under the Correct Rendering Provider
- Abide all - Local Coverage Determinations (LCD) or National Coverage Determinations (NCD)
- Bill The Appropriate Code Sets
- Have Proper Documentation
- Send Proper Documentation When Asked by the Government or a Commercial Payer
- Internal Reviews
- External Reviews

WE KNOW WHAT THEY WANT
BUT HOW DO WE PROVE IT
THINGS TO THINK ABOUT – TOOLS TO USE

1. Safe and effective - What are the approved locations for the service billed?
2. Not experimental or investigational – Start with the CPT, HCPCS & ICD10
   - Is there a current CPT code for the year the service was performed?
   - Does your staff have a current CPT code book?
   - Has the code changed in any way when compared to previous year? Don't assume it hasn't.
   - Is it a Category III Code (temporary code)? These codes do not get paid.
3. Appropriate, including the duration and frequency in terms of whether the service or item is: - Is there an LCD "Local Coverage Determination? Is there an NCD "National Coverage Determination?"
   - Do you have the most recent LCD and/or Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary's condition or to improve the function of a malformed body member;
   - Furnished in a setting appropriate to the beneficiary's medical needs and condition.

WE KNOW WHAT THEY WANT
BUT HOW DO WE PROVE IT
THINGS TO THINK ABOUT – TOOLS TO USE

1. Novitas Fee Schedule – This tool will help you to identify supervision requires.
2. If you hear of a new type of medical equipment or test, make sure it is fully vetted by people in the health care industry which includes billers, attorneys, and consultants. The vender doesn't always know.
3. Ordered and furnished by qualified personnel – Who performed the service, who signed the medical records, who ordered the service, who billed the service?
4. One that meets, but does not exceed, the beneficiary's medical need – Is the medical record unique for the service performed and clearly explain what you did? Can you show the government your medical records?
5. For any service reported to Medicare, it is expected that the medical documentation clearly demonstrates that the service meets all of the above criteria. All documentation must be maintained in the patient's medical record and be available to the contractor upon request.

HOW DO YOU KNOW YOU MADE A MISTAKE DENIAL MESSAGES & LETTERS FROM A FEDERAL CONTRACTOR START HERE

- The denial messages is the first step in determining how you were judged by the government.
- Audit Request & Results “After a clinical review, nurse reviews and processes a claim for payment, either an electronic remittance advice (ERA) or a standard paper remittance (SPR) is sent with the final claim adjudication and payment information.”
- EOBs – “Explanation of Benefits” – Look at the Denial Code

DENIAL MESSAGES

MCS Denial Message:	RARC Displayed on the RA:	Description	Additional Description	Explanation
073	M127, 596, 287, 95	Missing patient medical record for this service.	The information provided does not support the need for this service or item.	Denial was received because the provider did not respond to the development request; therefore, the services billed to Medicare could not be validated.
119/120	N205	Information provided was illegible.	The information provided does not support the need for this service or item.	The documentation received from the provider responding to the development request was illegible and a claim payment decision could not be made.

DENIAL MESSAGES, CONT.

MCS Denial Message:	RARC Displayed on the RA:	Description	Additional Description	Explanation
198/533	N109, N705, N706, 596, 287, 294/ N206	The supporting documentation does not match the claim.	Information requested from the billing/rendering provider was not provided or not provided timely or was insufficient/incomplete. These are non-covered services because this is not deemed a "medical necessity" by the payer. The information provided does not support the need for this service or item.	The documentation submitted for development response does not support the information on the claim for which the documentation was requested, such as: -Beneficiary does not match -Date of service does not match -Rendering provider billed does not match rendering provider who authored the medical record documentation.

DENIAL MESSAGES, CONT.

MCS Denial Message:	RARC Displayed on the RA:	Description	Additional Description	Explanation
F09	N32	Claim must be submitted by the provider who rendered the service.	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. This item or service was denied because information required to make payment was incorrect.	The provider receiving the request for records has indicated the service was billed in error.
915	N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	Exact duplicate claim/service. This a duplicate of a charge already submitted.	The claim submitted for review is a duplicate to another claim previously received and processed.

DENIAL MESSAGES, CONT.

MCS Denial Message:	RARC Displayed on the RA:	Description	Explanation
124, 125, 128, 129, A10, A11	N109/N115, 596, 287, 412	ALERT: This claim was chosen for medical record review and was denied after reviewing the medical records. This decision is based on a Local Medical Review Policy (LMRP) or LCD. A copy of this policy is located on the internet. If you do not have web access, you may contact the contractor to request a copy of the LMRP/LCD.	The information provided does not support the need for this service or item. The service was medically reviewed by the medical review department and did not meet the guidelines established by Medicare or local policy for the service billed.

DENIAL MESSAGES, CONT.

MCS Denial Message:	RARC Displayed on the RA:	Description	Additional Description	Explanation
B19	N109/MA81, 596, 297, 412	ALERT: This claim was chosen for medical record review and was denied after reviewing the medical records.	The information provided does not support the need for this service or item.	The service was medically reviewed by the medical review department and did not meet the signature requirements established by Medicare.

DENIAL MESSAGES, CONT.

MCS Denial Message:	RARC Displayed on the RA:	Description	Additional Description	Explanation
139, 141 142, 147, A14, A15	N109, N115	ALERT: This claim was chosen for medical record review and was denied after reviewing the medical records. This decision is based on a Local Medical Review Policy (LMRP) or LCD. A copy of this policy is located on the internet. If you do not have web access, you may contact the contractor to request a copy of the LMRP/LCD.	Procedure/treatment has not been deemed "proven to be effective" by the payer.	The service was medically reviewed by the medical review department and did not meet the guidelines established by Medicare and is considered experimental.

NOW WE KNOW WHAT THEY WANT
BUT HOW DO WE PROVE IT
START WITH THE EASY STUFF

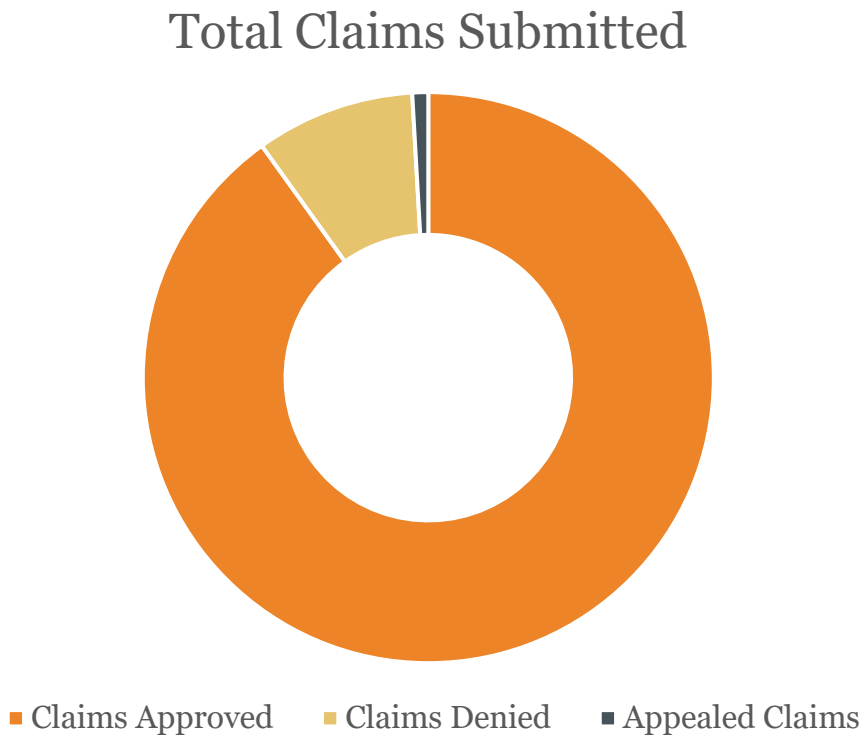
- Verify the medical record will support the diagnosis billed. Never pick a diagnosis because some one said, “it will get paid”.
- Billing for services that you did not actually render – Who was listed as the rendering provider on the claim?
- Billing for services that were not signed before the claim was sent and paid by a payer.
- Billing for a service that was not documented or cannot be found.
- Billing a provider that wasn’t the rendering provider.
- Billing under a provider because they were enrolled in Medicare/Medicaid even through they didn’t see the patient.
- Billing for services under your NPI number when out of town.
- Billing incorrectly a Locum provider.
- Billing a clinical E/M level – using the old rules for your documentation.
- Billing for services that were performed by an improperly supervised or unqualified employee – DME codes changed the requirement for some codes to require a “person responsible for fitting must have expertise in the service being performed” Additional training!

WE KNOW WHAT THEY WANT
BUT HOW DO WE PROVE IT
START WITH THE EASY STUFF

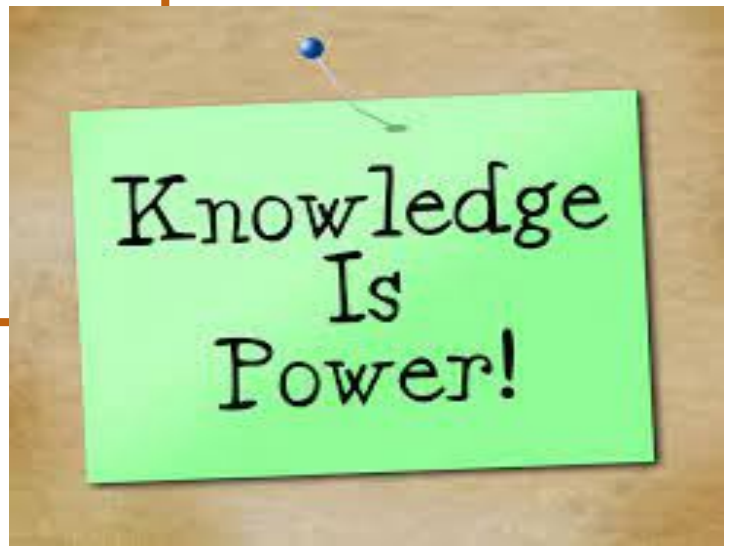
- Billing for services that were performed by an employee who has been excluded from participation in the Federal health care programs.
- Billing for services of such low quality that they are virtually worthless.
- Billing for a service that doesn't have an appropriate CPT/HCPCS but you billed one that was close.
- Billing separately for services already included in a global fee, like billing for an evaluation and management service the day after surgery.
- Failing to send all medical records necessary to support the code(s) billed.
- Failing to send medical records when requested by a federal or commercial payer.
- Failing to support medical necessity because you ordered and billed a diagnostic service which was never reviewed prior to the procedure.
- Billing for services that were not medically necessary – Hopefully, this presentation helped all of us to learn something useful.

DENIALS CAN HURT YOUR BOTTOM LINE

- Of all claims submitted, roughly 10% are denied.
- Only 1% of those claims can be appealed.
  - For example: If a practice is submitting 50 claims a day, with an average reimbursement rate of $100/claim, the daily revenue would be $5,000. If 10% of those claims are denied (and only 1% can be appealed), the practice is losing $400 every day and a whopping $100,000 per year.
  - Additionally, the practice is losing money with every claim that is appealed, roughly anywhere from $25-$118 per claim.



CONCLUSIONS



- As slide 43 demonstrated, if you have 10% of your claims denied the first time, it is not only expensive to rebill (approximately $25 - $18 per claim) but if you don't fix the problem, you not only don't get paid but it cost you more money.
- The rules may seem difficult but not as difficult as taking care of a patient and paying for the privilege.
- You've already made the first step! You came to the presentation today.

THANK YOU

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REFERENCES AND RESOURCES

- https://oig.hhs.gov/documents/physicians resources/947/roadmap_web_version.pdf (slide 15)
- https://www.fda.gov/medical-devices/recently-approved-devices/2022-device-approvals (slide 24)
- Data from AAPc webinar: "Common denials" 2022 (slide 41)
- https://www.ssa.gov/OP_Home/ssact/title18/1862.htm
- U.S. Dept of Health & Human Services, Office of Inspector General "A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse."
- https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?Adf-Window-Id=w162npcszcu
- https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00154325
- https://racmonitor.com/more-money-for-cms-means-more-medicare-audits/
- Blue Cross and Blue Shield of Oklahoma Facility *BluePrint* Manual (05/08)
- https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?Adf-Window-Id=w4wpbjecl1
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- https://www.audiology.org/news-and-publications/audiology-today/articles/coding-and-reimbursement-what-is-medical-necessity/
- Office of the Inspector General, Social Security Administration, "Fiscal Year 2022 Audit Work Plan."
- https://www.aafp.org/fpm/2006/0700/p28.html
- https://aginginplace.org/finance-legal/medically-necessary-defined/