

# The Business of Medicine



## Objectives

- Coding as a profession
  - How the coder fits in
  - Hospital vs. physician services
  - Hierarchy of providers
- Reimbursement aspects
  - Payers
  - Medical necessity
  - ABN



## Objectives

- Regulations
  - HIPAA
  - Compliance
  - OIG Workplan
- What the AAPC will do for you



## Coding As A Profession

- Evolution of the coding profession
- Certification opens doors
  - consultants
  - educators
  - medical auditors



## Coding As A Profession

- What is coding?

Coding is the process of translating a written or dictated medical record into a series of numeric or alpha-numeric codes.



## Coding As A Profession

- Physician-based coders
  - medical coders
  - coding specialists
- Hospital-based coders
  - health information coders
  - medical record coders
  - coder/abstractors
  - coding specialists



## Coding As A Profession

- Rapidly changing profession
  - updates and policies are changed as often as quarterly
  - increasing use of electronic health records (EHR) will continue to broaden and alter the job responsibilities

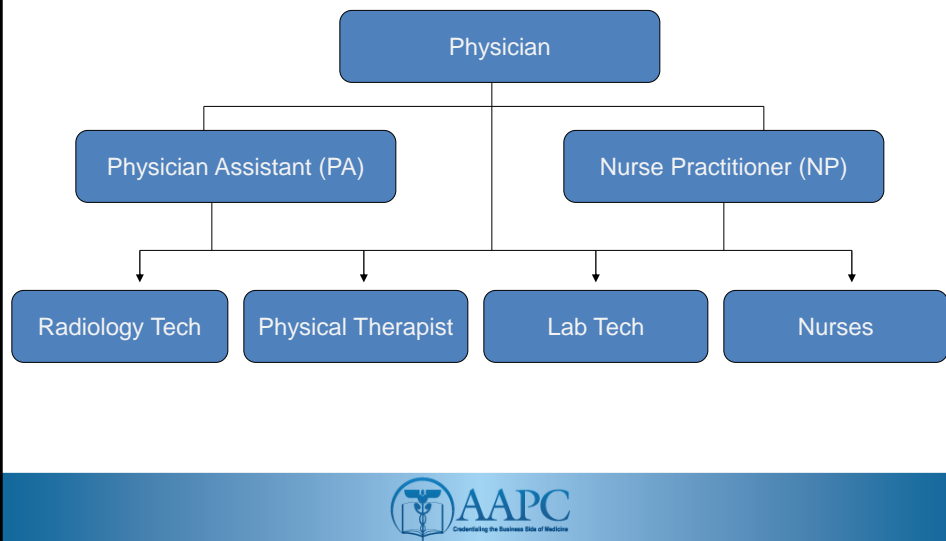


## Hospital vs. Physician Services

- Physician-based medical coding
  - CPT®
  - HCPCS
  - ICD-9-CM Volumes 1 & 2
- Hospital-based medical coding
  - ICD-9-CM Volume 1, 2, & 3
  - MS-DRGs
  - APCs



## Hierarchy of Providers



## Payers

- Self-pay
- Insurance
  - Private (commercial) insurance
    - BCBS (Blue Cross/Blue Shield)
    - Aetna
    - Cigna
    - Etc
  - Government insurance
    - Medicare
    - Medicaid
    - TriCare



## Medicare

- Part A – Inpatient hospital care
- Part B – Outpatient medical care
- Part C – Medicare Advantage
- Part D – Prescription drug coverage



## Medical Necessity

Services or supplies that:

- are proper and needed for the diagnosis or treatment of your medical condition,
- are provided for the diagnosis, direct care, and treatment of your medical condition,
- meet the standards of good medical practice in the local area, and
- aren't mainly for the convenience of you or your doctor.



## National Coverage Determinations

- National Coverage Determinations (NCD) help to spell out CMS policies on when Medicare will pay for items or services
  - Each Medicare Administrative Carrier (MAC) is then responsible for interpreting national policies into regional policies
  - LCD's only have jurisdiction within their regional area



## Sample LCD



### LCD L30273 - Vitamin D Assay Testing

#### Contractor Information

**Contractor Name:**

Highmark Medicare  
Services, Inc.

**Contractor Number(s):**

12102, 12202, 12302, 12501, 12301, 12201, 12401, 12402,  
12101, 12502, 12901

**Contractor**

**Type:**

MAC Part A &  
B

Source: Highmark Medicare Service <https://www.highmarkmedicare services.com/policy/mac-ab/l30273-r5.html>



**Indications and Limitations of Coverage and/or Medical Necessity**

*Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.*

Vitamin D is called a "vitamin" because of its exogenous source, predominately from oily fish in the form of vitamin D2 and vitamin D3. It is more accurate to consider fat-soluble Vitamin D as a steroid hormone, synthesized by the skin and metabolized by the kidney to an active hormone, calcitriol. Clinical disorders related to vitamin D may arise because of altered availability of the parent vitamin D, altered conversion of vitamin D to its predominant metabolites, altered organ responsiveness to dihydroxylated metabolites and disturbances in the interactions of the vitamin D metabolites with PTH and calcitonin. This LCD identifies the indications and limitations of Medicare coverage and reimbursement for these services.

**Indications:**

Measurement of vitamin D levels is indicated for patients with:

- chronic kidney disease stage III or greater
- cirrhosis
- fibromyalgia
- granuloma forming diseases
- hypocalcemia
- hypercalcemia
- hypovitaminosis D
- hypervitaminosis D
- long term use of anticonvulsants or glucocorticoids and other medications known to lower vitamin D levels
- malabsorption states
- obstructive jaundice
- osteomalacia
- osteoporosis
- osteogenesis imperfecta
- osteosclerosis
- psoriasis
- rickets
- vitamin D deficiency on replacement therapy; to monitor the efficacy of treatment

Source: Highmark Medicare Service <https://www.highmarkmedicare.com/policy/mac-ab/l30273-r5.html>

**Limitations:**

For Medicare, testing may not be used for routine screening.

All assays of vitamin D and its metabolites need not be performed for each of the above conditions. Often, one type is more appropriate for a certain disease state than another. The most common type of vitamin D deficiency is that of 25 OH vitamin D. A much smaller percentage of 1, 25 dihydroxy vitamin D deficiency exists; mostly in those with renal disease. It is expected that the medical record will justify the tests chosen for a particular disease entity, that all available components of 25 OH vitamin D and other metabolite levels will not be performed routinely on every patient and that supportive documentation for test choices will be available to the Contractor upon request.

This Contractor does not expect to receive billing for the various component sources of 25 OH vitamin D separately (such as stored D or diet derived D). Only one 25 OH vitamin D assay will be considered for reimbursement on any particular day, if medically necessary, for the patient's condition.

Once a beneficiary has been shown to be vitamin D deficient, further testing may be medically necessary only to ensure adequate replacement has been accomplished for this vitamin deficiency, although, generally, other parameters are measured.

Source: Highmark Medicare Service <https://www.highmarkmedicare.com/policy/mac-ab/l30273-r5.html>





# Sample LCD

## CPT/HCPCS Codes

Italicized and/or quoted material is excerpted from the American Medical Association, *Current Procedural Terminology (CPT)* codes.

82306 VITAMIN D; 25 HYDROXY, INCLUDES FRACTION(S), IF PERFORMED

Source: Highmark Medicare Service <https://www.highmarkmedicare services.com/policy/mac-ab/l30273-r5.html>



# Sample LCD

## ICD-9 Codes that Support Medical Necessity

It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-9-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

**The following ICD-9-CM codes support the medical necessity of CPT code 82306.**

010.00 -	PRIMARY TUBERCULOUS COMPLEX UNSPECIFIED EXAMINATION - UNSPECIFIED
018.96	MILIARY TUBERCULOSIS TUBERCLE BACILLI NOT FOUND BY BACTERIOLOGICAL OR HISTOLOGICAL EXAMINATION BUT TUBERCULOSIS CONFIRMED BY OTHER METHODS (INOCULATION OF ANIMALS)
135	SARCOIDOSIS

Source: Highmark Medicare Service <https://www.highmarkmedicare services.com/policy/mac-ab/l30273-r5.html>



## Advance Beneficiary Notice

- Providers are responsible for obtaining an ABN prior to providing the service or item to a beneficiary.
  - The form must be filled out in its entirety as well as the cost to the patient and the reason why Medicare may deny the service
  - Only the approved Form CMS-R-131 is valid and the forms may not be altered



## HIPAA

- National standards for electronic health care transactions and code sets;
- National unique identifiers for providers, health plans, and employers;
- Privacy and Security of health data.



## HIPAA

- National Standards x12
  - 4010
  - 5010 eff. Jan. 1, 2012
- Code Sets
  - HCPCS
  - CPT®
  - CDT
  - ICD-9-CM (ICD-10-CM eff. Oct. 1, 2013)
  - NDC



## HITECH

- The Health Information Technology for Economic and Clinical Health Act
  - Promote the adoption and meaningful use of health information technology
  - Strengthened HIPAA
  - Patient audit trail



# HIPAA

## Large Health Care Provider Restricts Use of Patient Records

Covered Entity: Multi-Hospital Healthcare Provider

Issue: Impermissible Use

A nurse practitioner who has privileges at a multi-hospital health care system and who is part of the system's organized health care arrangement impermissibly accessed the medical records of her ex-husband. In order to resolve this matter to OCR's satisfaction and to prevent a recurrence, the covered entity: terminated the nurse practitioner's access to its electronic records system; reported the nurse practitioner's conduct to the appropriate licensing authority; and, provided the nurse practitioner with remedial Privacy Rule training.

<http://www.hhs.gov/ocr/privacy/hipaa/enforcement/examples/allcases.html#case1>



## Need for Compliance

- Benefits of a compliance plan:
  - faster, more accurate payment of claims
  - fewer billing mistakes
  - diminished chances of a payer audit
  - last chance of running afoul of self-referral and antikickback statutes
  - increased accuracy of physician documentation that may result from a compliance program actually may assist in enhancing patient care.
  - show the physician practice is making a good faith effort to submit claims appropriately
  - sends a signal to employees that compliance is a priority while providing a means to report erroneous or fraudulent conduct, so that it may be corrected.



## OIG Compliance Plan

1. Conduct internal monitoring and auditing.
2. Implement compliance and practice standards.
3. Designate a compliance officer or contact.
4. Conduct appropriate training and education.
5. Respond appropriately to detected offenses and develop corrective action.
6. Develop open lines of communication with employees.
7. Enforce disciplinary standards through well-publicized guidelines.

<http://oig.hhs.gov/fraud/PhysicianEducation/05compliance.asp>



## OIG Workplan

- Published yearly
- Outlines priorities
- Targets areas for improvement



## OIG Work Plan – FY 2012

### Evaluation and Management Services Provided During Global Surgery Periods

We will review industry practices related to the number of E/M services provided by physicians and reimbursed as part of the global surgery fee to determine whether the practices have changed since the global surgery fee concept was developed in 1992. Under the global surgery fee concept, physicians bill a single fee for all of their services that are usually associated with a surgical procedure and related E/M services provided during the global surgery period. The criteria for global surgery policy are in CMS's *Medicare Claims Processing Manual, Pub. 100-04, ch. 2, § 40*.

(OAS; W-00-09-35207; various reviews; expected issue date: FY 2012; work in progress)

Source: [http://oig.hhs.gov/reports-and-publications/archives/workplan/2012/WP01-Mcare\\_A+B.pdf](http://oig.hhs.gov/reports-and-publications/archives/workplan/2012/WP01-Mcare_A+B.pdf)



## OIG Work Plan – FY 2012

### Appropriateness of Medicare Payments for Polysomnography

We will review the appropriateness of Medicare payments for sleep studies. Sleep studies are reimbursable for patients who have symptoms consistent with sleep apnea, narcolepsy, impotence, or parasomnia in accordance with the CMS *Medicare Benefit Policy Manual, Pub. No. 102, ch. 15, § 70*. Medicare payments for polysomnography increased from \$62 million in 2001 to \$235 million in 2009, and coverage was also recently expanded. We will also examine the factors contributing to the rise in Medicare payments for sleep studies and assess provider compliance with Federal program requirements.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Source: [http://oig.hhs.gov/reports-and-publications/archives/workplan/2012/WP01-Mcare\\_A+B.pdf](http://oig.hhs.gov/reports-and-publications/archives/workplan/2012/WP01-Mcare_A+B.pdf)



## AAPC and You

- Founded in 1988 for physician-based medical coders
- Over 110,000 Members Worldwide
- Over 78,000 Certified Members
- Over 440 local chapters across the United States

