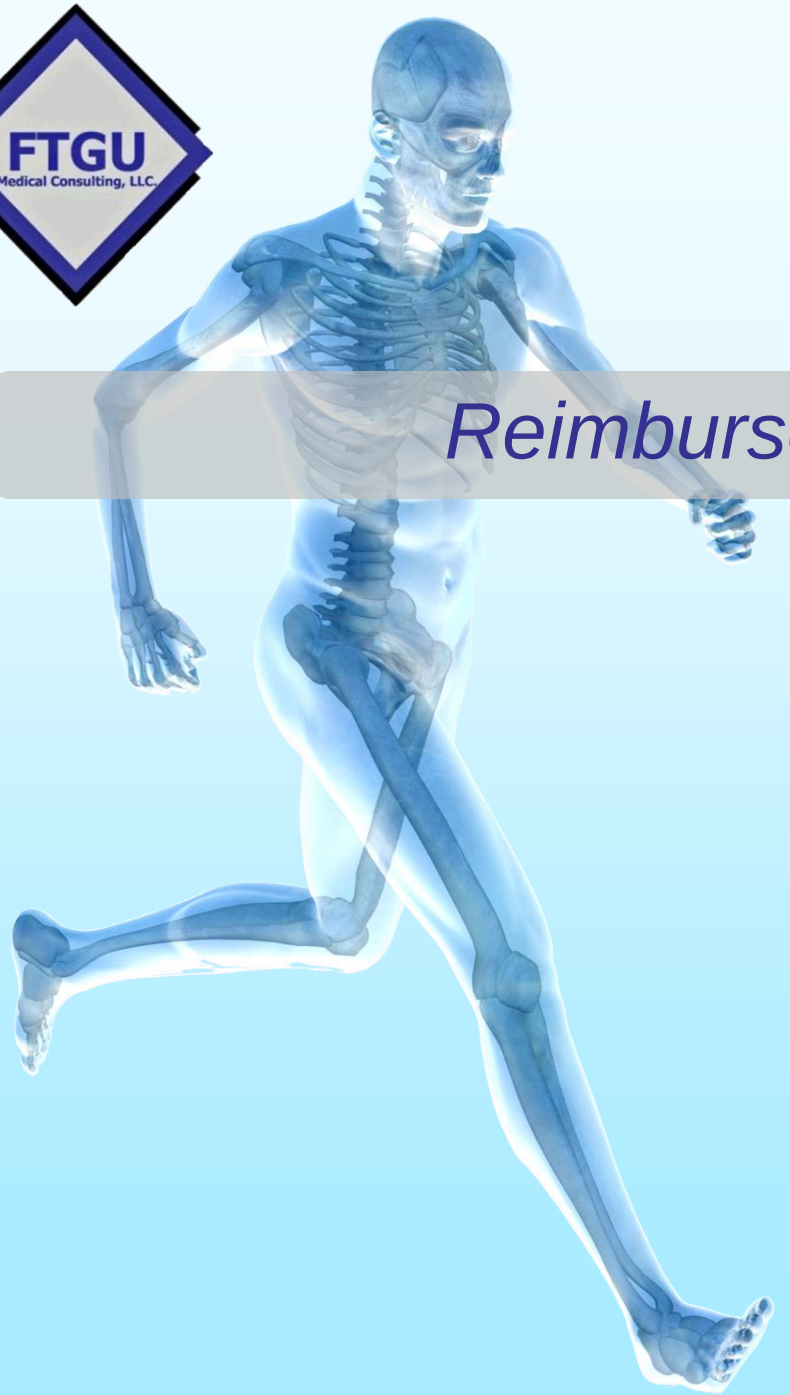

FTGU Medical Consulting

Reimbursement Potpourri

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The "Good" Fight!

- Medicare Changes
  - Separate E&M with an Injection
  - Shoulder is an Ipsilateral Joint
  - Pain Management is included in the Global Package
- Dealing with Medical Necessity Denials
  - Diagnosis driven
  - Satisfying LCD or Corporate Policy Criteria
- Unlisted Procedure Codes
- Spine Reimbursement Issues
- Worker's Comp Fallacy

Medicare – Separate E&M with an Injection

2013 NCCI Edits: Chapter 1, Section D

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. *E&M services on the same date of service as the minor surgical procedure are included in*

Revision Date (Medicare): 1/1/2013
I-17

the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI does contain some edits based on these principles, but the Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits. Neither the NCCI nor Carriers (A/B MACs processing practitioner service claims) have all possible edits based on these principles.

Focus on Medical Decision Making

- 2013 CCI update emphasizes that E&M is included in the payment for an injection (minor surgical procedure)
- UNLESS there is a separately identifiable E&M Service (kept the old language)
- **What does this mean?**
- **Medical Decision Making is the key:**
  - **Multiple pathologies addressed, or**
  - **Same pathology addressed in multiple ways**
    - **Subscription for Physical Therapy**
    - **Prescription drug therapy**
    - **Order for DME**

Separate E&M Examples

NOT a Separate E&M

02-07-13-JAB-cg: The patient is in today for treatment of his right knee for degenerative osteoarthritis. As well-documented, he receives a Hyalgan series and gets a Hyalgan booster about every three months and does extremely well with this. He does get a little bit of effusion toward the end of a treatment cycle but is able to maintain his activity levels with no limitations.

Examination: On physical examination today, he shows normal stance, posture and gait. He does have a mild effusion in his right knee, and range of motion remains consistent at 0-135. His neurovascular examination with respect to sensory, deep tendon reflexes and pulses is symmetrical and intact.

Plan: We have aspirated him today of about 10-15 cc of normal appearing joint fluid and injected him with a Hyalgan booster. We will plan on seeing him on return to the clinic in about three months or p.r.n. problems. Fifteen minutes face to face.

Separate E&M

Plan:

1. Degeneration of lumbar or lumbosacral intervertebral disc

[redacted] had a L gluteal trigger point injection done in clinic tody. Recommend periformis stretches. She had a discussion with [redacted] regarding appropriate stretches/activities/treatment which we agree with. Recommend increase Lyrica, add 75mg at noon, for 150mg BID and 75mg at noon. Return to clinic in 6 months. PoC

Medicare – Shoulder is an Ipsilateral Joint

2013 CCI Edits: Chapter 4, Section F-22

> *22. CMS considers the shoulder joint to be a single anatomic structure. An NCCI procedure to procedure edit code pair consisting of two codes describing two shoulder joint procedures should never be bypassed with an NCCI-associated modifier when performed on the ipsilateral shoulder joint. This type of edit may be bypassed only if the two procedures are performed on contralateral joints.*

- If a shoulder code is a Column 2 code to a Column 1 code, it should NOT be unbundled with a 59 modifier
- Consider an arthroscopic rotator cuff repair with a subacromial decompression, partial acromioplasty and a limited debridement of a torn labrum.

Pre-2013 Coding	2013 Coding
29827	29827
29826	29826
29822-59	(29822 should not be coded)

Medicare Global Package

- Medicare Global Package:
  - Pre-Operative Visits (day of and day before procedure)*
  - Intra-Operative Services
  - Complications following services (not requiring a return trip to the OR)
  - Post-Operative Visits
  - Post-Surgical Pain Management by the surgeon
  - Miscellaneous Services (dressing changes, suture removal, tubes, drains, etc.)
  - Supplies (except those defined as exclusions)

***E&M can be billed separately day of or day before with a 57 modifier if MDM includes decision for surgery**

Injections in the Global Period

- Commercial Carriers vary in their definition of the Global Package…most will cover pain management in the global period. Adding a 58 modifier to the injection code will unbundle from the previous surgery.
- A 58 modifier should **never** be added to an injection code on a Medicare claim during the global period of a major surgery (for same anatomic structure).

Medicare =

Medical Necessity Denials

- Diagnosis or Policy driven
- Sending Progress Notes or Op Report is NOT helpful
- First Step – Check list of approved diagnoses in LCD or corporate policy
- Second Step – Review LCD or corporate policy for medical necessity criteria
  - Gather all relevant documents – progress notes, radiographic images, previous procedures
  - Submit an appeal package with a cover letter

UHC FAI Corporate Policy

UnitedHealthcare®

MEDICAL POLICY

FEMOROACETABULAR IMPINGEMENT SYNDROME

Policy Number: 2012T0530E
Effective Date: February 1, 2012

COVERAGE RATIONALE

Surgical treatment, both arthroscopic and open, for femoroacetabular impingement (FAI) syndrome is proven.

Information Pertaining to Medical Necessity Review (When Applicable)
Surgical treatment for femoroacetabular impingement (FAI) syndrome is medically necessary in patients who meet ALL of the following criteria: **

- pain unresponsive to medical management (e.g., restricted activity, nonsteroidal anti-inflammatory drugs)
- moderate-to-severe persistent hip or groin pain that limits activity and is worsened by flexion activities (e.g., squatting or prolonged sitting)
- positive impingement sign (i.e., sudden pain on 90 degree hip flexion with adduction and internal rotation or extension and external rotation)
- radiographic confirmation of FAI (e.g., pistol-grip deformity, alpha angle greater than 50 degrees, coax profunda, and/or acetabular retroversion)
- do not have advanced osteoarthritis (i.e., Tönnis grade 2 or 3) and/or severe cartilage damage (i.e., Outerbridge grade III or IV)

Plus Pre-Authorization!

CIGNA Facet Joint Injection Policy

Cigna Medical Coverage Policy

Subject **Minimally Invasive Treatment of Back and Neck Pain**

Effective Date 7/15/2012
Next Review Date 7/15/2013
Coverage Policy Number 0139

FACET JOINT INJECTION

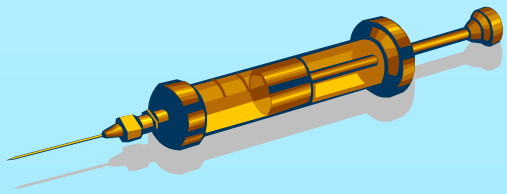
Diagnostic

Cigna covers a diagnostic facet joint injection (CPT codes 64490-64495) as medically necessary when used to determine whether chronic neck or back pain is of facet joint origin when ALL of the following criteria are met:

- Pain is exacerbated by extension and rotation, or is associated with lumbar rigidity
- Pain has persisted despite appropriate conservative treatment (e.g., nonsteroidal anti-inflammatory drugs (NSAIDs, exercise)
- Clinical findings and imaging studies suggest no other obvious cause of the pain (e.g., spinal stenosis, disc degeneration or herniation, infection, tumor, fracture)

Therapeutic

Cigna does not cover therapeutic facet joint injection (CPT codes 64490-64495) for the treatment of acute, subacute, or chronic neck or back pain or radicular syndromes because it is considered experimental, investigational, or unproven.



UHC Rhizotomy Policy

UnitedHealthcare®

MEDICAL POLICY

ABLATIVE TREATMENT FOR SPINAL PAIN

Policy Number: 2012T0107K
Effective Date: April 1, 2012

Thermal radiofrequency ablation of facet joint nerves is proven for chronic cervical, thoracic and lumbar pain when confirmed by:

- Temperature 60 degrees Celsius or more
- Duration of ablation 40 - 90 seconds
- Positive response to medial branch block injection at the side and level of the proposed ablation, **AND**
- Confirmation of needle placement by fluoroscopic guided imaging

Thermal radiofrequency ablation is proven:

- When performed at a frequency of six months or longer (maximum of 2 times over a 12 month period), **AND**
- Provided there has been a 50% or greater documented reduction in pain for 10 to 12 weeks.

Thermal radiofrequency ablation is unproven:

- When performed more frequently than every six months; or
- When there has been no significant improvement after medial branch block injection

Add EMR Templates to Ensure Compliance with Corporate Policies

Trigger Point Injections

Acceptable MEDICARE Diagnois code for trigger point injections, 20552 and 20553.	
720.1	SPINAL ENTHESOPATHY
723.9	UNSPECIFIED MUSCULOSKELTAL DISORDERS AND SYMPTOMS REFERRALBLE TO NECK
726.19	OTHER SPECIFIED DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION
726.32	LATERAL EPICONDYLITIS
726.39	OTHER ENTHESOPATHY OF ELBOW REGION
726.5	ENTHESOPATHY OF HIP REGION
726.71	ACHILLES BURSITIS OR TENDINITIS
726.72	TIBIALIS TENDINITIS
726.79	OTHER ENTHESOPATHY OF ANKLE AND TARSUS
726.9	ENTHESOPATHY OF UNSPECIFIED SITE
729.0-729.1	RHEUMATISM UNSPECIFIED AND FIBROSITIS-MYALGIA AND MYOSITIS UNSPECIFIED
729.4	FASCIITIS UNSPECIFIED

Update Your Injection Superbills!

Unlisted Procedure Codes

- Need to write a cover letter describing procedure
  - Be specific regarding the steps to complete the procedure
  - Explain why procedure is beneficial to the patient
- Always indicate a comparison code
- Examples:
  - Arthroscopic Iliopsoas Tendon release – 29999; Comparison Code = 27036 (capsulectomy or capsulotomy, hip, with or without excision of heterotopic bone, with release of hip flexor muscles [i.e., gluteus medius, gluteus minimus, tensor fascia latae, rectus femoris, sartorius, iliopsoas])
  - Open Gluteus Medius Repair – 27299; Comparison Code = 23412 (open rotator cuff repair)
  - Arthroscopic Trochanteric Bursectomy – 29999; Comparison Code = 27062 (Excision, trochanteric bursa)

Spine Policies

- Aetna – Biomechanical Cages are unproven for ACDF
- Aetna – Lumbar Fusion with instrumentation is unproven for Degenerative Disc Disease
- UHC – Lumbar Fusion with instrumentation should not be performed routinely to address lumbar spinal stenosis (724.02 or 724.03)
- Medicare now covers spinous distraction devices (X-STOP)
- UHC will NOT pay for Lumbar Artificial Disc replacement

Texas Worker's Comp – Bad Ruling!!

- Case: Texas Health Care PLLC vs. Texas Mutual Insurance
- Date of Ruling: March 22, 2012
- Facts of case (M4-12-1864-01): Complainant originally filed a claim to Texas Mutual on 6/29/11 for a 4/12/11 DOS. Complainant received a denial on 7/28/11 because 99253 was not a valid code. Complainant changed the incorrect code to 99222 and filed a corrected claim on 8/28/11. Texas Mutual denied to corrected claim for failure to meet the 95-day filing deadline.
- Texas Mutual's Position: "… even though the billing code has been changed to a valid code [the corrected claim] constitutes a new bill with respect to Rule 133.250"

TDI Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted documentation finds that a bill was dated as submitted to the respondent on August 25, 2011; however the bill date of August 25, 2011 is not within 95 days after the date on which the health care services were provided. Consequently, documentation submitted by the requestor in this medical fee dispute does not sufficiently support that the medical bill was submitted timely.
3. The requestor failed to sufficiently support timely submission of the services in dispute. Therefore, in accordance with Texas Labor Code §408.027(a) provider's right to reimbursement is forfeited.

Texas Administrative Code §133.20

<<Prev Rule | **Texas Administrative Code** | Next Rule>>

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 133	GENERAL MEDICAL PROVISIONS
SUBCHAPTER B	HEALTH CARE PROVIDER BILLING PROCEDURES
RULE §133.20	**Medical Bill Submission by Health Care Provider**

(a) The health care provider shall submit all medical bills to the insurance carrier except when billing the employer in accordance with subsection (j) of this section.

(b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation.

(c) A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills.

This section means that a provider has 95-days after receipt of an EOB from an incorrect carrier to file to the correct WC carrier

Texas Administrative Code §408.027

Sec. 408.027. PAYMENT OF HEALTH CARE PROVIDER. (a) A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.

Sec. 408.0272. CERTAIN EXCEPTIONS FOR UNTIMELY SUBMISSION OF CLAIM. (a) In this section:

(1) "Group accident and health insurance" has the meaning assigned by Chapter 1251, Insurance Code.

(2) "Health maintenance organization" has the meaning assigned by Chapter 843, Insurance Code.

(b) Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

(1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:

(A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;

(B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or

(C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or

(2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

(c) Notwithstanding Subsection (b), a health care provider who erroneously submits a claim for payment to an entity described by Subdivision (1) of that subsection forfeits the provider's right to reimbursement for that claim if the provider fails to submit the claim to the correct workers' compensation insurance carrier within 95 days after the date the provider is notified of the provider's erroneous submission of the claim.

(d) Notwithstanding any other provision of this section or Section 408.027, the period for submitting a claim for payment may be extended by agreement of the parties.

This is the clause that TDI is using to rule against the provider

Again, this section references the provider's responsibility if the original claim is filed to the wrong carrier

Texas Administrative Code §133.20 Revisited

(e) A medical bill must be submitted:

(1) for an amount that does not exceed the health care provider's usual and customary charge for the health care provided in accordance with Labor Code §§413.011 and 415.005; and

(2) in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care.

(f) Health care providers shall not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an explanation of benefits except in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills).

(g) Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier.

Definition of an Incomplete Bill

According to Section 133.20(g), **a corrected claim is only considered a "new" claim (for the purposes of the timely filing statute) if the insurance carrier returns an INCOMPLETE BILL that it could not process.** The use of the phrase "corrected claim" in Section 133.20(g) is NOT meant to prejudice the ability of providers to correct claims as part of the reconsideration process but rather to indicate the provider's responsibility for correcting incomplete claims within the filing deadline. Moreover, Section 133.20(f) clearly states that a claim is considered "complete" when the carrier has taken final action and provided an EOB. As a result, once an original EOB is received by the provider, the claim is considered "filed" and, for the purposes of the statute, if the claim was filed within the 95-day filing deadline, the claim can no longer be denied for failing to meet the submission deadline.

Texas Administrative Code §133.200

According to Section 133.200, a COMPLETE bill (or claim) is defined as follows:

RULE §133.200 **Insurance Carrier Receipt of Medical Bills from Health Care Providers**

(a) Upon receipt of medical bills submitted in accordance with §133.10(a)(1) and (2) of this chapter (relating to Required Medical Forms/Formats), an insurance carrier shall evaluate each medical bill for completeness as defined in §133.2 of this chapter (relating to Definitions).

(1) Insurance carriers shall not return medical bills that are complete, unless the bill is a duplicate bill.

(2) Within 30 days after the day it receives a medical bill that is not complete as defined in §133.2 of this chapter, an insurance carrier shall:

(A) complete the bill by adding missing information already known to the insurance carrier, except for the following:

(i) dates of service;

(ii) procedure/modifier codes;

(iii) number of units; and

(iv) charges; or

(B) return the bill to the sender, in accordance with subsection (c) of this section.

Carriers cannot return a Complete Bill

Provider responsibility if carrier returns an Incomplete Bill – 95-day deadline applies!

Texas Administrative Code §133.250

Once a carrier has accepted a COMPLETE claim, any dispute to an adverse determination by the carrier must be handled according to Section 133.250. According to this section:

RULE §133.250 Reconsideration for Payment of Medical Bills

(a) If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action.

(b) The health care provider shall submit the request for reconsideration no later than 10 months from the date of service.

(c) A health care provider shall not submit a request for reconsideration until:

(1) the insurance carrier has taken final action on a medical bill; or

(2) the health care provider has not received an explanation of benefits within 50 days from submitting the medical bill to the insurance carrier.

Provider has 10-months to dispute the carriers decision

If correcting a COMPLETED claim were not a part of the normal reconsideration process, it would have been explicitly defined as such in either Section 133.20 or Section 133.250. Since it was NOT defined in either of these sections (or in any other section of the code), it is more than reasonable to assume that a corrected claim was NEVER intended to be treated as a new claim by the authors of the code

Filing a TDI Complaint

- Online TDI complaint form

  https://wwwapps.tdi.state.tx.us/inter/perlroot/consumer/complform/complform.html

- Mail:

  Texas Department of Insurance
  Division of Workers' Compensation, MS-8
  7551 Metro Center Drive, Ste 100
  Austin, Texas 78744

- Fax: (512) 490-1030
- Email: DWC-CRCSIntakeUnit@tdi.texas.gov

What's on Your Jump Drive

- This Presentation
- Two coding white papers:
  - Fracture coding advice for a proximal femoral fracture
  - Spine Coding Simplified—Removal of Hardware and Exploration of Fusion
- 4 Sample Appeals
  - Unlisted Code – Open Procedure
  - Unlisted Code – Scope Procedure
  - Satisfying a corporate policy for MNEC
  - Texas Work Comp – corrected claim is NOT a new claim
- Sections of the Texas Administrative Code referenced in this session

Reaching for Profitability!

Understanding the Rules

Missing the Boat!

Look for Partners that can help you navigate these troubled waters!

Thank you for your time…

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