Medicare Coding and Billing 2016

By
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ICD-10 Honeymoon is Over

- On October 1 Medicare will end the one year grace period that they allowed for ICD-10 Diagnoses.
- After that date your diagnoses need to be exact and relate the patient's condition.
- It is expected that all third party payers will be using the precise nature of the ICD-10 Diagnoses to perform more screening reviews using the computer during claims processing.

More Reviews Coming

- There will also be a "significant" increase in chiropractic reviews and audits after October 1.
- This could be part of the lead-up to the January 2017 implementation of pre-approval for more than 12 visits in an episode of care.
- This will be for those doctors with an error rate above the 85th percentile or those doctors with a pattern of billing outside of the norms when compared to their peers.

Medicare Coding

- There are two code sets that are used to communicate information to the MAC.
    - ICD-10-CM codes.
    - CPT codes.

ICD-10 Coding

- ICD-10-CM stands for International Classification of Disease, 10th edition, Clinical Modification.
- This is how we communicate the patient's condition to Medicare.
- We need to be as accurate as possible when coding conditions.
- ICD-10 codes are much more specific than ICD-9.
- This means that your documentation needs to be more accurate to support the codes.

Coding Must Match Procedures

- Third party payers, especially Medicare, are comparing diagnoses to procedures to ensure that they are consistent.
- Medicare will compare the level of adjustment code to the number of subluxation diagnoses.
- Other third party payers might need to see a muscle diagnosis if you bill for trigger point therapy.
- This can work the other way.
- If you have a diagnosis of degenerative disc disease, they may question it if you don't have an x-ray of that region billed.

Choose the right code

- One of the most common errors with ICD-10 is the failure to check the tabular index after finding a code in the alphabetical index.

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- For example; if you have a patient with low back pain and pain radiating down the right leg you would probably look at the alphabetical index and diagnosis M54.31, Sciatica, right side.
- If you failed to check the tabular index, you would miss this:

M54.31 - Sciatica, right side

ICD-9: 724.3

M54.3	**Excludes1:**	lesion of sciatic nerve (G57.0) sciatica due to intervertebral disc disorder (M51.1-) sciatica with lumbago (M54.4-)
M54	**Excludes1:**	psychogenic dorsalgia (F45.41)
M50-M54	**Excludes1:**	current injury - see injury of spine by body region discitis NOS (M46.4-)

- You would have the incorrect diagnosis.
- The correct diagnosis would be M54.41, Lumbago with sciatica, right side.
- Be sure and check the tabular index for the excludes, includes, and ands (which mean and/or).

ICD-10 Coding

- When ICD-10 coding for Medicare, refer to the Local Coverage Determination (LCD) for the primary and secondary codes that are acceptable to your Medicare Administrative Contractor (MAC).
- There are variations from one jurisdiction to another.
- The Local Coverage Determination has a list of diagnoses that your local Medicare Administrative Contractor accepts for Medicare.
- Download a copy of your LCD and print it out.
- At minimum, the doctor and the insurance biller should have a copy on hand for reference.
- Check from time to time to see if there is a new LCD.

CPT Coding

- CPT® stands for Current Procedural Terminology®
- The CPT® Code Set is owned by the American Medical Association.
- This is why there was a delay in the implementation of the ICD-10 codes.
- The ICD-10 codes can be used both for diagnosis and procedures coding.
- They are used for only diagnosis with physicians.
- The procedure codes that chiropractors use to bill covered procedures to Medicare are:
  - 98940
  - 98941
  - 98942
- Remember that the only Medicare covered procedure for chiropractors is the adjustment.

- The only reason to bill any other procedure would be at the request of the patient and then only if they have a secondary insurance that would require a denial from Medicare before they paid for the service.

Modifiers

- With all of the coding options available, sometimes there is no code to fit the situation.
- When that happens it is time to use a modifier.
- Some modifiers are specific to Medicare and some can be used with all insurance.
    - AT = Active Treatment
    - GA = Waiver of Liability Statement Issued as Required by Payer Policy
    - GY = Noncovered Service
    - GZ = Used when service is expected to be denied and no ABN is on file. Use of this modifier results in an automatic audit.
- It is allowable to use up to four modifiers on the same code.
- Medicare carriers and MACs are required to accept two modifiers.
- When using multiple modifiers, the first one takes precedence.
- For example; when you have a signed ABN form on file and you are still under active treatment, you should use AT,GA as the modifier.
- It should be noted that several jurisdictions state that the use of the AT and GA together is not allowed.

Q6 Modifier

- Services provided by a Locum Tenens physician
- Use this modifier when you have another doctor filling in for you.
- A Locum Tenens doctor can fill in for 60 days.

Medicare Billing

- The CMS-1500 form (or its electronic equivalent) is how we communicate with our local Part B Medicare Administrative Contractor the services we have performed and why we performed them.
- You are talking to a computer and all that it knows is what you tell it through the numbers that you put on the 1500 Form.
- Completing the CMS 1500 form requires specific attention to detail.
- There are blanks that are completed differently depending on the status of the patient.
- There are even blanks that are completed differently depending on the participation status of the doctor.
- For example:
- **Item 9 -** Enter the last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank.
- **NOTE:** Only participating physicians and suppliers are to complete item 9 and its subdivisions and only when the beneficiary wishes to assign his/her benefits under a MEDIGAP policy to the participating physician or supplier.

- Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for **all** Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer.
- **Medigap -** Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in §1882(g)(1) of title XVIII of the Social Security Act (the Act) and the definition contained in the NAIC Model Regulation that is incorporated by reference to the statute.
- It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare.
- It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.
- Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.
- **Item 9a -** Enter the policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP.
- **NOTE:** Item 9d must be completed, even when the provider enters a policy and/or group number in item 9a
- **Item 9b -** Leave Blank
- **Item 9c -** Leave blank if item 9d is completed. Otherwise, enter the claims processing address of the Medigap insurer.
- **Item 9d -** Enter the Coordination of Benefits Agreement (COBA) Medigap –based Identifier (ID).
- As you can see, there is more to billing a claim than just filling in a few blanks on a form.
- You need know how to obtain the required information from the patient and how to provide it to Medicare.
- This is why I have written a new book on Medicare Coding and Billing.
- The book will include details on both diagnostic and procedure coding as well as correctly billing Medicare for those procedures.
- There will be additional details to help you better understand Medicare's response to your billing.
- I expect to have the book available within 90 days.
- ChiroCode will be accepting advanced orders at the ChiroCode.com store.