Michigan Department of Health & Human Services (MDHHS)

Protecting Revenue:
Coding and Billing
in the Family Planning Setting

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April 19, 2018

Today's Agenda

- Identify Challenges
- Managing Revenue: Front End
- Capturing the Visit – Codes for Billing
- Strategies for Quality Assessment and Improvement (QA / QI)
- Coding and Billing Scenarios
- Managing Revenue: Back End
- Resolving Challenges - Strategies
- Q & A and Action Planning

The Reimbursement Team

- Managing the "**Revenue Cycle**" of your health center effectively is key to **fiscal sustainability**

- The following roles must <u>all work together</u> in your agency to assure efficient, effective reimbursement management:

Front Desk	→	Clinical Staff	→	Check-out	→	Charge Capture and Billing Team	→	Manage-ment
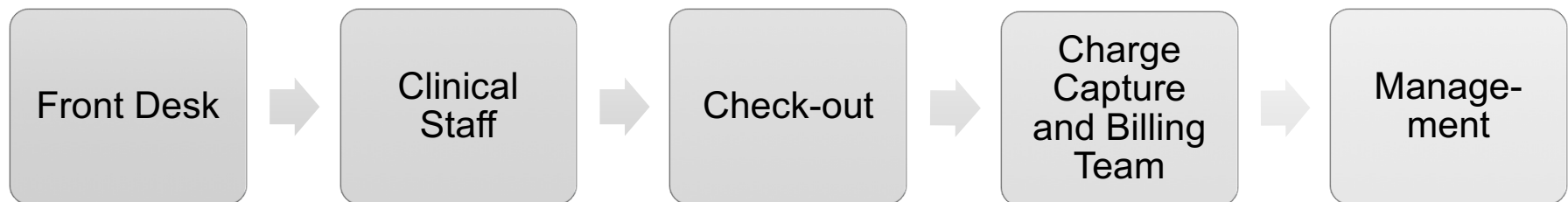
The Revenue Cycle

There are 3 main components of the revenue cycle, all of which offer opportunities to strengthen fiscal practices:

- **Claim submission**
- **Remittance review**
- **Denial appeals**
- **A/R Follow-up and collections**
- **Reporting and analysis**

Back End:
Post-Visit

Front End:
Pre-Visit

Intermediate:
Visit
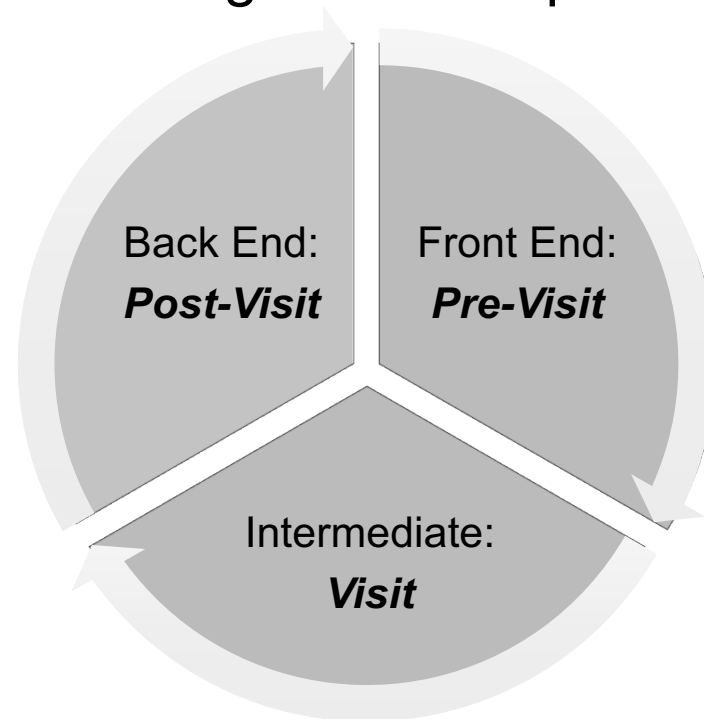
- **Appointment scheduling and registration**
- **Insurance verification**
- **In person fiscal assessment**
- **Authorizations**

- **Patient encounter**
- **Coding of visit**
- **Checkout**

Challenges:
Getting Paid for Contraceptive Services

FRONT END

CLINICAL ENCOUNTER

BACK END
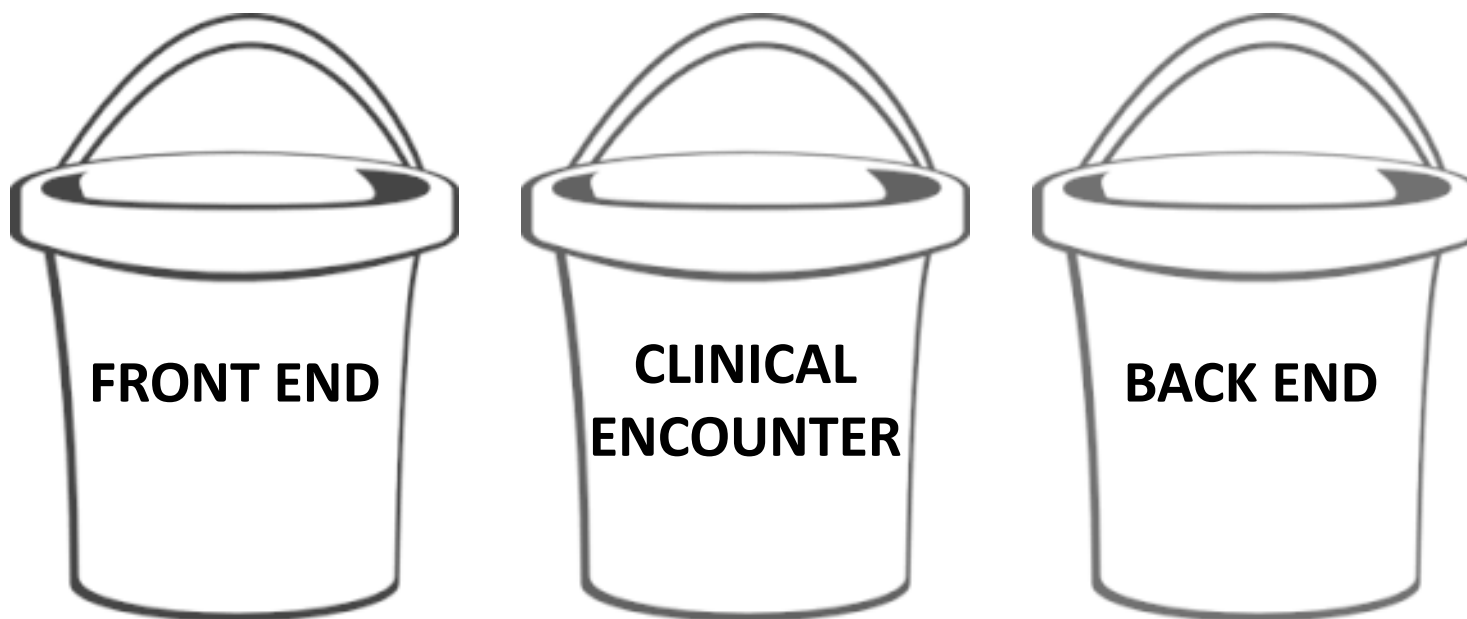
Common Challenges

- Coverage - Patient not having coverage

- Stocking - Hard for clinic to afford to stock expensive LARC devices impacting same day insertions

- Coding - Clinicians do not properly document and code for all services leading to revenue loss

- Billing - Claims billed incorrectly

- Culture change – less funding, more people with insurance, fiscal sustainability

Challenges (2)

- Changing mindset regarding payment expectations

- Training/turnover

- Unclear policies and procedures

- Data extraction issues (user knowledge, system limitations)

- Time to do your job right – multi-tasking expectations

- Others?

Common Coding Challenges

- Contraceptives and units not coded correctly

- Incorrect ICD / CPT codes

- Missing services

- EHR and templates using codes not supported in documentation

- Modifier misuse causing under / overpayments

- Incorrect claim submission details (FP indicators, units, demographics)

Common Coding Challenges (2)

- Lab tests: documented but not billed or billed but not done

- Other add-on services not billed. Example: After hours access add-on, Interpreter services...)

- Medical necessity of services or tests not clear to outside reviewer or supported

- Under-reporting of charges resulting in low payments
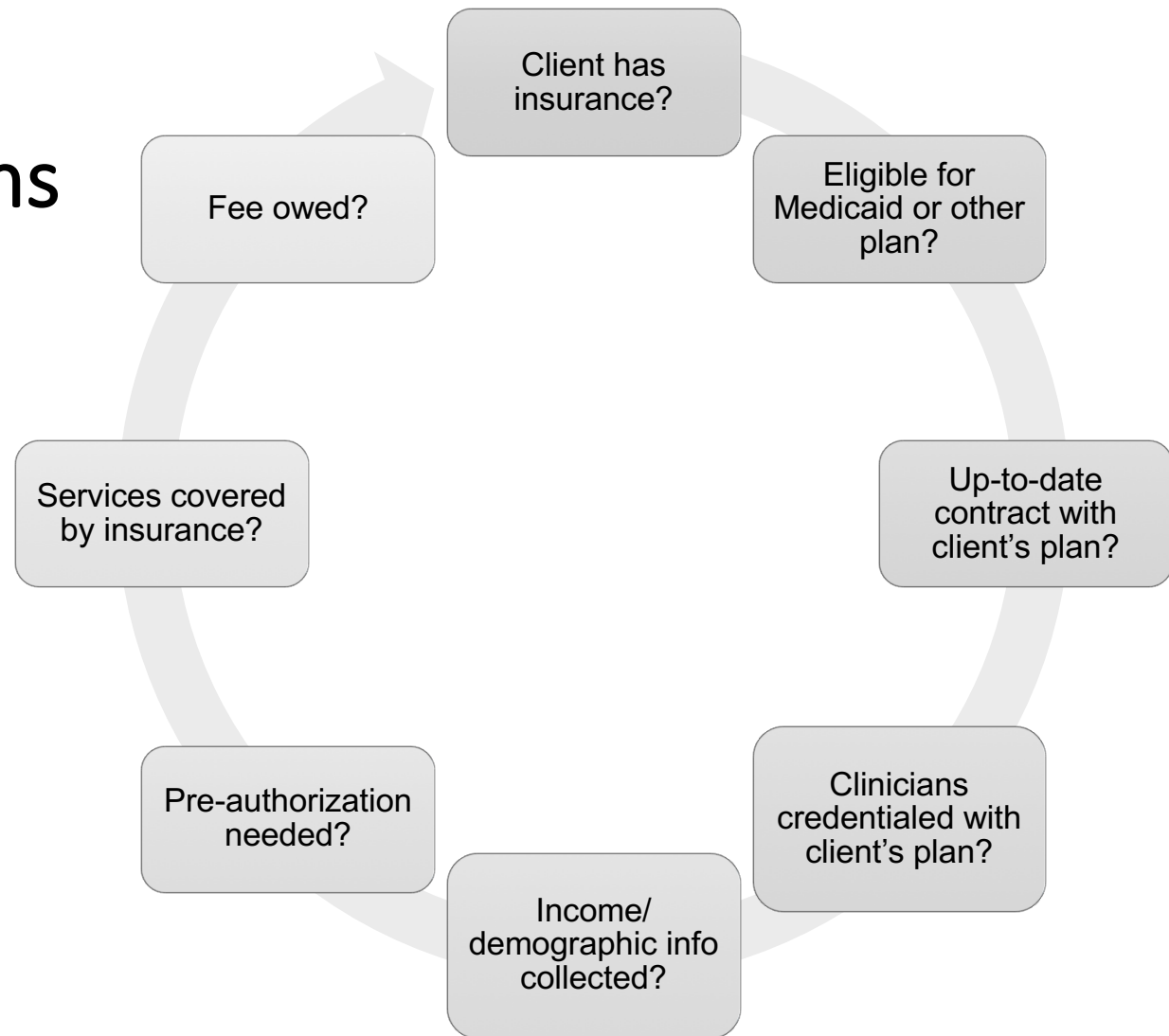
- Others?

Managing Revenue

Front End

Front End: Pre-visit

Activities tying into the revenue cycle:

- Scheduling

- Registration & client intake

- Information/insurance verification & authorization

- Financial counseling & screening

- Collection of fees & outstanding expenses

Front End: Key Questions

- Client has insurance?
- Eligible for Medicaid or other plan?
- Up-to-date contract with client's plan?
- Clinicians credentialed with client's plan?
- Income/ demographic info collected?
- Pre-authorization needed?
- Services covered by insurance?
- Fee owed?

ACA: Contraceptive Services

- Plans must cover preventive services without charging patients a copayment or coinsurance *(Grandfathered, religious-based plans and other exclusions may apply)*

- Contraceptive methods and contraceptive counseling are included in this category

Patients should NOT have any out-of-pocket costs, including payment of deductibles, co-payments, co-insurance, fees, or other charges for coverage of contraceptive methods, including LARC

What's Covered?

- ALL 18 FDA-approved methods of contraception, including sterilization, LARC insertions and removals, and related education and counseling

- Services related to follow-up and management of side effects, counseling for continued adherence, and device removal

FDA-Approved List

- Sterilization surgery for women
- Sterilization surgical implant for women
- Implantable rod
- IUD Copper
- IUD with Progestin
- Shot/Injection
- Patch
- Vaginal Contraceptive Ring
- Oral Contraceptives (Combined Pill)

- Oral Contraceptives (Progestin only)
- Oral Contraceptives Extended/Continuous Use
- Diaphragm with Spermicide
- Sponge with Spermicide
- Cervical Cap with Spermicide
- Female Condom
- Spermicide alone
- Plan B/Plan B One Step/Next Choice
- Ella

- *April 19, 2018*

What's Not Covered ?

- Brands within one category
  - Oral Contraceptives: all brands may not be covered
  - IUD with Progestin: payer may only cover one choice
    - Mirena, Liletta, Skyla, Kyleena
- Can apply for a waiver exception with most plans

- Any rule that denies coverage without cost-sharing for an entire method category of contraception is not allowed
  - A plan cannot say it only covers generic forms of birth control and therefore deny coverage for all IUDs

National Women's Law Center CoverHer Hotline (Payor Issues)

- FAQs about laws re: BCM coverage requirement

- What plans are and are not allowed to do around cost-sharing; known issues

- Appeal letters for insurance companies: instructions and sample letters

- Website: www.coverher.org

- Hotline: 1-866-745-5487 and coverher@nwlc.org

COVER HER
The health care you need. The coverage you deserve.
NATIONAL WOMEN'S LAW CENTER   CoverHer.org

state of birth control
coverage: health plan
violations of the affordable care act

Benefit Verification

- Front desk staff should verify patient coverage **before EACH visit**

- Provide patients with information regarding method choices PRIOR to the appointment

  - Example: refer them to Bedsider.org

  - When scheduling, as reminder texts, patient portal...

- LARC manufacturers also offer a free benefit verification process

Track Coverage Eligibility - Example

Plan	Implant	Implant insertion	Implant removal	LNG-IUS	Copper IUD	IUD insertion	IUD removal
Plan A	Yes	Yes	Yes	Yes, Mirena No, Skyla	Yes, w/ prior authorization	Yes, ParaGard and Mirena	Yes
Plan B (Grandfathered Plan)	Yes, w/ co-pay	Yes, w/ prior authorization	Yes, w/ co-pay	Yes, w/ co-pay	Yes, w/ co-pay	Yes, w/ prior authorization	Yes, w/ co-pay
Plan C (Grandfathered Plan)	Yes	Yes	Yes	Yes, w/ referral	Yes, w/ referral	Yes, ParaGard and Mirena	Yes

Title X Program Guidance – 2 Parts

- https://www.hhs.gov/opa/sites/default/files/ogc-cleared-final-april.pdf
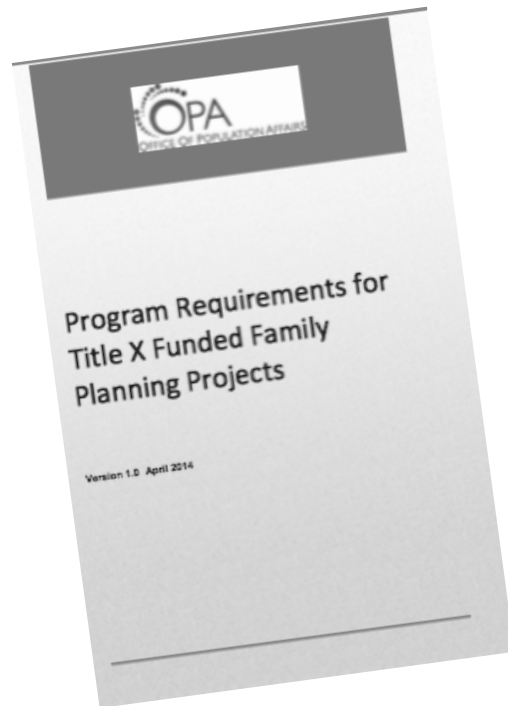
MDHHS, Title X and Setting Fees

- Title X-funded health centers provide services regardless of one's ability to pay, insurance or lack thereof, and documentation status

- A **Schedule of Discounts must** be developed for individuals with family income between 101% and 250% of the FPL to assure that services are billed based on ability to pay (Section 8.4.2)

  - Based of Federal Poverty Level Guidelines (FPL), household income and size

MDHHS, Title X and Setting Fees

- MDHHS policy requires that the schedule of discounts **must** be developed with sufficient proportional increments to assure services are billed based on ability to pay

- Sub-recipients **must** use the mandated quartile proportional increments that MDHHS distributes each year in developing their schedule of discounts

- Sub-recipients may request and **mus**t receive an MDHHS approved waiver to use other proportional increments.

MDHHS, Title X and Setting Fees

< 100% of FPL must not be charged, but third parties authorized to pay must be billed *(8.4.1)*	**Between 101% - 250% of FPL** must be charged discounted fees based on your Schedule of Discounts, with effort made to obtain third party reimbursement *(8.4.2, 8.4.6)*	Fees must be waived for individuals w family **incomes above 100% of FPL** who, as determined by the service site project director, are unable, for good cause, to pay for family planning services *(8.4.3)*

2018 FPL

- Nancy, a single mom with 2 young children, presents with no coverage

- How large is her household size?

- What is the maximum income she can have to have her fees discounted to 0%?

PERSONS IN FAMILY/ HOUSEHOLD	FPL 2018
1	$12,140
2	$16,460
3	$20,780
4	$25,100
5	$29,420
6	$33,740
7	$8,060
8	$42,380
For family units with more than 8 persons, add $4,320 for each additional person.	

Household Size

- Your household size includes:

    - Patient applying

    - Spouse/Partner

    - Any children being supported in your household

    - **Anyone who is included on patient's federal income tax return**

Verification of Income

- Family income should be assessed before determining whether copayments or additional fees are charged.

  - MDHHS does not require verification of income.   Client income is self-reported.

  - Income must be documented in the client record and there must be proof of application of the sliding fee scale.

  - Eligibility for discounts for minors who receive confidential services must be based on the income of the minor (Section 8.4.5)

Guidelines – Copays / Deductibles

- Insured clients whose family income ≤250% FPL should not pay more (in copayments or additional fees) than what they would otherwise pay when the schedule of discounts is applied
(Section 8.4.6)

Collecting Co-Pays and Applying Sliding Fee Scales
A Job Aid for Front Desk Staff

5 STEPS FOR COLLECTING CO-PAYS AND APPLYING THE SLIDING FEE SCALE

1: Find out the client's income, family size and whether she/he has insurance.

2: Check the client's insurance eligibility and determine the client's co-pay amount based on her/his insurance plan.

3: Determine where the client's income puts her/him on the sliding fee scale.

4: If the co-pay is less than the client would pay on the sliding fee scale, she/he should pay the co-pay, and the agency should bill the insurance company the fee for the services.

5: If the co-pay is more than what the client would pay based on the sliding fee scale, the client pays what she/he would pay based on the sliding fee scale, and the agency should bill the insurance company the fee for the services.

REMEMBER!
Clients should never pay more than what they owe based on the sliding fee scale.

HOW IT WORKS
Below is a sample sliding fee scale and two scenarios to show how to determine the co-pay when the client has insurance. Your agency's scale may be different since each agency has its own sliding fee scale.

Sample Client:
- Your client's income is $25,000/year.
- She has two children.
- She has insurance. Her co-pay is $20.
- To apply the sliding fee scale, first, match her income to your sliding fee scale.
- The sliding fee scale will show you the discount she would receive. In this situation, her discount would be 80%.

Family Size	Federal Poverty Levels 2014									
	100%	120%	140%	160%	180%	200%	220%	240%	250%	
1	$11,670	$14,004	$16,338	$18,672	$21,006	$23,340	$25,674	$28,008	$29,175	
2	$15,730	$18,876	$22,022	$25,168	$28,314	$31,460	$34,606	$37,752	$39,325	
3	$19,790	$23,748	$27,706	$31,664	$35,622	$39,580	$43,538	$47,496	$49,475	
4	$23,850	$28,620	$33,390	$38,160	$42,930	$47,700	$52,470	$57,240	$59,625	
5	$27,910	$33,492	$39,074	$44,656	$50,238	$55,820	$61,402	$66,984	$69,775	
6	$31,970	$38,364	$44,758	$51,152	$57,546	$63,940	$70,334	$76,728	$79,925	
7	$36,030	$43,236	$50,442	$57,648	$64,854	$72,060	$79,266	$86,472	$90,075	
8	$40,090	$48,108	$56,126	$64,144	$72,162	$80,180	$88,198	$96,216	$100,225	
9+	For families with more than 8 people, add $4,060 for each additional person									
	100%	90%	80%	70%	60%	50%	40%	20%	10%	
					Discount					

Reference: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Available at http://aspe.hhs.gov/poverty/14poverty.cfm

SCENARIO 1:
- If fee for services = $125
- With 80% discount, fee = $25
- Insurance co-pay = $20
- Client pays $20
- Bill client's insurance the full fee
- Insurance co-pay is less than the fee, client pays the co-pay

SCENARIO 2:
- If fee for services = $60
- With 80% discount, fee = $12
- Insurance co-pay = $20
- Client pays $12
- Bill client's insurance the full fee
- Discounted fee is less than the co-pay, client pays the discounted fee

REMEMBER!
If the client requests confidential services, do not bill the insurance company.

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Applying Discounts

- Determine client's income, household size and whether she/he has insurance

- Check insurance eligibility and determine client's co-pay

- Determine where income puts client on sliding fee scale

- If co-pay < client would pay on sliding fee scale, pay co-pay, and agency should bill insurance company fee for services.

- If the co-pay > what client would pay based on sliding fee scale, pay based on the sliding fee scale, and the agency should bill the insurance company the fee for the services.

- Brenda's income is $25,000/year

- She has two children

- She has insurance. Her co-pay is $20

- To apply the sliding fee scale, first, match her income to your sliding fee scale

- The sliding fee scale will show you the discount she would receive. In this situation, her discount would be 80%

2017 GROSS FAMILY INCOME:	<= 100%	120%	140%	160%	250%
# IN FAMILY					
1	$12,060	$14,472	$16,884	$19,296	$30,150
2	$16,240	$19,488	$22,736	$25,984	$40,600
3	$20,420	$24,504	$28,588	$32,672	$51,050
4	$24,600	$29,520	$34,440	$39,360	$61,500
5	$28,780	$34,536	$40,292	$46,048	$71,950
6	$32,960	$39,552	$46,144	$52,736	$82,400
7	$37,140	$44,568	$51,996	$59,424	$92,850
8	$41,320	$49,584	$57,848	$66,112	$103,300
DISCOUNT	100%	90%	80%	70%	10%

SCENARIO 1:	SCENARIO 2:
• If fee for services = $125	• If fee for services = $60
• With 80% discount, fee = $25	• With 80% discount, fee = $12
• Insurance co-pay = $20	• Insurance co-pay = $20
• Brenda pays $20	• Brenda pays $12
• Bill Brenda's insurance the full fee	• Bill Brenda's insurance the full fee
• **Insurance co-pay < fee, client pays the co-pay**	• **Discounted fee < co-pay, client pays the discounted fee**

Best Practice

- Review the patient volumes in each of your slide categories

  - Is there a distribution of discount amounts applied across self pay clients or are all your clients at 100% slide and no fees?

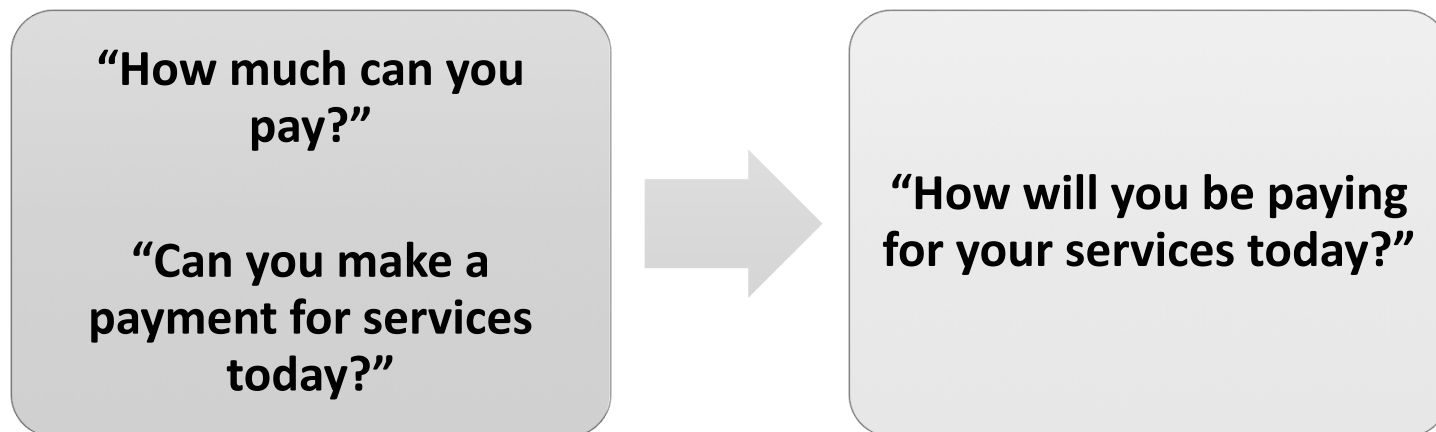 - Does it make sense to you or seem like an opportunity for improvement?

Fees: Talking to Patients

- Set expectations about fees at first scheduling call with patient

- May be difficult for staff to talk to patients about income and fees

- Don't assume teens and other clients don't want insurance billed for family planning (confidential) services – ask first

- Michigan Medicaid does not send home EOB's – explain to clients

Best Practice: Scripts that incorporate messaging about income verification are a good way to support staff who interact with patients and ensure consistency with every patient at every visit.

Talking to Patients

- Listen to your team as they communicate to the patients to uncover if messaging is accurate

"How much can you pay?"

"Can you make a payment for services today?"

→

"How will you be paying for your services today?"
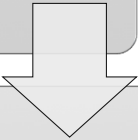
Clinical Encounter

Documentation Done Well

- Justifies billed claims

- Improves patient care and safety

- Protects the medical professional

- Follows Medicaid and other payer rules and regulations
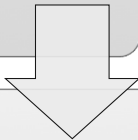
- Reduces improper payments

From Centers for Medicare & Medicaid Services (CMS)

Documentation Drives Coding

If it isn't documented and captured in your system,
it can't be coded or billed – loss of revenue!

Always follow coding guidelines and bill only for
medically necessary services

Stress Compliance
at ALL Times in Your Agency

General Principles Documentation Include:

- Medical record should be complete and legible

- Documentation of each patient encounter should include the:

  - Reason for the encounter and relevant history, physical examination findings, and prior diagnostic results

  - Assessment, clinical impression, or diagnosis

  - Medical plan of care

  - Date and legible identity of the observer

From Centers for Medicare & Medicaid Services (CMS)

General Principles Documentation (2)

- Document the:

  - Rationale for ordering diagnostic and other ancillary services

  - Past and present diagnoses

  - Health risk factors

  - Patient progress, treatment changes, and response

  - Diagnosis and treatment codes reported on the health insurance claim form or billing statement

From Centers for Medicare & Medicaid Services (CMS)

Who Did What?

- Ensure documentation is clear on ***who provided what services*** so you get credit with outside auditors

- Tell the story so it makes sense to someone else

- Do I need to refer back to other visits to figure out the story?

EHR Related Challenges

- ❑ Over-documentation of elements
- ❑ Templated, repetitious documentation across records - cloning
- ❑ Missing documentation / time capture
- ❑ Auto assigned codes not supported
- ❑ Drop down lists not providing specificity
- ❑ Over-clicking of check boxes
- ❑ Electronic signature and authentication issues
- ❑ Vendor response to updates and software bugs

Outside reviews focusing more heavily on EHR-related documentation issues

Documentation Checklist

✓Is it complete and accurate?

✓Are orders dated and signed?

✓Are required times captured?

✓Are charts reviewed on a regular basis?

✓Are clinicians available to clarify / answer questions?

✓Ensure easy access to valid codes which reflect actual services
  provided

Codes for Billing

Codes We Use to Bill for Services

- For every **"WHAT"** there must be a **"WHY"**

- Services must be **Medically Necessary**

WHAT – **CPT / HCPCS**

WHY – **ICD-10 Diagnoses**

Special circumstances – **Modifiers**
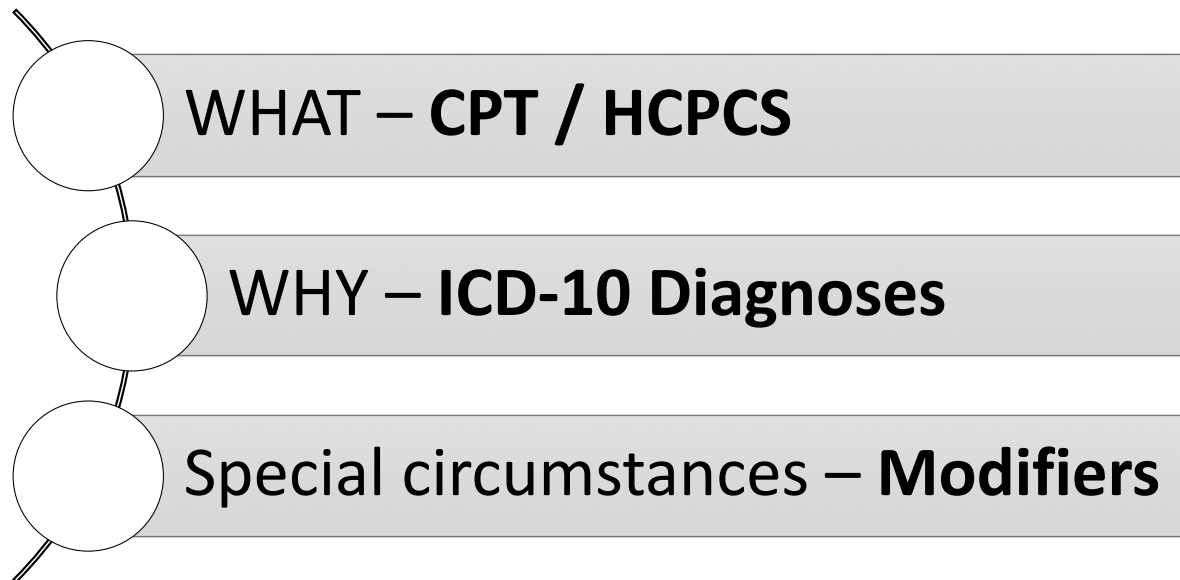
Procedure Codes: "What"

CPT defines services and procedures provided, such as: medical visit including family planning counseling, LARC insertion or removals, lab tests, and immunizations

HCPCS identifies drugs, contraceptives, supplies

ICD-10 Diagnosis Codes – "Why"

Set of codes defining diseases, signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease

Supports medical necessity of services and procedures provided

Must be supported by documentation in patient's medical record

Only **licensed provider** determines the diagnosis

ICD-CM Coding Rules

- List the primary diagnosis first, then others
  - Code assigned to the diagnosis, condition, problem, or other reason shown in the documentation to **be chiefly responsible** for services provided
  - Code to the highest level of specificity
- Most specific description at the <u>completion of visit</u>
  - If diagnosis is not established, code for symptom
  - Don't code for "rule-out" diagnoses
- Don't code a diagnosis that doesn't apply to the visit

Modifiers: "Special Circumstances"

Two-digit codes that accompany a CPT code in order to further describe a situation that may impact or modify reporting and reimbursement of services

Essential for accurate coding and reimbursement

Who assigns them?

Common Modifiers for Family Planning and LARCS	
Modifier	**Description**
22	Increased Procedural Services (not used on E/M codes)
25	Significant, Separately Identifiable E/M by Same Clinician on Same Day as Other Procedure or Service
51	Multiple Procedures – same session and clinician
52	Reduced Service
53	Discontinued Service
59	Separate Procedures or Distinct Procedural Services
76	Repeat procedure same physician / QHCP
77	Repeat procedure different physician / QHCP

Liz's Visit

Same Day LARC Insertion

- Liz, a 18 year old female, returns to our clinic for a 7pm appointment seeking contraception but is not sure what method is best for her

- She has not had intercourse since her LMP

- She meets with the clinician and is counseled over 50% of the 20 minute encounter on the different BCM's and their side effects. Together they decide the Skyla IUD is the best fit for her and that she wants to have it inserted at this appointment.

- Liz has a UPT and a HIV rapid test which are both negative, CT and GC screening tests are ordered and Susan inserts the IUD

- How would we code this visit?

E/M: Evaluation & Management Codes

The "Office or Medical Visit"

- There are 2 types of E/M codes commonly used for family planning services:

  - **Preventive codes**

  - **Problem codes**

Patient Type Impacts $...

- Impacts both coding rules and reimbursement

  - **New Patient (per CPT)**
    - "One who has **NOT** received any professional services from the physician, or other qualified healthcare professionals (QHCP) or another physician of the **exact same specialty and subspecialty** who belongs to the same group practice, **within the past 3 years**"

  - **Established Patient**
    - Within 3 years

Preventive Visits

- **E/M codes 99381-99397**

  - Used for periodic health screening visits (well visits, annuals, check-ups)

- **Age-specific codes**

  - Age and gender appropriate medical history

  - Physical exam, as indicated

  - Anticipatory guidance, risk factor reduction interventions, or counseling

  - Contraception

  - Management of insignificant problems

Problem Visits

- Services to evaluate clients with a problem or chief complaint in the outpatient clinic setting

  - **New patients 99201-99205**

  - **Established patients 99211-99215**

> **Examples:** Routine contraceptive initiation and surveillance, family planning counseling and education, contraceptive problems, suspicion of pregnancy, STI testing and treatment, and evaluation of other reproductive system symptoms

Two Methods to Calculate E/M Level
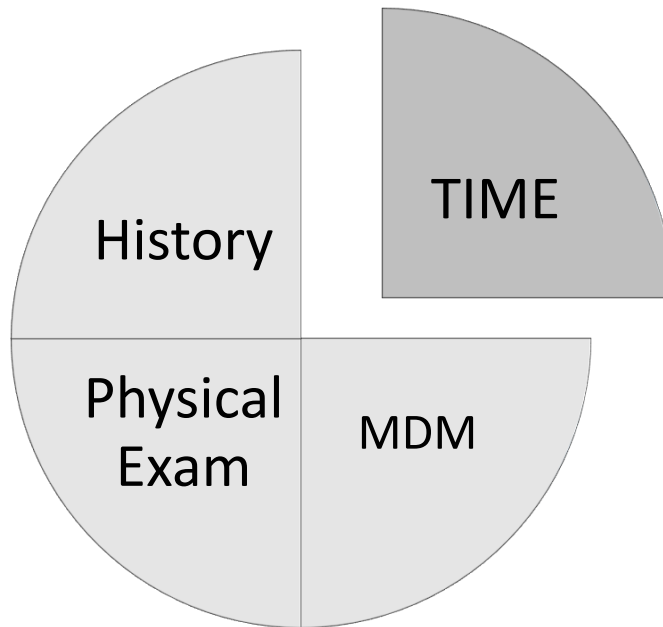
- Composite of 3 components (History + Physical Exam + Medical Decision Making)

Or

- TIME, when greater than 50% of clinician's face-to-face time is spent in counseling

One method does NOT fit all visits

55

"3 Key Components" Method

History

- Chief Complaint (CC)
- History of the present illness (HPI)
- Review of body systems (ROS)
- Past, family, social history (PFSH)

Physical Exam

- Single or multiple organ system / body area examination

Medical Decision Making

- Number of diseases & management options
- Amount & complexity of diseases
- Risk of complication

"Time Based" Method

Time can be used when:

- $\geq$ 50% of clinician's total Face-to-Face (FTF) time with the patient is spent on counseling or coordination of care

MUST document in the Medical Record:

- Time - total duration of encounter
- That > 50% of time is spent counseling
- Nature and extent of the issues discussed, patient questions and clinician response, and recommendations or next steps

Time Factor - Counseling

- Counseling is defined as a discussion with a patient or their family about:
  - Test results
  - Prognosis
  - Risks and benefits of management (treatment) options
  - Instructions for management (treatment) or follow-up
  - Importance of compliance with chosen management (treatment) options
  - Risk factor reduction
  - Patient and family education

Examples of Documenting Time

- "A total of ____ minutes of a _____ minute visit was spent counseling patient about _____. "

- "I met with patient for 20 minutes and counseled her for over 50% of that time on ………."

  - *The note must reflect what was discussed with the client and/or family. It should be **PATIENT-SPECIFIC**.*

  - *Used of "canned" or template notes is discouraged as they may not support medical necessity of the services billed.*

Changing Trends: QFP

- Quick starts, less pelvics, less breast exams, less pap smears, more counseling...

- Are you still scoring high-level E/M codes with minimal exams for new patients?

- Using time to score the E/M may result in higher reimbursement...

Family planning services
- Contraceptive services
- Pregnancy testing and counseling
- Achieving pregnancy
- Basic infertility services
- Preconception health
- Sexually transmitted disease services

Related preventive health services
(e.g., screening for breast and cervical cancer)

Other preventive health services
(e.g., screening for lipid disorders)

E/M - Using Time

- Liz is an established patient of the clinic

- Meets with clinician and **counseled >50% of 20 minute face-to-face encounter** on different methods and their side effects

New	Time (typical)		Established	Time (typical)	
99201	≤ 15	(10)	99211	≤ 7	(5)
99202	16-25	(20)	99212	8-12	(10)
99203	26-37	(30)	99213	13-20	(15)
99204	38-53	(45)	99214	21-33	(25)
99205	> 53	(60)	99215	>33	(40)

Preventive Codes

AGE	NEW	EST.
5-11 years	99383	99393
12-17 years	99384	99394
18-39 years	99385	99395
40-64 years	99386	99396
65 years +	99387	99397

*If Liz, **(18 year-old female)**, presented as an established patient for a well-woman or annual visit...*

E/M: New Patient

Requires all 3 elements must be met or exceeded

Level	1	2	3	4	5
History	Problem Focused 1-3 History of Present Illness (HPI) No Review of Systems (ROS) No Past, Family and/or Social History (PFSH)	Expanded Problem Focused 1-3 HPI 1 ROS No PFSH	Detailed 4 HPI 2-9 ROS 1 PFSH	Comprehensive 4 HPI 10 ROS 3 PFSH	Comprehensive 4 HPI 10 ROS 3 PFSH
Exam	Problem Focused <1 Body Areas (BA)/Organ System (OS)	Expanded Problem Focused 2-4 BA/OS	Detailed 5-7 BA/OS	Comprehensive 8 Organ Systems	Comprehensive 8 Organ Systems
Medical Decision Making (MDM)	Straightforward	Straightforward	Low Complexity	Moderate Complexity New Problem w/ RX Acute Complicated Illness/ Injury Undx'd, New Problem 1 or more chronic Illness w/mild exacerbation	High Complexity New Problem with work-up planned and high level of acuity
Time	10 minutes	20 minutes	30 minutes	45 minutes	60 minutes

E/M: Established Patient

Requires 2 of 3 elements must be met or exceeded

Level	1	2	3	4	5
History	Provider not required, but a provider must be in the building. Patient must have been seen previously and this is just a follow-up, not a new problem.	Problem Focused 1-3 HPI No ROS No PFSH	Expanded Problem Focused 1-3 HPI 2-9 ROS No PFSH	Detailed 4 HPI 2-9 ROS 1 PFSH	Comprehensive 4 HPI 10 ROS 2 PFSH
Exam		Problem Focused <1 BA/OS	Expanded Problem Focused 2-4 BA/O	Detailed 5-7 BA/OS	Comprehensive 8 Organ Systems
Medical Decision Making (MDM)		Straightforward	Low Complexity	Moderate Complexity New Problem w/ RX Acute Complicated Illness Injury Undx'd, New Problem 1 or more chronic Illness w/mild exacerbation	High Complexity New Problem with work-up planned and high level of acuity
Time		10 minutes	15 minutes	25 minutes	40 minutes

Summary: Problem E/M

- Choose E/M based on scores of 3 key elements
  - History, physical exam, medical decision making

- Compute counseling time as a percentage of total face-to-face time
  - If >50%, find the E/M based on documented time factor

- Select the E/M code that is greater to maximize reimbursement

CPT: Capture the Procedure

Liz had an IUD placed today

- What code do we need to capture Liz's IUD insertion?
- What if Liz had an IUD removed and a new one inserted?

CPT	Description
58300	Insert IUD
58301	Remove IUD
11976	Remove contraceptive capsule implant
11981	Insert non-biodegradable drug delivery implant
11982	Remove non-biodegradable drug delivery implant
11983	Removal with reinsertion of non-biodegradable drug delivery implant

Nexplanon Implant

- What if Liz was having Nexplanon inserted into her arm today instead of an IUD?

- What if Liz was having the implant removed and a new one inserted?

CPT	Description
58300	Insert IUD
58301	Remove IUD
11976	Remove contraceptive capsule implant
11981	Insert non-biodegradable drug delivery implant
11982	Remove non-biodegradable drug delivery implant
11983	Removal with reinsertion of non-biodegradable drug delivery implant

Insertion – Device 1:1

Liz had a Sklya IUD placed

Code	Description
J1050	Depo Provera 1 mg. – report units
J7296	IUD – Kyleena *(new code 1.1.2018)*
J7297	IUD Liletta
J7298	IUD – Mirena
J7300	IUD – ParaGard
J7301	IUD - Skyla
J7303	Contraceptive vaginal ring
J7304	Contraceptive hormone containing patch
J7307	Nexplanon

Extended Hours Access

- Additional reimbursement for visits scheduled on evenings (after 6:00 pm), weekends and federal holidays

- Liz' appointment was scheduled at 7 pm

CPT	Description
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service.
99051	**Services provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.**

Liz had patient-centered counseling on all methods of contraception before choosing an IUD

April 19, 2018

ICD-10	Description
Z30.011	Initial prescription of oral contraceptive pills
Z30.012	Prescription of EC
Z30.013	Initial prescription Depo Provera
Z30.015	Initial prescription of vaginal ring
Z30.016	Initial prescription of patch
Z30.017	Initial prescription of Nexplanon implant
Z30.09	Other general counseling and advice on contraception *(Family planning advice)*

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Liz also had an IUD inserted at the same appointment

ICD-10	Description
Z30.014	Initial prescription of IUD *(not the IUD insertion)*
Z30.017	Initial prescription of Nexplanon implant
Z30.430	Insertion of IUD
Z30.431	Routine checking of IUD
Z30.432	Removal of IUD
Z30.433	Removal and reinsertion of IUD
Z30.46	Surveillance of Nexplanon implant (includes routine checking, removal and reinsertion)

Liz had a UPT test
done which was
negative
(CPT 81025)

ICD-10	Description
Z32.00	Pregnancy test, result unknown
Z32.02	... result negative
Z32.01	.... result positive

The clinician had documented Liz had NOT had any intercourse since her last visit – so why was the UPT done? Was it medically necessary? It's always a best practice to document the basis or why you are performing tests so it's clear to outside auditors that will review your charts

	Liz had a HIV rapid test done that was negative (CPT 86703)

ICD-10	Description
(Z11.3)	Screening for infections with a predominantly sexual mode of transmission (STD screening)
(Z11.4)	Screening for HIV
Z20.2	Contact with and (suspected) exposure to infections with a predominantly sexual mode of transmission
Z20.6	Contact with and (suspected) exposure to HIV

She was screened for Chlamydia and Gonorrhea

Liz's Visit: Same Day LARC Insertion

	CPT Code + Modifier	ICD-10-CM
E/M	99213-25 (based on time) 99051 – After hours access	Z30.09 Encounter for family planning advice
Px	58300 IUD insertion	Z30.430 IUD Insertion
Labs	81025 UPT 86703 HIV *87491 CT (outside lab typically* *87591 GC bill for these tests)*	Z32.02 Pregnancy test, result negative Z11.4 HIV screening Z11.3 STD screening
LARC	J7301 Skyla IUD	Z30.430
Modifiers	-25 to indicate E/M was separate and distinct from insertion	

Kyleena IUD – New Code

- **J7296 Kyleena IUD *(New code effective as of 1/1/2018)***
  - Q9984 Kyleena IUD *(Use this code for dates of service 7/1/2017 through 12/31/2017)*

- Ensure systems and forms are up-to-date

- Monitor payments and remittances - resolve issues

340B Outpatient Drugs: MDHHS Medicaid

- If a contraceptive supply is purchased at the 340B price, the **actual acquisition cost** must be billed to Medicaid

- Professional/institutional claims must include the **modifier "U6"**

- Pharmacy claims must include a Submission Clarification Code of 20

- http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf (Pg 620 5.1 SPECIAL BILLING INSTRUCTIONS)

Every Method Has Specific Codes

Method	ICD-10	Description
OCP	Z30.011	Initial prescription of Oral Contraceptive Pills
	Z30.41	Surveillance / refill of OCP
Depo Provera	Z30.13	Initial prescription of injectable contraceptive
	Z30.42	Surveillance / refill of injectable contraceptive
EC	Z30.012	Prescription of Emergency Contraception (EC)
Patch	Z30.016	Initial prescription of hormone patch
	Z30.45	Surveillance / refill of patch
Vaginal Ring	Z30.015	Initial prescription of vaginal ring
	Z30.44	Surveillance / refill of ring
Other	Z30.018	Initial prescription of other contraception *(barrier, diaphragm)*
	Z30.49	Surveillance of other contraception
BCM Counseling	Z30.09	FP Advice - *(i.e. Counseling on all methods before deciding on a LARC insertion)*

LARC Specific ICD-10 Codes

Method	ICD-10	Description
IUD	**Z30.014**	**Encounter for initial prescription of IUD** *(Note: not coded with IUD insertion; Example: used if a device needs to be ordered for a patient for insurance reasons)*
	Z30.430	**Insertion of IUD**
	Z30.431	**Routine Checking of IUD**
	Z30.432	**Removal of IUD**
	Z30.433	**IUD removal and reinsertion**
Implant	**Z30.017**	**Initial prescription of implantable subdermal contraceptive – includes Nexplanon insertion**
	Z30.46	**Routine checking, removal or reinsertion of Nexplanon**

Unspecified Codes

- Avoid coding unspecified codes whenever possible – for example:

  - Z30.019 Initial prescription of contraceptives, unspecified

  - Z30.9 Contraceptive management, unspecified

  - Z30.40 Surveillance of contraceptives, unspecified

- Monitor for quality coding

Outpatient Gyn and Family Planning Encounters

Code	Category
Z00.0	Encounter for general adult medical examination • Z00.00 ...**without** abnormal findings • Z00.01... **with** abnormal findings
Z01.41	Encounter for routine gynecological examination • Z01.411 ...GYN exam **with** abnormal findings • Z01.419 ...GYN exam **without** abnormal findings

Abnormal Findings

- Code dependent on what is known at time of encounter

- Additional code reported to describe abnormal finding(s)

- Chronic conditions should not be considered "abnormal findings" unless a change in their status has occurred

- If no abnormal findings at exam, but test result abnormal

  - Report without abnormal findings for visit

  - Subsequent visits will include code for the condition

- Preventive also with a problem-focused exam – code abnormal findings

Preventive with Problem Visit

- Maria, a 22 year old established patient, presents for her well visit. She also is complaining of a discharge.

- Clinician probes Maria and documents the discharge has been consistent for about 2 weeks, is thick and grayish white, has an foul odor, and is worse after sex.

- Clinician performs a full pelvic exam noting the discharge but also performs a wet mount. She diagnoses Maria has bacterial vaginosis (BV), prescribes an antibiotic and provides additional education on the issue for 10 minutes

- Can we bill for a preventive and a problem visit?

CPT Guidelines: Preventive with Problem

- "If an abnormality is encountered or a pre-existing problem is addressed in the process of performing this preventive medicine E/M service, and if the problem/abnormality is significant enough to <u>require additional work</u> to perform the key components of a problem-oriented E&M service, then the appropriate office/outpatient code 99201-99215 should also be reported."
  - E/M problem service should be clearly documented, distinct, and separate from the documentation of the preventive service

Preventive with Problem

- Code preventive medicine services codes (99381 – 99397) for the routine exam, Include ICD code for ...*with abnormal findings* (i.e. Z01.411 GYN visit with abnormal findings)

- Code appropriate office visit code (99201 – 99215) reported with modifier -25 attached, "Significant, separately identifiable [E/M] service by the same clinician on the same day of the procedure or other service," for the problem service

- Clearly document the complaint, additional work done and the appropriate ICD-10 code(s) separate from the preventive service

Maria's Visit: Preventive with BV

	CPT + Modifier	ICD-10
E/M	- 99395 (Preventive 18-39 yrs, est. patient) - 99212-25	- Z01.411 Encounter for GYN exam <u>with abnormal findings</u> - N76.0 Acute vaginitis
Labs	87210 Wet prep Others as indicated	- N76.0 Acute vaginitis
Modifiers	25 to indicate the problem E/M is separate and distinct from Preventive service	

Julie's Visit

IUD Removal and Implant Insertion

- Julie had an IUD inserted 5 years ago but is now experiencing bleeding and cramping

- She has not been at the clinic in over 3 years

- NP and Julie discuss the bleeding and other possible contraceptive methods for 12 of 18 minute face-to-face encounter

- After considering her options and RLP goals, Julie requests an implant

- Julie is given a UPT which is negative

- NP removes the IUD and inserts Nexplanon

- How would we code this visit?

E/M - Using Time

- Julie's IUD is 5 years old and she has not been to our center for a visit in the last 3 years –> new patient

- Counseled 12 of 18 minute encounter on different methods and side effects

New	Time (typical)		Established	Time (typical)	
99201	≤ 15	(10)	99211	≤ 7	(5)
99202	16-25	(20)	99212	8-12	(10)
99203	26-37	(30)	99213	13-20	(15)
99204	38-53	(45)	99214	21-33	(25)
99205	> 53	(60)	99215	>33	(40)

Julie's Visit: IUD Removal / Implant Insertion

	CPT + Modifier	ICD-10
E/M	99202 - 25	- N92.6 Irreg. menstruation - Z30.09 Family planning advice
Px and other services	- 11981 (implant insertion) - 58301-51 or 59 (IUD removal)	- Z30.017 Insertion of implant - Z30.432 IUD removal
Labs	81025 UPT	Z32.02 Pregnancy test, negative
Supply	J7307 Nexplanon	Z30.017
Modifiers	25 to indicate the E/M is separate and distinct from Px's 51 or 59 on the multiple Px's – payer dependent – typically 51	

Over or Under Coding?

- Jackie presents as a new patient for contraception
  - She has a detailed history taken. Vitals are done but a full exam is deferred. She is counseled at length about different birth control methods and decides to start the pill. Dr. Smith sends a prescription to her pharmacy.

- What level E/M would we code?
  - 99201, 99202, 99203, 99204, 99205

Answer – E/M Level

- The correct answer is **99201**

- New patients require 3/3 key components or total FTF time along with >50% was spent counseling

- No time was documented which would have resulted in a higher E/M level

- Vitals were only exam element –> Level 1 Problem focused exam

- Based on our coding chart, can not be scored higher than a 99201 without time

E/M: New Patient

But if the clinician documented over 50% of a 30 minute visit was spent counseling, 99203

Requires all 3 elements must be met or exceeded

	99201	99202	99203	99204	99205
History	Problem Focused	Expanded Problem Focused	Detailed	Compre-hensive	Compre-hensive
Exam	Problem Focused	Expanded Problem Focused	Detailed	Compre-hensive	Compre-hensive
MDM	Straight Forward	Straight Forward	Low complexity	Moderate complexity	High complexity
Time	10 min	20 min	30 min	45 min	60 min

MDHHS Fee Schedule – Example

- Clinic A determines they have been undercoding services and makes a focused effort to capture counseling time, provide coding training, monitor charts and follow-up with feedback. How may this impact revenue?

Code	MA Fee $ 2018	Volume	Pre QI Revenue	Post QI Volume	Post QI Revenue
99201	$24.96	200	$4,992.00	150	$3,744.00
99202	$42.00	250	$10,500.00	240	$10,080.00
99203	$60.42	100	$6,042.00	140	$8,458.80
99204	$92.12	50	$4,606.00	65	$5,987.80
99205	$115.89	20	$2,317.80	25	$2,897.25
	Total	620	$28,457.80	620	$31,167.85

10% increase

E/M and Procedures

Daniela is having an LARC inserted, when would you bill an E/M code?

A. When you separately counsel Daniela on different options and together decide on the LARC then insert it

B. When you take care of a separate and distinct issue along with the LARC insertion

C. Each time you are inserting an LARC

D. A and B

E. All of the above

ACOG*: E/M with Procedures

If clinician and patient discuss a number of contraceptive options, decide on a method, and then an implant or IUD is inserted during the visit, an E/M service may be reported, depending on the documentation.

If the patient comes into the office and states, "I want an IUD," followed by a brief discussion of the benefits and risks and the insertion, an E/M service is not reported since the E/M services are minimal.

If the patient comes in for another reason and, during the same visit, a procedure is performed, then both the E/M services code and procedure may be reported.

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Procedure CPT

- **Procedure CPT includes:**
  - Brief focused history
  - Checking use of medications and allergies
  - Review of procedure, side effects and related questions
  - Administration of local anesthesia
  - Performance of procedure
  - Post-operative observation

- **Bill only the procedure CPT code when...**
  - Counseling provided was in the context of the procedure
  - Other cognitive services given on same day did not require significant history, exam, or medical decision making

ACOG*: CPT + E/M Visit

- If reporting both an E/M and a procedure, documentation must indicate a significant, separately identifiable service

  - Documentation must indicate either the key components or time spent counseling

- Modifier 25 is added to the E/M code

  - This indicates that two distinct services were provided: an E/M service and a procedure

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Failed Insertions

- What if the clinician opens the packaging of a LARC method but the product is ultimately not used by Daniela?

- This can occur due to:
  - Error or accident (e.g., non-sterile technique)
  - An insertion that is discontinued for medical reasons or at the patient's request
  - Mechanical defects in the product that renders it unusable

Replacements: Failed Insertions

- Manufacturers of LARC methods provide replacement products under some conditions; however, they do not typically supply credit refunds

- Providers should keep the LARC device and record its lot number to facilitate a request for a replacement product from the manufacturer

- LARC method may need to be sent to the manufacturer as proof of the failed insertion or product defect

- Additional guidance:
http://larcprogram.ucsf.edu/failed-insertions

Failed IUD Insertion

	CPT Code + Modifier	ICD-10-CM code
E/M	none	
Px and other services	58300 -52 IUD Insertion	Z30.430 insertion of IUD
Contraceptive	Seek replacement device or bill J7296, J7297, J7298, J7300 or J7301	Z30.430
Modifier Use	- 52 Reduced service - 53 Discontinued Service	

Document why the insertion failed and include relevant ICD-10 codes for the insertion as well as the defect or patient complication

ACOG*: Ultrasound with IUD Insertion

- US may be used to confirm the location when the clinician incurs a difficult IUD placement (e.g., severe pain)
    - Code 76857 Ultrasound, pelvic, limited or follow-up, or
    - Code 76830 Ultrasound, transvaginal
- Not common practice to use US to confirm placement; Should not be routinely billed
- Occasionally, needed to guide IUD insertion. Code 76998 (Ultrasonic guidance, intraoperative)

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IUD Common Codes

- **Procedure Codes:**

  - 58300 IUD Insertion

  - 58301 IUD Removal (*code both for a re-insertion with Modifier 51 or 59*)

- **Contraceptives:**

  - J7296 IUD – Kyleena® *(new code 1.1.2018)*

  - J7297 IUD - Liletta®

  - J7298 IUD - Mirena ®

  - J7300 IUD – ParaGard®

  - J7301 IUD – Skyla®

- **Related Diagnosis Codes**

  - Z30.430 Insertion of IUD

  - Z30.431 Routine checking of IUD

  - Z30.432 Removal of IUD

  - Z30.433 Removal and reinsertion of IUD

  - Z30.012 Prescription of emergency contraception (EC)

ICD-10: IUD Problem-Related

ICD-10	Desc

T83.31xA
T83.31xD
T83.31xS
	- Breakdown (mechanical) of IUD, initial encounter
	   …subsequent encounter
	   …sequela

T83.32xA
T83.32xD
T83.32xS
	- Displacement of IUD, initial encounter (missing string)
	   …subsequent encounter
	   …sequela

T83.39xA
T83.39xD
T83.39xS
	- Other mechanical complication of IUD
	   …subsequent encounter
	   …sequela

Implant Common Codes

- **Procedure Codes**
  - 11981 Insertion, implant
  - 11982 Removal, implant
  - 11983 Removal with reinsertion, implant

- **Related Diagnosis Codes**
  - Z30.017 Insertion of implant
  - Z30.46 For routine checking, reinsertion, or removal of implant

- **Contraceptive**
  - J7307 Nexplanon®
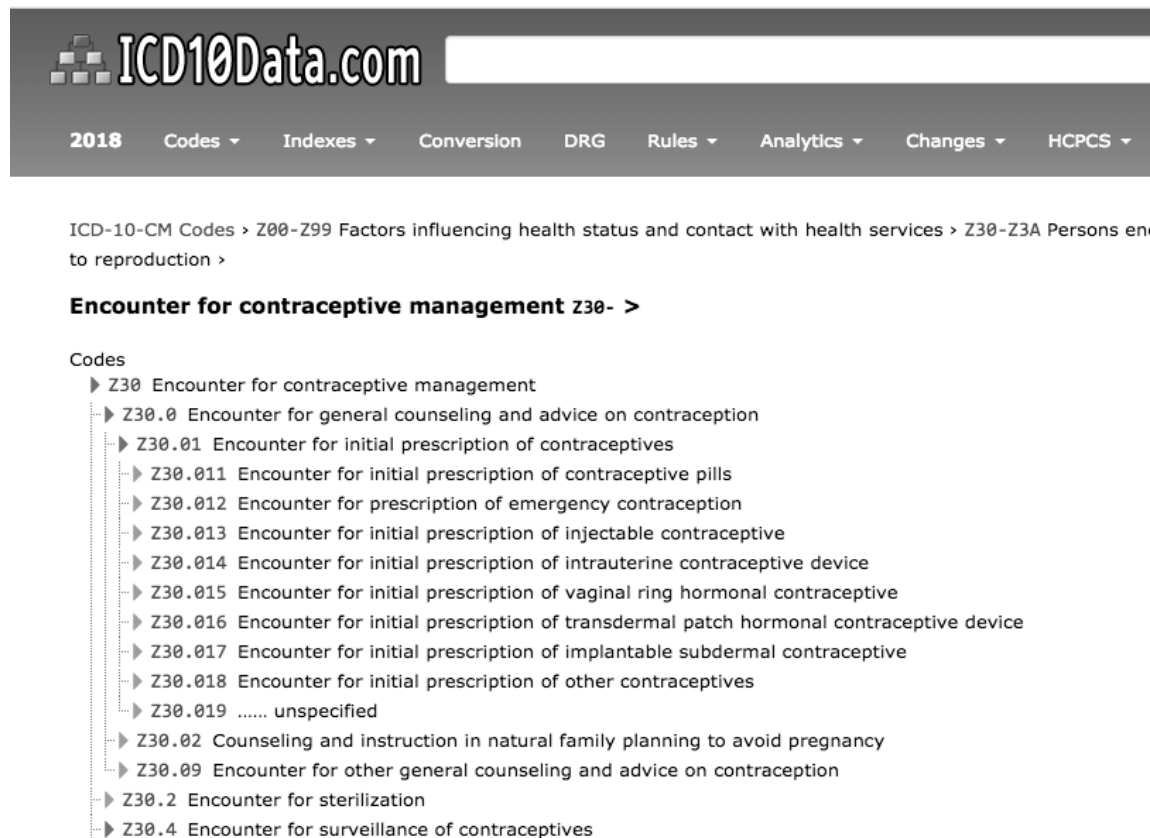
Resources: Family Planning Podcasts

CODING WITH ANN

Episode #1, Coding with Ann: October 2016 Changes to ICD-10   +

Episode #2, Coding with Ann: October 2016 Common Codes for Contraception   +

Episode #3, Coding with Ann: October 2016 Common Miscoding of LARC Services   +

Episode #4, Coding with Ann: E/M Coding Using Counseling Time   +

Episode #5, Coding with Ann: Best Practices for Implant Coding & Reimbursement   +

Episode #6, Coding with Ann: Coding IUD Services   +

Episode #7, Coding with Ann: Common Modifiers for Billing Family Planning Services   +

Episode #8, Coding with Ann: Best Practices for ICD-10 Diagnosis Coding for STD & HIV Screening   +

https://www.fpntc.org/training-packages/coding

Resources: ICD-10

Strategies for QI / QA

Achieving Coding Consistency

- Coding is not always black and white – don't under-estimate the value of having a certified coder on staff

- Inconsistencies can lead to lowered facility reimbursement, possible audits, and even affect patient care

- Training, communication, monitoring, and reviews help keep coding consistent

- Clinician query is essential for billing staff in order to address compliance and coding questions

Strategies: Improving Coding Accuracy

- Document and code for what you do

- Ensure medical necessity of services (ICD-10)

- Avoid unspecified codes

- Keep coding resources updated

- Check educational sources

- Review ICD and CPT guidelines

- Create coding manual

Strategies: Improving Coding Accuracy (2)

- Ensure consistent training and information dissemination
- Promote open communication, centralize answers
- Conduct internal chart audits
- Periodically review specific payer payment policies
- Regularly share coding tips / audit results with team
- Regularly review Explanation of Benefits (EOB's)
- Determine which codes ARE or ARE NOT being paid by which payers and WHY

Why Self Audit?

Compliance requirement / spot fraud	Reduces risk of an unwanted outside audits, take-backs, fines	Improves staff performance and attitudes
Creates a more reliable accounts receivable	Improves overall patient experience	Increases reimbursement opportunities

Audit Planning

- Risks - Who / What is focus?

- Your current internal capacity to handle an audit?

- Expected start and completion dates?

- Announced or unannounced?

- Tools, data, and people needed?

- Report expectations?

- Schedule of follow-up reviews set?

- Actions defined and measured

Focus on Quality

Audit Planning - Focus

- Documentation and coding

- Charge capture processes and forms

- Remittance reviews and denial management

- Timely billing of services

- Accounts Receivable (A/R)

- Other ideas?

Audit Planning – Coding

CODING

- By type of service
- By level of service
- LARC insertions matched to paid devices
- Procedures / injections with E/M to ensure separate and distinct services
- Other ideas?

CHART REVIEWS

- Prospective chart reviews allow you to correct improper codes before claims are submitted and turn into an under- or over-payment of services

Documentation and Coding: Frequency Distributions

- Compare your most frequently billed codes to other benchmarks and like peer groups

  - Do you notice any missing codes?

  - Do you have higher or lower utilization of codes than your peers?

  - Can you explain the variances?

Documentation and Coding: E/M Profiling

- Compare clinician / service type coding and volumes internally and with relevant benchmarks to identify vulnerabilities

- Discuss findings with team and reinforce with education

Established Patient
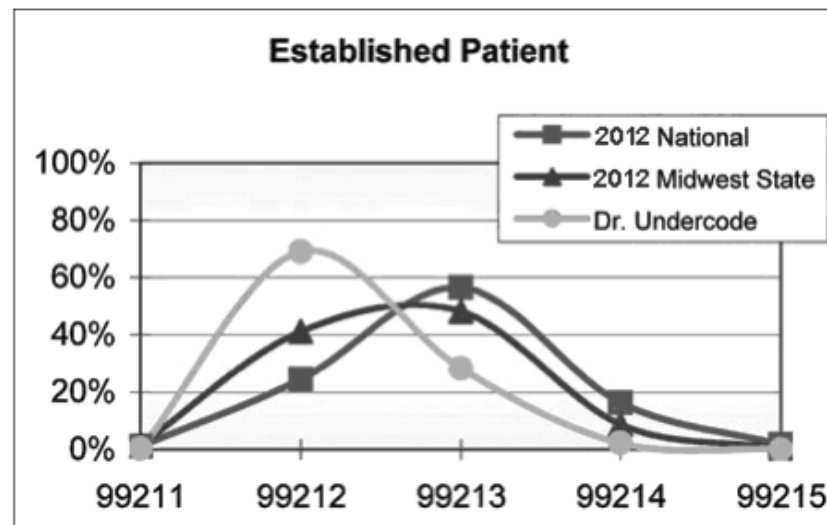
Use Your Data and Create Visuals

CPT Code	Clinician A # of Times	Clinician A %	Clinician B # of Times	Clinician B %	Clinician C # of Times	Clinician C %	Practice Totals # of Times	Practice Totals %	Benchmark1 %
99201 OV,New,Straightforward	5	2.76%	0	0.00%	3	1.06%	8	1.06%	1.23%
99202 OV,New,Expanded	98	54.14%	8	2.79%	17	5.99%	123	16.36%	15.79%
99203 OV,New,Low	72	39.78%	197	68.64%	255	89.79%	524	69.68%	46.84%
99204 OV,New,Moderate	6	3.31%	82	28.57%	6	2.11%	94	12.50%	29.85%
99205 OV,New,High	0	0.00%	0	0.00%	3	1.06%	3	0.40%	6.29%
Totals	181	100.00%	287	100.00%	284	100.00%	752	100%	100%
99211 OV,Est.,Minimal	68	2.88%	116	4.35%	133	6.47%	317	4.48%	3.49%
99212 OV,Est.,Straightforward	1655	70.16%	257	9.64%	226	10.99%	2138	30.18%	4.10%
99213 OV,Est.,Low-Expanded	475	20.14%	2046	76.72%	1542	74.96%	4063	57.36%	47.46%
99214 OV,Est.,Moderate-Detailed	125	5.30%	224	8.40%	128	6.22%	477	6.73%	41.69%
99215 OV,Est.,High-Comp.	36	1.53%	24	0.90%	28	1.36%	88	1.24%	3.26%
Totals	2359	100.00%	2667	100.00%	2057	100.00%	7083	100.00%	100.00%

April 19, 2018
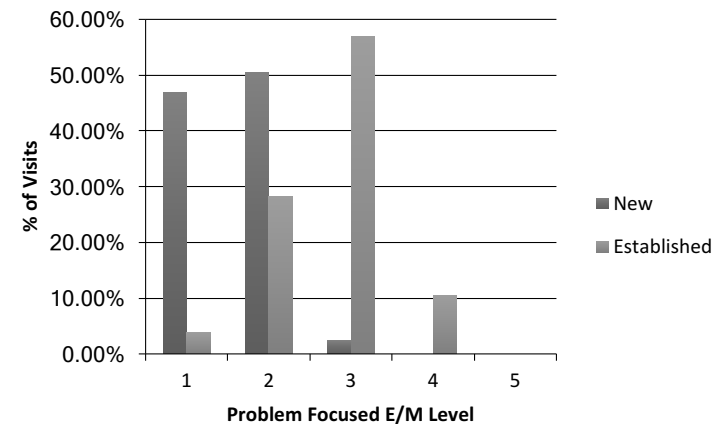
Audit Planning - Charge Capture

- Forms and processes should be audited

  - Superbill and template reviews
  - Denials for: Invalid codes and service code combinations that are not payable together
  - Insertions and devices – 1:1 match
  - Ancillary services – orders, medical necessity, capture

Audit Planning – Remittance Review

- Review remittances every month for denial codes and list the problem areas

- Trend by:

  - Denial issue
  - Payor frequency
  - Staff personnel responsible
  - How often are related denials are repaired and successfully paid versus not paid?

Audit Planning – Timely Billing

- Summarize third party payor contract requirements for timely filing into a usable grid

- Remittance review of denials for timely billing (Trend by denial, payor and staff)

- Audit of 90-day Delay Modifier usage

- Review of claim submission processes and cycle time

- Other ideas?

Claims Submission

- Clean claim submission rates

- Use internal and clearing house scrubbers / edits

- Examine denial rates by type, payor and staff related to the submission data and process

95% Clean Claim Upon First Submission

Audit Planning – Accounts Receivable (A/R)

- Involves follow-up on claims that have not been paid and self paying patient accounts with outstanding balances

- Trend outstanding balances by payor and type of service

- Group outstanding balances into buckets of timing such as < 30 days, 30-90 days, > 90 days

Implement Change

- Identify strategies to address root causes of the problem:

  - Learn what has worked at other organizations (copy)

  - Review the best available evidence for what works (literature, studies, experts, guidelines)

  - Remember the solution doesn't have to be perfect the first time

Coding and Billing Fix-It

Group Activity

Managing Revenue – Back End

Best Practices for Contraceptive Services

Revenue Management Challenges

1. Billing correct / optimal amount

2. Managing client fee collections

3. Managing payments

4. Avoiding and resolving denials

5. Understanding and using remittance reports

1) Bill the Correct Payer and Optimal Amount

Strategies:

- Develop and/or update financial and front-end policies and procedures

- Implement these procedures, assuring accurate gathering of potential insurance, family size and income information

- Utilize cost analysis and other data to adjust fee schedule, and to make other business decisions

- Provide training on documentation and coding

Why Is Cost Analysis Important?

- It's good business

- Title X requires Schedule of Fees and Discounts

- Need to set reasonable fees

- Keep our doors open

Does Title X Require a Cost Analysis?

- NO – but it's still good business to do one
    - Title X Program Guidelines (2001)
        - Programs must demonstrate they have done a cost analysis on which their fees are based.

    - Title X Program Guidelines (2014)
        - For persons from families whose income exceeds 250% of the FPL, charges must be made in accordance with a schedule of fees designed to recover the reasonable cost of providing services. (42 CFR 59.5(a)(8))

Payor Tracking Tool - Example

Contact Information	Private Insurance 1	Medicaid
Contact name/contact information	Cindy Smith, 888-888-8888 csmith@bcbs.com	John Jones, 999-999-9999 jjones@us.de.ma.org
Claim Submission on Timeframe	3 months	6 months
Services/Meds requiring prior authorization	Colposcopy	None
E/M Code Specifics	Use previous health E/M codes	Limit is 4 99211 codes/year
Lab Tests In-house	Preg test	Preg test, gonorrhea, chlamydia, syphilis
External Lab Required	Quest	No
Formulary Restraints	Depo-provera must be purchased at pharmacy	BCP – Ortho-Novum, Yasmin, Nora-BE
Bill with NP/PA/RN	Yes – 75% reimbursed rate	No
Non-covered Service Codes/Groupings	Skyla not covered	Can't get reimbursed for Depo, visit, and injection on same day, only visit and Depo
Counseling Codes Covered	Only 99401, 1/year	1/lifetime
Report Requirements/Measures	Annual – Chlamydia rates for sexually active women age 15-24. Benchmark : 48%	Quarterly – Chlamydia testing rates for sexually active women 15-24. Benchmark : 54%

2) Monitor and Manage Client Fee Collections

Strategies:

- Establish / update and implement policies on patient payment and collection processes

- Manage discounted fee collections at time of visit for uninsured clients

- Accurately discount and bill/collect for TPP client fees (copays, deductibles, coinsurances)

Title X Guidelines - Collections

- Reasonable efforts to collect charges without jeopardizing client confidentiality must be made (8.4.8)

  - Past due accounts for "no contact" clients cannot be referred to a collection agency

  - If the client comes expecting to pay for her service at the time of her appointment – the need to invoice may be avoided

Increased Fee Collections Impact

Charges (adjusted) for uninsured / self-pay client services for a month - $4,400

Scenario 1: 50 % collection rate - $2,200

Scenario 2: 95% collection rate - $4,180

A difference of $1,980, or $23,760 annually

Fee Schedules / Chargemaster

- An annual review of your Fee Schedule / Chargemaster should be specifically addressed in your policies and procedures

- Review Sliding Fee Scales

3) Monitor and manage payments from payors

Strategies:

- Develop/implement detailed written policies

- Analyze accounts receivable (A/R) on a monthly basis

- Analyze denial rates and trends on a monthly basis

- Implement strategies to manage TPP contract terms and relationships

A/R Management Reports

Establish reports and frequency of review:

- A/R aging
- Claims receivable
- Charges
- Insurance payments
- Denied claims
- Adjustments/write-offs
- Payment posting

4) Work those denials

Strategies:

- Avoid denials

- Analyze denial rates on a monthly basis

- Utilize reports to analyze denials

- Resolve unpaid or denied claims

Avoiding Denials

Most denial types can be avoided by efforts before filing:

- Registration denials
  - Strategy: implement insurance verification processes
- Credentialing denials
  - Strategy: Maintain credentials; have point-person
- Timely filing denials
  - Strategy: bill weekly; monitor reports
- Prior authorization denials
  - Strategy: identify services requiring prior authorization / track

Avoiding Denials (2)

Most denial types can be avoided by efforts before filing:

- Medical necessity / charge entry denials
    - Strategy: chart audits, scrubbing software
- Bundled/non-covered denials
    - Strategy: manage contract terms, scrubbing software

Avoidable Coding Denials

- Missing or incorrect patient demographics
- Invalid or missing procedure, diagnosis or supply codes
- Incorrect / missing units
- Missing or incorrect NDC
- Incorrect charges
- Misuse of Modifiers

Denials are Costly

- Must have a process for reviewing and resubmitting claims
- Denials take place for **many and multiple reasons**
  - Some can be addressed with minimal outlay of time, others take more effort
  - Prioritize easy fixes and expensive LARC devices
- What are the root causes of denials?

Person? ➤ Process? ➤ System?
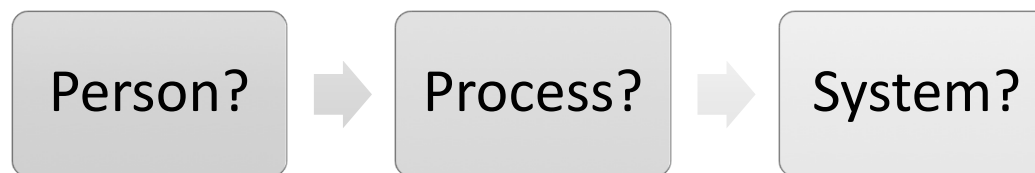
Resolve Unpaid or Denied Claims

- **Foster a good relationship with insurer contact**

  Call claims representative, ask specific questions, have specific claim examples available

- **Provide feedback regarding errors and corrections**

  Document findings to minimize future denials of same type

5) Review / Understand Remittance Reports

Strategies:

- Targeted review of Remittance Reports from different payers to identify process and payment issues:

  - Line items paid as expected?

  - Procedures ALWAYS billed with an E/M?

  - Same E/M code used repeatedly?

  - Necessary modifiers present?

  - Trend in denial reason codes?

  - Compare to other payers

Let's Recap: Getting Paid

- Set a goal for clean claim submission and track it
- Submit claims timely – create a payer grid
- Review remittances on a regular basis – line items
- Monitor modifier usage
- Track your Accounts Receivable and contact payers that are lagging in providing timely payments
- Work to resolve the root cause of issues
- Give feedback to the front end and rest of team – create visuals
- Set performance targets
- Other?

Opportunities for Improvement

- Identify opportunities for improvement that exist:
  - Points where "breakdowns" occur
  - "Work-a-rounds" that have been developed
  - Variation that occurs
  - Duplicate or unnecessary steps
- Identify team members to work with
- Implement change
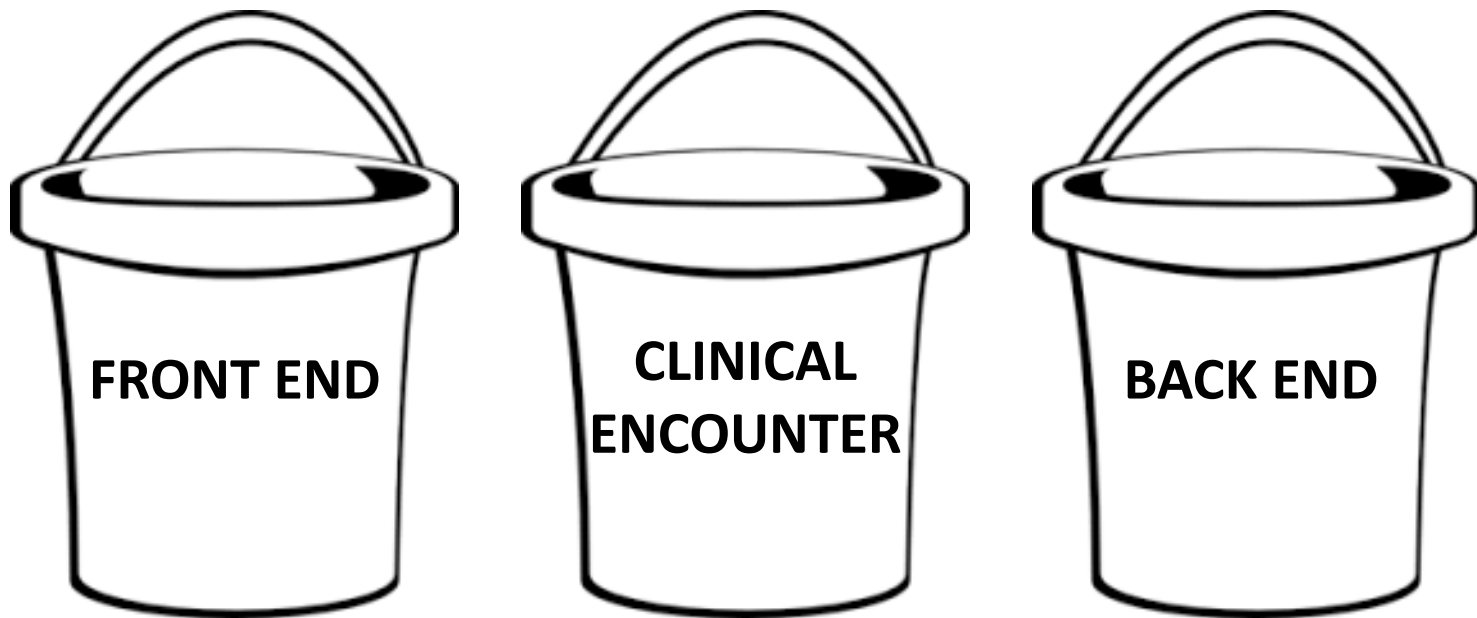- Track and celebrate successes along the way!

Resolving the Challenges

Group Table Activity

Resolving the Challenges

FRONT END

CLINICAL ENCOUNTER

BACK END

Resolving the Challenges: Action Planning

- Identify 2 challenges that resonated with you today

- What strategies can you share with your team to resolve the challenge?

- Who on your team do you need to work with?

  Complete form and take with you

Helpful Resources

- National Family Planning and Reproductive Health Association (NFPRHA) tools:

https://www.nationalfamilyplanning.org/gcfp

- Family Planning National Training Center (FP NTC) tools:

https://www.fpntc.org/

- FP NTC podcasts on family planning coding:

https://www.fpntc.org/training-packages/coding

Disclaimer

- The guidance and scenarios provided today are meant for education purposes only

- Code selection and claim submission is based upon medical record documentation for services rendered and diagnoses considered for each individual encounter.

- Inaccurate coding and reimbursement issues should be resolved with each payer. Check with the coding and coverage guidelines for a particular payer.

- Ann Finn, Healthcare Reimbursement Consultant, enjoys sharing her expertise and insights focusing on improving overall coding, charge capture and revenue management practices.

- Her company primarily focuses on providing technical assistance and training pertaining to reproductive health providers including family planning and STD services.

- AFC works collaboratively with many supporting Title X organizations, Health Departments, FQHCs, Planned Parenthoods, SBHC's and Providers across the country.

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