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Medicare Coding and Billing: Practical Survival Tips

by Roberta L. Buell, M.B.A.

The Resource Based Relative Value Scale (RBRVS) system of payment is not just for Medicare anymore. Estimates are that more than 70 percent of noncapitated HMO and PPO payments are RBRVS. Many of these managed care plans are ratcheting down reimbursement and actually paying less than Medicare. Before signing up with a managed care company that uses RBRVS as its basis for payment, physician practices would be well served to develop expertise with RBRVS pricing and payment policies. Here are key questions to ask.

■ *Which fee schedule is the current basis for payment?* Some PPOs, particularly those in California, are still using the 1992 and 1993 fee schedules. In oncology, use of these fee schedules may pay less than the 1994 and 1995 fee schedules, because relative value units (RVUs) were added to the infusion codes in 1993 and 1994.

■ *What conversion factor is used with the fee schedule?* Remember that in 1997 Medicare is paying $33 to $40. Being paid with a conversion factor less than $35–40 is not generous.

■ *Are geographical inflators used to pay for geographical differences in cost of living?* Believe it or not, certain managed care companies pay just on the RVUs without adjusting for geographical differences. This can cost physicians a bundle if they practice in California, New York, Florida, Alaska, or other high-cost areas. If the managed care companies are located in a low-cost area, physicians may not want to bring up this topic.

■ *How is the fee schedule going to be adjusted for inflation annually?* We can assume that cost of living (and doing business) will go up. If a physician group is signing a multiyear contract, it is important that there be some allowance for inflation.

■ *Does the managed care company pay for certain things or codes for which Medicare does not pay?* Some managed care companies do not administer the fee schedule the same way that Medicare does. They may pay for such things as Jamschidi needles, intravenous set-up, multiple pushes or infusions, after-hour services, and other items or services. This may make up for stingy conversion factors.

■ *What is the managed care company's policy about drug payment?* Be aware that certain managed care companies such as those in California and Oregon are paying on average invoice cost (if they can get the invoices). Find out up front what payment methodology will be used for drug reimbursement, and understand who will review drug claim denials.

Even if some answers to these questions clearly signal bad reimbursement, physicians might still want to sign up with a particular insurance plan. Indeed, they may need to sign up because patients may be currently in treatment or because a high number of patients in their area may be on the plan. That's okay—at least physicians won't be surprised by declining collections.

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WOULD YOUR PRACTICE SURVIVE A MEDICARE AUDIT?

Some physicians believe they are doing everything right just because Medicare pays time and time again for services. Yet even model cancer practices have been audited by Medicare, and the results have been costly.

For those who have not had the nail-biting experience of being audited, let's review what happens. Medicare sends a letter requesting patient records of all services occurring over a certain period of time. The physician practice usually has about three to four weeks to put this together.

Then, Medicare reviews these records, quantifies all the over-billed services in the sample, and then assumes the physicians have been doing the same things repeatedly over a three-year period. The fine is then calculated for the three-year period, and is usually in the six figures. However, the fine is negotiable, and no underbilled items are ever included in Medicare's figures. It is up to the physicians to point these out to Medicare, because Medicare does not care about what the physicians did not bill. You are guilty until proven innocent.

The first tip is to open mail regularly. The practice should not be up against a deadline simply because mail was unopened. The second tip is to get all records: hospital, office, DMERC, and whatever other services were billed. Then, if possible, make sure all services billed are documented somewhere in the records. If they are not, write an addendum. This sometimes works.

Here are some recent examples of documentation problems found by Medicare.

■ No documentation of a nurse visit when using 99211. If a nurse is injecting a patient only with a

continued on page 33

nonchemotherapeutic drug such as Procrit® or Neupogen, he or she must document a more extensive service (such as vital signs or a weight check) to justify a 99211. Otherwise, Medicare assumes that 90782 should have been billed.

■ Poor documentation of the time of chemotherapy infusions and separate or sequential hydration. This means that physicians must know the time the chemotherapy infusion went up and the time it was taken down. To bill 96410 or 90780, any amount of time up to an hour is allowable. However, many carriers use the standard of more than 30 minutes for subsequent hours (96412 or 90781). In addition, to bill for sequential or separate hydration (90780-90781 with GB, or in 1997, -59, which can be used for all payers—not just Medicare), records must clearly delineate when a nonchemotherapy infusion went off and the chemotherapy went on.

■ No definitive documentation of drug, fluids, and/or drug dosage given. It is not enough for a physician to write the order. Nurses must document that xx mg of a drug were infused in xx cc of normal saline over xx hours with time on and off documented. The epitome of the detail that certain carriers want physicians to use is that when they give 5cc of normal saline or sterile water and bill J7051, this should be documented. No kidding!

■ Billing for the same multiuse vial for several patients. This happens when one patient is given 20 mg of something, another patient gets 30 mg from the same 50 mg vial, and 50 mg is billed for both patients. Only really sharp auditors catch this. But the physician practice is at risk for this behavior or unclear documentation.

■ Insufficient documentation of the level of EM service billed. All Level 5 consults should have a review of ten body systems and a physical exam of eight organ systems with a past, family, and social history. There must also be evidence of complex decision making. Make sure the physicians understand EM coding and have regular review sessions.

■ Bad superbills. If a superbill is used to collect charges for billing, it stands to reason that billing is only as good as the superbill. Outdated codes, omitted codes, or poor structure will decrease payments in the short term and will decrease financial viability in the long term.

■ Using the wrong number of units for a J-code. For example, Novantrone (J9293) was in 20 mg units. Now it is in 5 mg units. Think of the money lost.

These are only the highlights of what might trigger a Medicare audit. Remember that documentation requirements may differ by particular region and by auditor. Also, please bear in mind that amounts charged in a Medicare audit are negotiable. Since documentation is the only defense, treat medical records just like gold in the bank.

FRAUD AND ABUSE: ARE YOU GUILTY?

Medicare's definition of fraud is physician misrepresentation. It can cost a bundle—$2,000 per incidence, nonnegotiable. Not knowing that one is breaking the rules is no excuse.

Examples of common forms of Medicare fraud in oncology practices include the following.

■ Billing 99211 without compliance with "incident to" rules. This means that nurses should not be billed "incident to" a physician service unless a physician is in the building. Also, nurses must be W-2 employees of the practice. Contractors cannot be billed "incident to."

■ Billing self-administered drugs as if they were injected in the office. Physicians should know better. Enough said.

■ Billing the DMERC for pump rental when the pump is used in the physician's office. Pumps can be billed only to the DMERC when the patient wears it home. Period. If a pump is used in your office, it is considered a supply, which is not payable by Medicare.

■ Billing Medicare for drugs received free of charge. If the patient or physician receives free drugs from a pharmaceutical company or if the physician receives a free sample, he or she cannot bill this, no matter what the sales representative says.

■ Billing experimental protocols as if they were approved. Combinations of drugs that are FDA approved, but are not approved in combination for a certain indication, cannot be billed as if given for an approved indication. Physicians should not fudge on diagnosis codes to have drugs paid.

■ Using a code for a purpose other than that for which it was intended.

Those physician practices that use billing services will be distraught to know they may be liable for the service's fraud. Read the contract thoroughly to determine who is responsible for fraud. Also, review billings and EOBs periodically to see what is being submitted, particularly for billing services that work on a percentage of collections.

STRATEGIES FOR COPING

Physicians should learn as much as they can about coding. Many people

continued on page 40

Medicare's Resource Based Relative Value Scale (RBRVS) system of payment is partly based on the skill level required and the time involved to perform a patient service relative to other services provided by the physician. The Health Care Financing Administration (HCFA) is obligated by congressional mandate to adjust the relative values in the Medicare fee schedule over the next two years. In 1996, the Health Care Financing Administration reviewed and adjusted the work values. The outcome may yield more than a 3 percent increase in 1997 for oncologists if HCFA makes no other offsetting changes.

TOTAL RELATIVE VALUES*

	1996	1997
99205	3.22	3.61
99213	.96	1.08
99214	1.48	1.64
99215	2.34	2.60
99223	3.78	4.20
99245	4.81	5.28
99255	4.85	5.36

*according to HCFA, November 22, 1996

Medicare Coding and Billing: Practical Survival Tips

continued from page 33

have taken for granted that in a managed care world coding does not count for much. The key to maintaining income levels is to track utilization. Whoever has the best data wins. In addition, most cancer practices are not capitated, and thus, payment is directly related to coding. Approval for drugs is directly linked to ICD-9 coding, so do not neglect it.

Many practices do not appeal denials nor go after money that is owed to them. Physicians should be aggressive about payment regardless of source. Pharmaceutical companies can often assist you. Also remember that patients may have sources of payment that they don't even know about. With managed care, patients are responsible for their coverage choices—even Medicare patients. This means that beneficiaries and employers should be involved in denials, plan choices, pre-existing conditions, and poor chemotherapy coverage.

Make sure billing operations are in gear. If more than 10 percent of your receivables are more than 120 days, you are not in good financial shape. The following are check points to ensure that your office stays on track.

- Percentage of collections are 70 to 80 percent for medical oncologists.
- Substantial denials are reviewed by a physician in the practice.
- Coding books—ICD-9, CPT, and HCPCS—are from 1997.
- Medicare bulletins are up to date.
- All pertinent personnel understand existing contracts and their terms.
- Drugs are appropriately paid by carriers.
- Providers understand their EM utilization.

To survive in today's competitive, complex world, become an active participant. Attend meetings of your local oncology society. Exchange ideas on how to manage the unmanageable. Don't allow yourself the luxury of being outdated. You own your destiny!

CAPITOL COMMENTS

continued from page 6

approved the bill unanimously. The following day the bill was approved by the full House of Representatives by a 111-0 margin. The legislature does not end its current session until the first full week of January, at which time any bills that have not been approved by both chambers must be reintroduced to be considered in the new General Assembly that convenes January 7, 1997. IMOS, ACCC, and others are hopeful that the overwhelming support of the House and the well-placed support in the Senate may lead to a happy new year indeed.

WELCOMING NEW STATE CHAPTERS

Two state oncology societies have joined the ranks of ACCC state chapters. The Nevada Oncology Society, led by Dr. Mary Ann Allison, and the Hawaii Society of Clinical Oncology, led by Dr. Carl Higuchi, became the thirteenth and fourteenth state chapter members, respectively. The ACCC Board of Trustees proudly welcomes the members of these societies to our association. Complete listings of members for both chapters are listed on the ACCC website **(http://www.assoc-cancer-ctrs.org)**.

SCORECARD, CONTINUED

In the November/December 1996 *Oncology Issues*, Arkansas was left off the legislative "scorecard." Arkansas became the eighteenth state to pass off-label drug legislation into law when Governor Jim Guy Tucker signed Senate Bill 816 on April 12, 1995. Effective July 28, 1995, the law requires coverage of off-label uses of FDA-approved cancer drugs when the off-label use is recognized as safe and effective for treatment of that specific type of cancer in any of the three compendia or two articles from major peer-reviewed professional medical journals.

PROFESSIONAL OPPORTUNITIES