National Committee on Vital and Health Statistics

Subcommittee on Standards

"Transparency of Claim Edits, Publication of Plan Payment Rules, Standardized Forms for Audits"

Testimony of

Holly Louie, CHBME

On Behalf Of

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My name is Holly Louie and I am an RN, certified coder and a Certified Healthcare Billing and Management Executive (CHBME). I am the Compliance Officer for Practice Management, Inc. a multi-specialty billing company in Boise, Idaho. I am here today representing the Healthcare Billing and Management Association (HBMA). Our more than 700 members process an estimated 350-400 million claims per year.

Based on Practice Management's daily operational challenges and the far more extensive experience of HBMA members with payors in every state, we well know that many payors do not follow the AMA CPT© guidelines and/or the CMS Correct Coding Initiative edits, conventions, guidelines and rules. The fact that CPT© codes are part of the HIPAA standard transaction sets, but the coding conventions that explain correct code use and reporting are not, has created a payor free-for-all in how to apply edits and permits widely divergent interpretations. In addition, some payors utilize the Correct Coding Initiative edits in totality, some use unique subsets and some rely upon no known methodology, other than their own internal decisions. To add even more complexity, some commercial coding policies are by plan! Some policies are published, but many are not.

It is not surprising that physician coding is targeted and under continual fire for inaccuracies. The correct answer for one payor is improper coding for another. The current environment requires knowing a different set of "rules" and coding guidelines for payors and their plans, rather than relying upon correctly and accurately reporting services consistent with one standardized set of procedural coding rules and edits. As a result, we must invest extensive resources to perform onerous, time consuming, expensive tasks to receive correct payment for medically necessary services that were correctly coded. This unnecessary guessing game involving idiosyncratic rules a given payor may have implemented places an ever-increasing burden on practices, billing companies and our clients to receive payment for their services. Imagine what your life would be like if in Chicago a red light means stop, in Denver it means go, in Orlando it means no left turn and in Los Angeles what it means is a secret. This is quite comparable to what we are asking our physicians, coders and billing professionals to figure out.

Some physicians and others in the healthcare industry have opined that they believe this is an intentional ploy by some payors to avoid paying legitimate claims and using these idiosyncratic, unknown and unpublished edits as justification. This is, of course, in spite of the rigorous, strict application of coding accuracy to which practices are held by auditors representing the same private and government payors. If physicians and their billing companies do not have sophisticated denial management processes and analysis, significant lost revenue will result and valid claims will not be paid. My opinion is not unsubstantiated. I will present data later in my testimony from three years experience in my company.

I will now provide this committee with specific examples from a variety of payors.

Incorrect claim adjudication: Per the CPT© instructions, "a modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code…" the CMS Medicare guidelines for modifier reporting mirror this definition.

- Modifier 24 is used to report an unrelated evaluation and management service during a postoperative period. We acknowledge there is a discrepancy between CMS and CPT© in that CPT© states the service is by "the same physician" and CMS does not include that statement in their publications. Regardless, that the service is unrelated is supported through the use of appropriate diagnosis codes, which clearly describe the disease, condition, signs or symptoms that would not be relevant to the diagnosis for the surgery. Multiple payors incorrectly deny these services as "bundled" into the surgical procedure. For example, a patient is in an accident and sustains multiple injuries that require surgery for a ruptured spleen.

  Postoperatively, the surgeon is also treating the patient's fractured ribs, pulmonary contusion and closed head injury. Quite obviously, these are not related to a spleen removal. However, when the physician receives a denial from the payor stating the services are part of the global surgery package, the only recourse is to file a written appeal that includes a copy of the medical record for each and every applicable visit. In some cases, physicians try to be proactive by sending all the reports with the claims but still see the services denied as included in the surgical package. This submission of paper records, even once, is unnecessary work and expense. The not uncommon need to send the records and then resend them with a subsequent appeal when the claim alone should be sufficient is unacceptable.

- Modifier 25 is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service. We understand that modifier 25 has a history of misuse. However, there are very legitimate reasons to report this modifier and expect reimbursement for medically necessary services otherwise there would be no need for the modifier. For example, a patient is struck in the head and has a brief loss of consciousness. As a result she falls and lacerates her knee. The physician repairs the knee laceration but also must evaluate the patient's head injury. In this case, both services are medically necessary and accurately reported. As described above, it is very common for the payor to deny the services as "bundled," which requires written appeals with copies of relevant medical records.

  In addition, a patient may occasionally see multiple providers of different specialties for unrelated reasons on the same date. For example, a patient sees their cardiologist for a problem related visit (an E/M service). Later that same day, the patient sees their dermatologist for a planned lesion excision (a minor procedure). The physicians are not in the same group, practice or specialty, but some payors deny the cardiologist's claim as bundled into the dermatologist's surgical procedure. I think it is clear this is problematic for several reasons. The two physicians may not even be aware of the other's services and have no access to the information. However, in order for the cardiologist to receive payment for his or her professional services, a written appeal and medical records must be sent to the payor. Even then, the service may be denied unless the dermatologist assists the cardiologist by also providing copies of medical records to prove the two encounters are unrelated. I believe this clearly demonstrates the unnecessary and unreasonable burden placed on providers to receive payment for correctly coded, medically necessary services.

- Modifiers 76 and 77 are used to report a repeat procedure or service by the same or different physician. We understand that no payor will pay for unnecessary, duplicative services. However, there are many times, predominately in the diagnostic specialties, such as radiology, where multiple exams may be medically necessary. Typical examples include premature neonates, trauma patients, stroke patients, cardiac patients, etc. who may require follow-up exams to measure progress or deterioration or to perform post-procedural examinations. These exams are frequently incorrectly denied as "duplicate."

  To put it in perspective, a one-view chest x-ray is a very high volume but low dollar exam that is commonly repeated for a variety of medically necessary reasons. The need for a physician or his billing company to implement costly manual processes for a service with a Medicare allowable of $8.55 (Idaho) is unreasonable. And while this is a small amount on one claim, over the thousands of exams performed each year it becomes real money that should have been paid promptly and not a routine occurrence that costs the practice unnecessary expenditures. This seems especially egregious when not only the modifier, but the actual time of the service is reported on the electronic claim.

  This so-called "duplicate" denial is compounded because multiple groups, physicians and sites of service are lumped together although the provider may have no way of knowing what another group performed. For example, a patient has an imaging exam in his physician's office in one state. The patient subsequently worsens, is seen and admitted to the hospital in a different, bordering state where the same imaging exam is performed hours later as an inpatient. It would seem obvious that the two exams cannot possibly be duplicate services; however, the second exam is denied as though it is. In order to justify the second exam, some payors (including Medicare contractors) are requiring not only modifier 77 but a redetermination request that includes the documentation for the denied exam and, in some cases, documentation from the first encounter as well. It is virtually guaranteed the two radiologists will not have access to this information. I want to stress that this is relevant only to medically necessary repeat exams to evaluate the patient's progress, effectiveness of treatment or change in condition. The intent is not to receive reimbursement for repeating exams for non-medically necessary reasons, such as protocols that state all imaging from other facilities must be "reread" when patients are admitted to the hospital or for quality assurance requirements.

- Modifier 59 is correctly used to report a distinct procedural service. In some cases, it is necessary to override bundling edits to accurately report services that should not be considered inclusive. For example, per the Correct Coding Initiative and CPT©, excision of an epidermal lesion includes a biopsy of that lesion because during many procedures on the integument system, the removed tissue is routinely submitted for pathology examination so it is considered a component of the surgery. To bill for obtaining a biopsy of a single lesion plus removal of the lesion would be redundant. However, if a biopsy only, vs. an excision or other procedure is performed on one lesion and an excision is performed on a different lesion, both may be reported through the use of modifier 59. The services are not bundled in this case. Many payors ignore modifier 59 and deny one of the services as "unbundled." As with all of the examples in this testimony, when the claim

is denied written appeals and surgical reports are necessary to justify what was already explained on the electronic claim.

The OIG published a report on the misuse of modifier 59 (attached) and CMS and AMA have published a number of documents and explicit instructions for correct use. Given the history of concerns regarding improper reporting of modifier 59, it is extremely concerning when a payor instructs idiosyncratic reporting of modifier 59 that is inconsistent with all authoritative coding guidelines and CPT© conventions. For example, per CPT© and the CMS correct coding initiative, transabdominal and transvaginal imaging are considered separate exams and not bundled. There is currently no combination code to report these services together. However, a Medicaid program currently requires modifier 59 on one of the exams in order to consider both for payment. This is problematic at many levels. It is clearly an incorrect use of modifier and an OIG risk area in all Compliance Guidance. It is inconsistent with all coding conventions, rules and guidelines, and because it is unique to one payor, crossover claims are also adversely affected. Members of NCVHS, I would submit to you that payors should not be permitted to invent their own rules that directly conflict with not only coding, but compliance guidance.

Improper payor requirements and denials for add-on codes: In most cases, when multiple surgical procedures are performed on the same day and during the same session, each additional procedure is subject to a reduction in value, based on the efficiencies achieved by performing multiple services in one session. Modifier 51 is appended to each additional procedure or service to explain this circumstance. Separate and distinct from the multiple procedure rules, the CPT© guidelines, CMS manual instructions and the Correct Coding Initiative identify certain procedures that are **only** reported in addition to a primary service. For example, a dermal autograft has a base code for the first 100 sq. cm. and an add-on code to report each additional 100 sq. cm. This convention of having codes that are only reported in addition to a primary procedure is found throughout CPT©. The relative value of add-on codes has already been appropriately adjusted through the RUC and fee schedule process. CPT© instructions also state that modifier 51 is not appended to any add-on services. Many payors routinely require modifier 51 (multiple procedure) appended to add-on services. These unpublished edits are not based on any known rationale and additional multiple surgical procedure payment reductions for already reduced services are inappropriate.

In addition to designated add-on codes, identified by a + sign, some CPT© procedures include parenthetical notes instructing that the code is reported in addition to other CPT© codes. For example, codes 76376 and 76377 describe 3D rendering and interpretation and are reported in addition to specific base imaging procedures. Code 99144 reports moderate sedation and is reported in addition to some surgical services when the specific guidelines are met. Many payors routinely deny these additionally reported services as integral to or included in the core service. In some cases, the EOB states the claim line denied due to a coding "error." We are not questioning payor policy coverage determinations, but we do take exception to inaccurately characterizing correctly coded claims as coding errors. Not only does this create confusion and work for the physician or billing company, it provides misinformation to the beneficiary. Consider, if you will, that virtually every EOB the patient receives instructs and encourages them to contact the fraud unit if they believe their physician has billed them inappropriately. We

frequently handle patient calls on behalf of our clients complaining that their insurance company told them the physician is coding incorrectly. The beneficiary now has an EOB that tells them the physician is coding incorrectly and a payor's representative confirming that opinion. Ladies and gentlemen, I believe that this type of deliberate miscommunication, based on idiosyncratic payor policy and not published and recognized coding conventions, is unconscionable.

Unpublished bundling edits: Many of my colleagues have published and testified about the innumerable payor edits. In addition to the examples outlined above, we learn of these edits when claims are denied, not through published instructions or policies. The fact that these unpublished edits are not consistent with CPT© or the correct coding initiative makes it a never-ending guessing game for the billing company and our physicians. This typically requires phone calls, written appeals, claim resubmissions and a variety of work that may be unrewarded. To increase the problem, the EOB denial reasons are misrepresentative, i.e. coding errors, non-covered service, not medically necessary, information provided does not support the service, exceeds number of services allowed, investigational, codes submitted are invalid and myriad other explanations. In reality, the problem is payor coverage determinations, policy specific determinations, failure to obtain precertification and a host of other reasons related to ***coverage, not coding***. Each of these could be reported by an accurate explanation, not through mis-use and mis-reporting of idiosyncratic coding edits.

Unlisted services: The CPT© guidelines and CMS instructions state, "select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT© code that merely approximates the service provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code." The reporting of an unlisted service typically requires submission of reports to enable the payor to make a payment determination. It has been our experience that the service frequently is denied on review, the reason for the denial is "invalid CPT© code" and the explanation given is that a CPT© code exists to report this service. In fact, there is not a CPT© code but the payor is requesting a code that "merely approximates the service" in order to issue payment. Physicians and their billing companies are left with a choice of no reimbursement or reporting an inaccurate code to accommodate the payors' incorrect CPT© coding edits. As described above, this is a monumental compliance concern. As more and more focus on preventing false claims, fraud and abuse is initiated and implemented, will physicians be forgiven for incorrect coding when the payors actually require it? Is "correct coding" even achievable when there is no established set of guidelines universally required for code reporting?

ICD-9 CM: I understand diagnosis coding is not the focus of today's meeting, but I think it imperative this Committee understand the coding edit problems are not limited to CPT©. While it is commonly believed HIPAA required implementation of the ICD-9 CM code sets and conventions, the fact is that payors, including Federal contractors, also continue to utilize idiosyncratic edits to deny services for "invalid" diagnosis. Common examples include failure to recognize conditions originating in the perinatal period, failure to accept V codes for multiple services and failure to follow the ICD-9 CM coding conventions for malignancy sequencing. Similar to the CPT© issues discussed above, although all of the diagnosis codes are valid, the payor specific coverage policies create the need to customize coding for each payor and in some cases, for each payor's product or plan. When you add these mislabeled edits

to the CPT© edit issues, the magnitude of work for physicians and their billing companies increases exponentially, the amount of work on paper continues to grow, not lessen, and the desired electronic processing cannot be successfully implemented.

Analysis of the problem through denial management data capture: I would now like to come full circle and share my company's experience with the edit issues described above and by my esteemed peer group. I also want to point out that all services for our clients are coded by certified coders with expertise in the specialty. In my company we have implemented a robust denial management program that includes; up front edits such as CCI, some customized edits to review and address idiosyncratic payor edits we have identified, back-end work by employees who investigate denials and attempt to resolve the problem and, finally, a review by a coding/compliance expert for those cases where coding is allegedly the problem. Since I am my company's Compliance Officer, I can also assure you that our Denial Management program is fully integrated with our Compliance Program.

As an aside, not all practice management systems are capable of programming these widely variable edits. Some physicians and billing companies have found they may be able to contract for some customized programming, but it can be cost prohibitive. Regardless, it is time consuming, expensive and identifying all idiosyncratic payor edits is virtually impossible, especially when they may change on a regular basis.

A detailed analysis of denials that met the above criteria in 2009 showed that 61% of all denials were due to idiosyncratic payor edits. We also found that when written appeals disputing these denials were sent, we were successful in ~86% of the cases.

For dates of service in 2010, my company evaluated and addressed 2,888 claim line denials accounting for $749,838 in charges. For the first ten months of 2011, that number is 3,464 claim lines for a total of $863,208. Members of the committee, I am not implying that every one of those claims should have been paid. What I am stating is that the reason for the denial should not result from idiosyncratic, unknown or unpublished coding edits that are inconsistent with coding guidelines; and explanation of benefits should not incorrectly and inaccurately state coding errors were the cause of the denial leaving us to guess what the problem really is. Obviously, this experience is not unique to my company. If we are to assume for a moment that this experience is comparable to HBMA members at large, we are talking about 2,078,400 claims and $517,924,800 in the first ten months of 2011. That does not include the thousands of physicians who do not utilize the services of an HBMA member.

SUMMARY:

The current lack of standardization for coding conventions, code pair edits and explanations for denials has allowed idiosyncratic payor edits to proliferate. Billing companies and physicians frequently do not know why a claim was denied or how to address the problem. Coverage policy and payment determinations are misrepresented as coding issues or errors, leading to confusion for billing companies, physicians and beneficiaries. The cost to analyze the denials, rely upon manual and paper processes, contend with improperly delayed payments, program systems, educate physicians and attempt to receive correct payment for medically necessary, correctly coded services is onerous and an unnecessary cost.

HBMA and coding professionals view this issue as a critical problem and are certain that the elimination of unpublished and non-standard coding edits would make dramatic progress towards administrative simplification and reduced practice, administrative and insurer overhead. We also believe standardizing coding conventions and edits would significantly enhance compliance efforts by establishing clear guidance, conventions and rules that everyone involved in the claims process could be held accountable for.

HBMA strongly recommends mandatory standardization of all coding conventions and coding edits and denial explanations that accurately describe coverage and payment policy vs. coding issues. The need for manual, paper processes to address the problems this lack of standardization creates are unsustainable.

RECOMMENDATIONS:

1. CPT© coding conventions should be adopted as part of the HIPAA required standards
2. The CCI edit pairs should be the required methodology for all code pair edits
3. Remittance advice reason codes and explanations must be accurate and standardized
4. Denials based on payor coverage policies should not be characterized as coding errors
5. Enforcement of all HIPAA violations should be consistent and predictable