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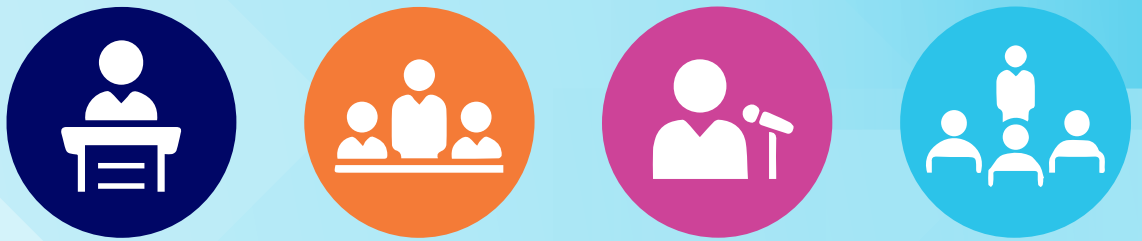

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Pesky Payers:
What Are They Doing and What Do You Need to Do

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Disclosures:

No financial conflicts of interest

Disclaimer

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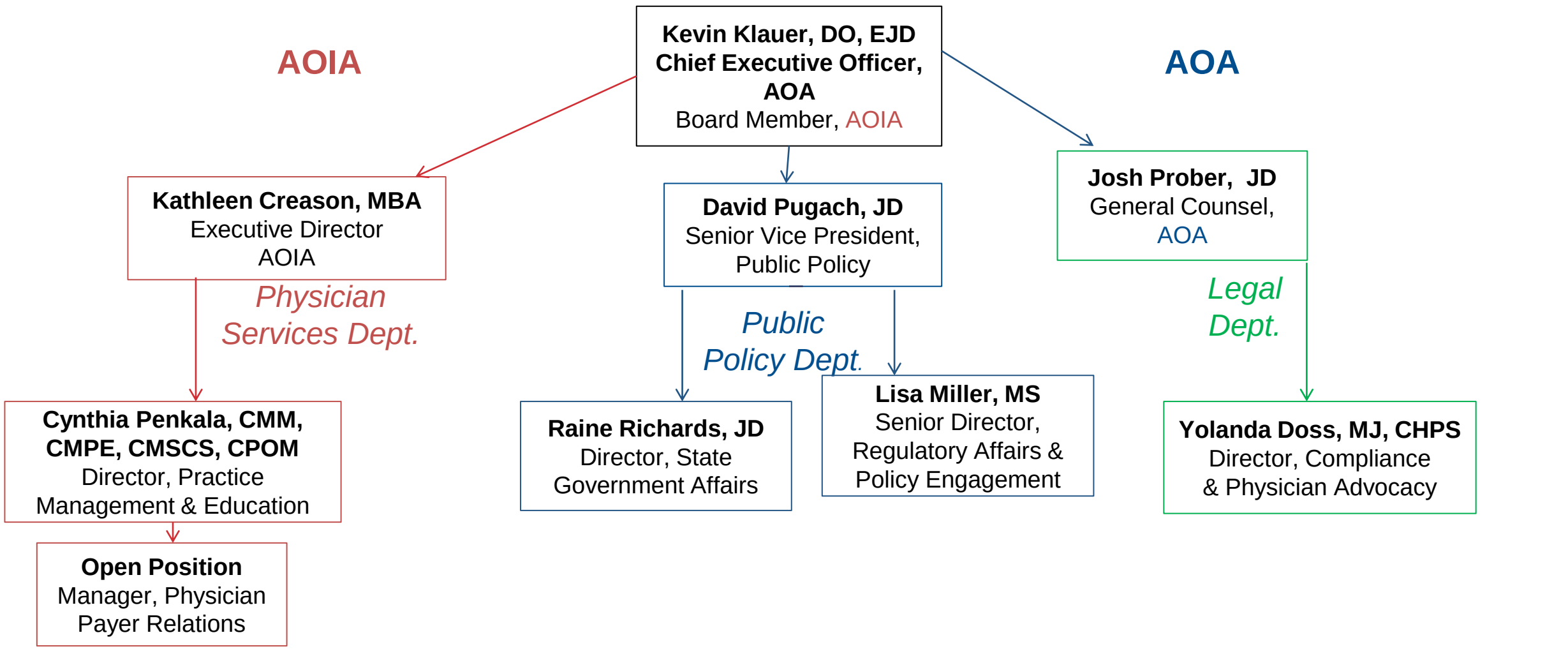
Learning Objectives

- Describe the changes within the AOA/AOIA Physician Services department.
- Identify key issues and challenges facing physicians in 2020 and beyond from the practice and payment realms.
- Discuss the components of ongoing public and private sector reforms and what physicians can do to prepare for and thrive in a constantly changing environment.
- Locate the appropriate resources for assistance.

Physician Services at AOA/AOIA

Who is involved?



Who do I contact?

The Physician Services Department

physicanservices@osteopathic.org

or

312-202-8194

We will review the issue and direct you to the right person/team within the AOA/AOIA.

Physician Challenges

Physician Issues and Challenges

- Changes in reimbursement structure
- Data requirements, EHR interoperability
- Physician burnout
- Administrative burden
- Third party interference in patient care
- Changing insurance marketplace

Majority of challenges are tied to efforts to bend the cost curve, not the delivery of patient care….

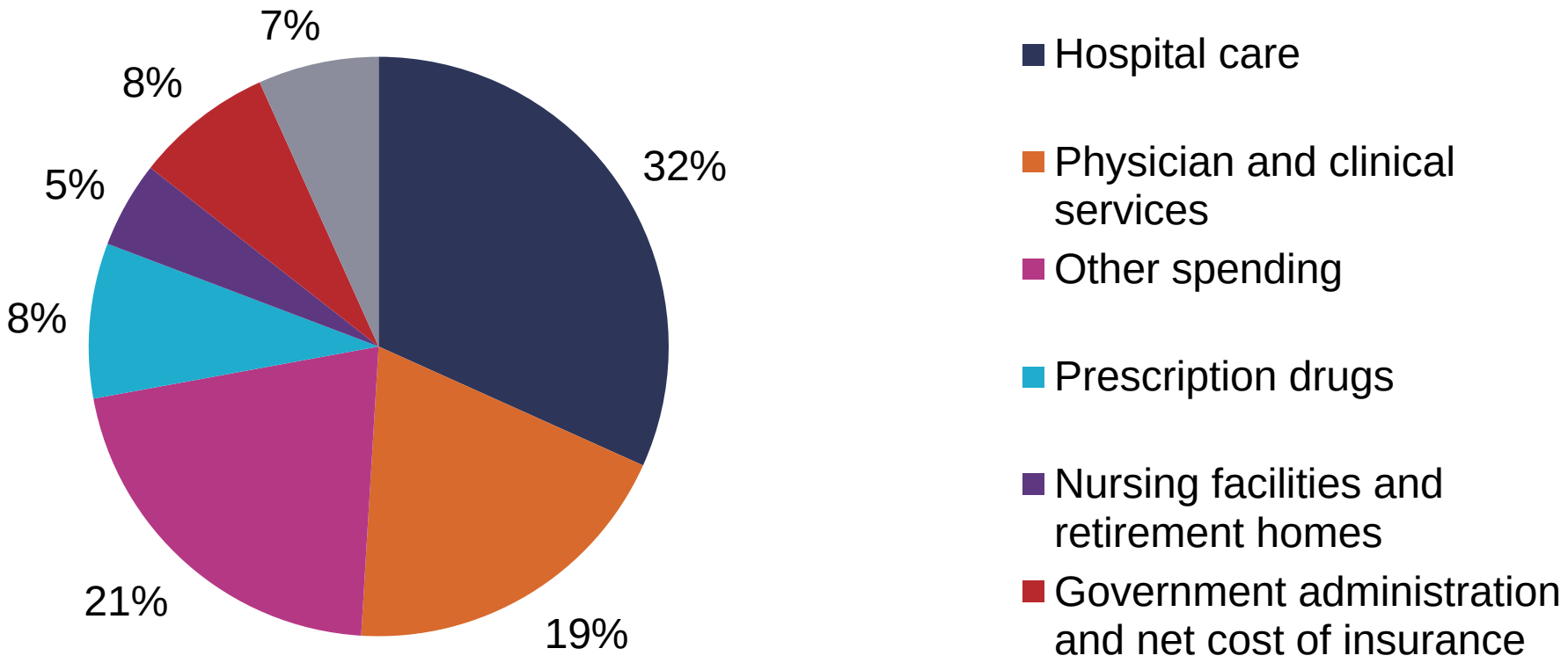
SOURCE: *Health Affairs*

Healthcare Spending

- U.S. healthcare spending reached $3.6 trillion, or $11,172 per person in 2018*
- Overall spending increased 4.6% in 2018
- Spending on physician and clinical services grew by 4.1% to $725.6 billion in 2018, **slower than 4.7% in 2017**
- The share of Gross Domestic Product (GDP) devoted to healthcare was 17.7% in 2018

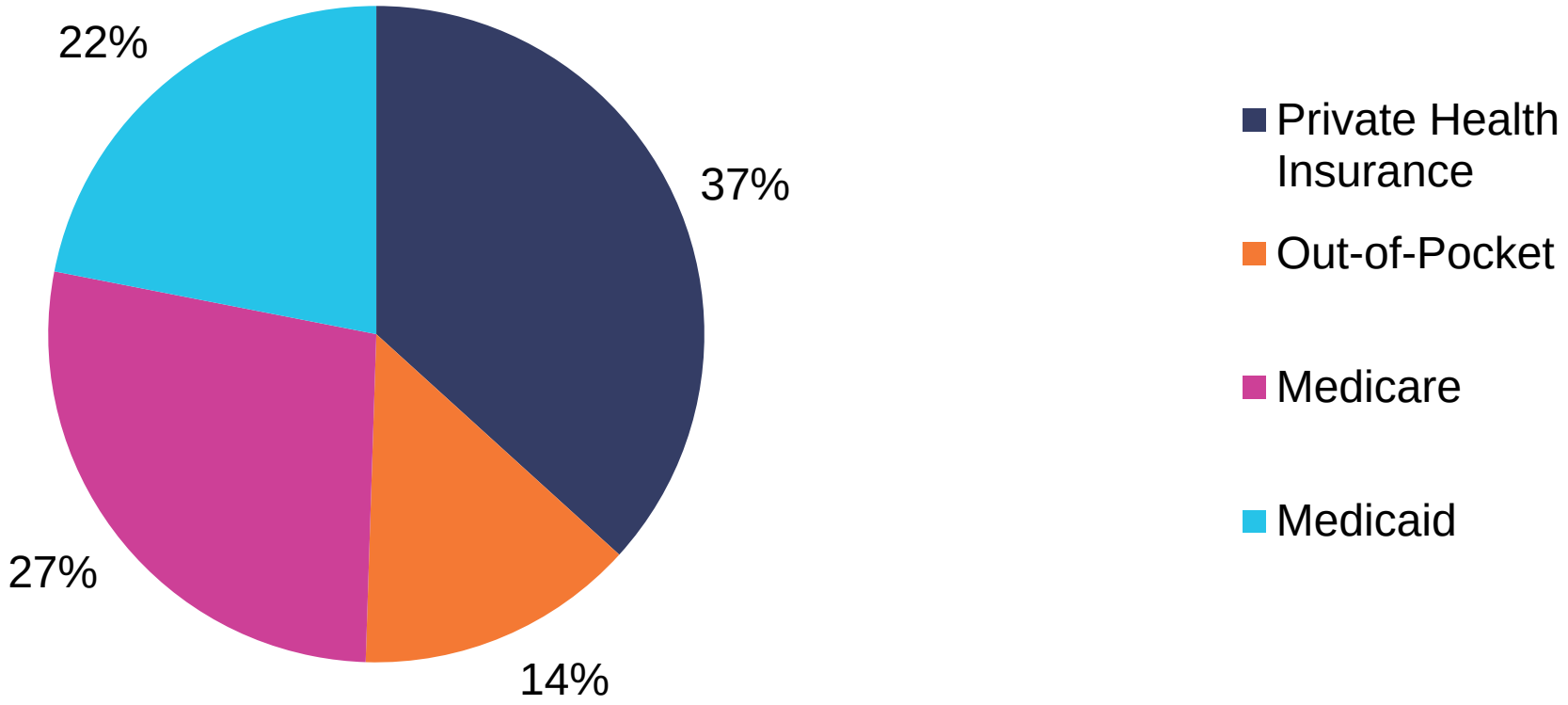
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group
*Includes all sources of funds: Public and private payers, out-of-pocket consumer spending, etc.

Healthcare Spending: Where did the money go?



NOTE: “Other spending” includes dental services, other professional services, home health care, durable medical equipment, other nondurable medical products, government public health activities, and Investment.
SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, 2018 data

Healthcare Spending: Who's paying the bill?



SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, 2018

Healthcare Spending: What's the Bottom Line?

- General trends of the last decade:
  - More physician visits, smaller piece of the "payment pie"
  - Drugs are an increasing share of pie
  - Aging population increasing
- Current spending projections aren't favorable
  - Healthcare spending projected to grow 5.6% per year through 2025
  - Healthcare share of GDP expected to rise to almost 20% by 2025
  - Out-of-pocket spending growth is projected to average 4.8% per year through 2025
- We spend too much, too inefficiently on health care in this country
  - U.S. both orders and spends more on medical tests and treatments per person than any other country

Bottom line: payers have/will continue to respond by instituting policy changes and market reforms designed to bend the cost curve and cut total expenditures

Market Response – Operational Reforms: How are Payers Responding to Cost Pressure?

- Out-of-pocket cost / shift to consumer cost-sharing
- Narrow networks / specialty networks
- Take-it-or-leave-it contracting
- Facility steerage
- Pre-authorization / prior-determination / pre-certification
- Tiered pharmaceutical formularies
- Audits, reviews and scorecards

Designed to cast a broad net; osteopathic physicians and Osteopathic Manipulative Treatment (OMT) procedures are not being singled out.

Private Payer Update

Modifier-25: Why is it a Target of Private Payers?

- In 2004, OIG reported 35% of claims appended with Modifier-25 did not meet the required reporting standards
- In OIG encouraged Medicare Administrative Contractors (MACs) to:
  - Re-examine their review, edit, audit protocols for claims appended with Modifier-25
  - Private payers followed CMS' lead, and then some…
  - CMS continuous indications that Medicare data shows Modifier-25 overutilization, potential duplication/overvaluation errors
- Private payers "fixated" on Modifier-25 "Revenue Enhancement," "Provider Compliance," Fraud, Waste, and Abuse Prevention and Detection"

Payers' Response

- Payers' payment reduction policies covering minor procedures/other care and same-day E/M services vary from company to company, but they are fruit of the same tree.
- Payers' policies and implementation timelines differ, but the impetus for effectuating these policies is generally the same:
  - To curb providers' overutilization/incorrect utilization of E/M codes appended with Modifier-25 and to prevent duplicate payments that occur when a provider is reimbursed for resources not directly consumed during the provision of a service
- As far as the AOA is aware, at least four (4) companies have policies in effect (or going into effect) impacting reimbursement levels for contracted physicians:

AOA Advocacy

AETNA

- Effective January 1, 2020 claim edit lifted E/M c/OMT
- States impacted; all 50 states and DC

Note: Must ALWAYS follow the insurers guidelines for submitting appeals for denied claims.

- Documentation must support the significant, separately identifiable E/M service and medical necessity for services provided

AOA Advocacy

AETNA

- 2018 New policy prior authorization requirement for OMT
- States impacted: DE, NJ, NY, PA, WV
- Effective August 1, 2019 reversal of policy
- Efforts continuing to help physicians recoup from denials

Note: Must ALWAYS follow the insurers guidelines for submitting appeals for denied claims.

AOA Advocacy

Anthem

- Policies differ by Anthem plan, but generally include one or more of the following:
  - "When the E/M reported with minor surgery is eligible for separate reimbursement, the maximum allowance for the reported E/M code will be reduced by 50%."
  - "When the problem oriented E/M is eligible for separate reimbursement, the maximum allowance for the reported problem oriented E/M code will be reduced by 50%."
  - "Update Regarding Evaluation and Management with Modifier-25 Same Day as Procedure when a Prior E/M for the Same or Similar Service has Occurred"
- States impacted: CA, CO, CT, GA, IN, KY, ME, MO, NV, NH, NY, OH, VA, WI
- September 2019 AOA/OPSC/Anthem meeting
- Efforts continuing on state level

Note: Must ALWAYS follow the insurers guidelines for submitting appeals for denied claims.

AOA Advocacy

Health Care Services Corporation (HCSC) independent licensee of BCBSA

- November 17, 2017 – Clinical validation for claims submitted with Modifier-25 or Modifier-59
- States impacted: IL, MT, NM, OK, TX
- July 2018 AOA/HCSC meeting
- Efforts continuing on state level

Note: Must ALWAYS follow the insurers guidelines for submitting appeals for denied claims.

AOA Advocacy

Empire BCBS *independent licensees of BCBSA*

- April 2019 Educational letters sent to physicians re: use of Modifier-25
- Effective May 1, 2019 Empire may deny the E/M service with a Modifier-25 billed on the day of a related procedure when there is a recent service or procedure for the same or similar diagnosis on record.
- State(s) impacted: NY

Note: Must ALWAYS follow the insurers guidelines for submitting appeals for denied claims.

AOA Advocacy

Note: Denials have been overturned, if the supporting documentation fully supported medical necessity of the E/M and OMT codes, highlighting the importance of proper and complete documentation.

Note: Must ALWAYS follow the insurers guidelines for submitting appeals for denied claims.

Note: Documentation must ALWAYS support the significant, separately identifiable E/M service and medical necessity for services provided

Denials & Audits

Denials & Audits

Denials

- The refusal of an insurance company or carrier to honor a request by an individual (or his or her provider) to pay for health care services obtained from a health care professional.
- Can be entire claim or line item
- 75% of providers ranked denials as greatest RCM challenge
- 65% of denials are never worked
- 2 out of 3 denials can be recovered

*Consolidated Health Services

Audits

- A mechanism of review to determine compliance:
  - Coding
  - Documentation
  - Other payment guidelines
- Payor focus:
  - Appropriate documentation
    - Medical Necessity
    - Separate & Distinct services
  - Ultimate outcome:
    - Prevent fraud and abuse within health payment system

Two Main Reasons for Denials

- Technical Errors

- Insurance policy coverage issues

Top Denials

- **Technical Errors**
  - Duplicate claim = abusive biller
  - Missing modifier
  - Insurance not active
  - Not primary carrier

- **Policy Coverage Errors**
  - Self-funded plan (employer plan)
    - Not covered service
  - Claim edits
  - Prior authorizations

- **AOA**
  - **E/M service performed on the same day as OMT**

Denial Tips

- Review claims before they go out the door
- Appeal **ALL** denials
- If needed appeal through all levels
- Use the word APPEAL in your written correspondence
- Hold payers accountable to timely filing

Who are the auditors?

- Medical Record Review (MRR)
- Comprehensive Error Rate Testing (CERT)
- Department of Justice (DOJ)
- Federal Bureau of Investigation (FBI)
- Medicare Administrative Contractors (MACs)
- Medicare Contractor Review (MR)
- Office of the Inspector General (OIG)
- Recovery Audit Contractors (RACs)
- **Zone Program Integrity Contractor (ZPIC)- “FRAUD”**

Common Audit Risk Areas

- Failure to comply with medical policies.
- Medical Necessity v. Maintenance.
- Time Based Codes.
- Using the wrong code.
- Overutilization of Evaluation and Management.
- Improper Use or overutilization of Modifiers.
- Patients complaints

Audit Tips

- **Ask for an extension!!!!!**
- Ask for one auditor to be your contact
- Keep copies of ALL audit communications from start to finish
- Date and page stamp copied or scanned documents before submission
- Review records before you send out
- Send and present documentation in a clear and orderly way
- Send only the records that were requested, **if illegible send transcript**
- Save the ‘because’ for the appeal
- Send documents certified mail that includes tracking and verification of receipt.
- Send emails using confirmation receipts and/or “read” receipts
- Retain receipt verification
- **Don’t miss any deadlines**

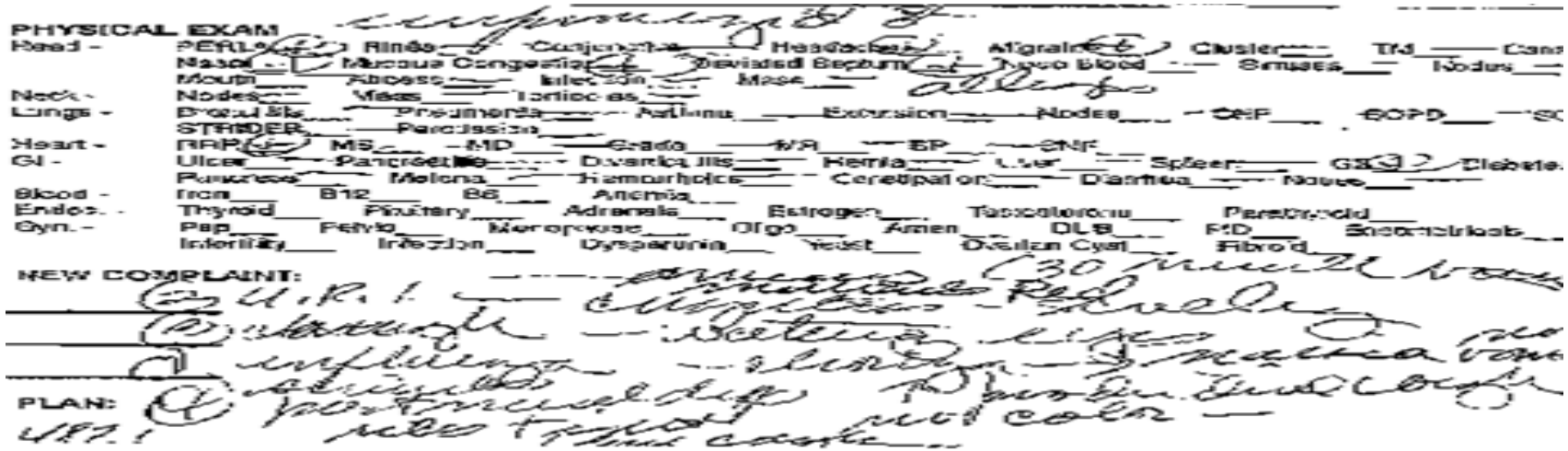
What Can You Do?

Defensive vs. Justifiable

If You Want Different Results
You Have To Do Something Different

Starts with Documentation

- **Always has**
  - If it's not documented it wasn't done!
  - Must be clear and legible
  - Must have date and signature on every page



Clinical Documentation Improvement

- Then → Now
  - Trigger your memory → What if?
  - For you → For others

- **Defensible CDI**
  - Take the guesswork out of the documentation
  - Connect the documentation dots
    - CC → OMT

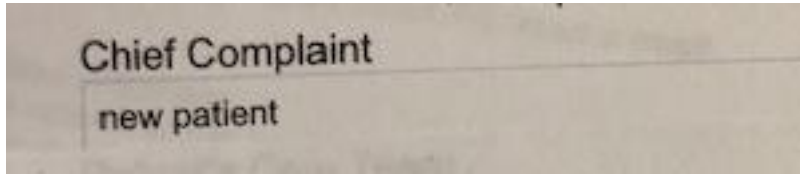
Clinical Documentation Improvement

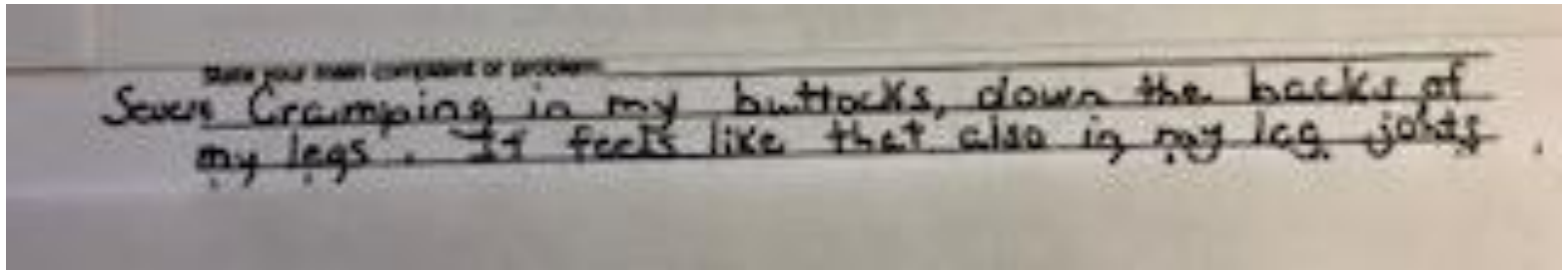
- Laterality
- Encounter type
- Anatomical details
- Severity
- Disease relationships
- Diagnosis for every procedure performed
- Diagnosis for every test ordered

USE YOUR ICD-10 BOOK!

Chief Complaint

- A concise statement describing the symptom(s), problem(s), or other factors that is the reason the patient is there
- Is typically provided **by the patient in their own words**
- Must be clearly documented
- Follow-up or F/U is not enough
- “Follow-up for hypertension” is OK
- Poor CC “ patient here for multiple medical problems”





Medical Decision Making vs. Medical Necessity

- **Medical Decision Making** involves choosing a level of service (based on the documentation) that reflects the physicians effort when deciding a course of treatment

- **Medical Necessity** involves **substantiating** that the patients condition and the required the treatment (a story narrative)

CDI Medical Decision Making (MDM) & Medical Necessity

Consists of:

- The number of diagnoses or Treatment Options to be considered
- The amount and/or Complexity of data to be reviewed
- The risk of complication and/or Morbidity/Mortality, which addresses
  - Level of Risk
  - Presenting Problem(s)
  - Diagnosis Procedure(s) Ordered, and
  - Management Options Selected

Tell the story!

How did you get from the chief complaint to your plan of care?

Indications for the Use of OMT

Document somatic dysfunction:

- Found in your **examination** and suggested in your plan (E/M visit)
- Provide the rationale for treating the areas with somatic components of the examination, especially if the patient's presenting complaint(s) do not include these regions
- Frequency and duration factors should be included in the medical record if they contribute to the physicians' approach.

Tell the story!

Do not list the regions as ICD 10 codes

Documenting Somatic Dysfunction

Somatic dysfunction is identified on the physical examination by one or more elements of

TART:

- **T**issue texture changes
- positional **A**symmetry
- **R**ange of motion alterations
- e.g. **T**enderness (changes in palpatory sensitivity)

Has it changed since the previous visit?

Procedure Documentation Example

- OMT is a procedure and should be documented in that manner
- A procedure must be substantiated in the record not just in your mind
- Patient decided to proceed with recommended OMT today
- Which regions were treated
- Which techniques were utilized
- How patient tolerated the treatment

Cloned Note

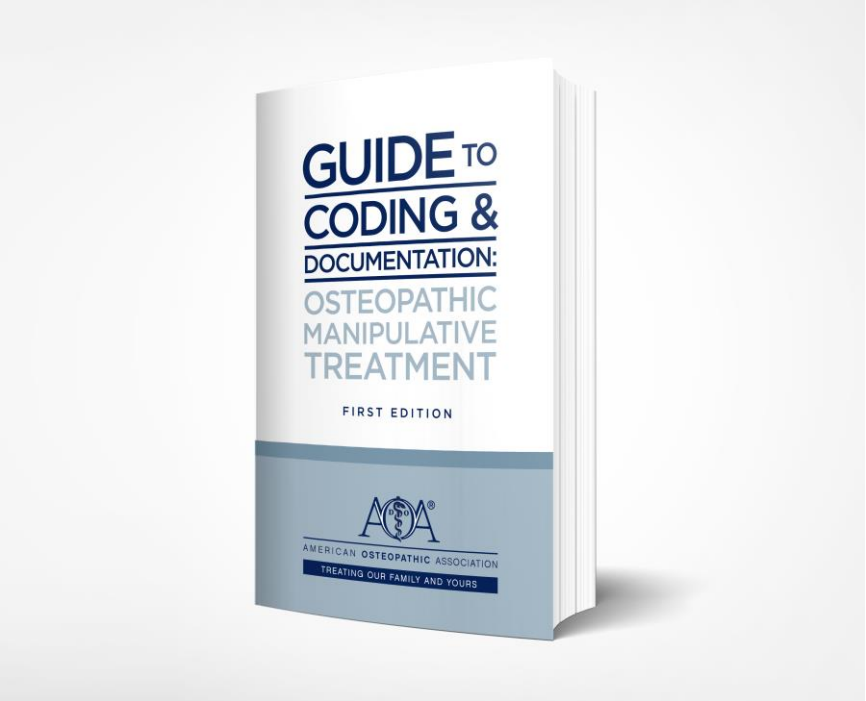
- “Cloned notes are notes that have little or no change from day-to-day and patient to patient. These types of notes do not support the medical necessity of a visit.” Medicare Bulletin
- Issues with Copy and Paste:
  - Outdated or redundant information
  - Inability to identify origin of information
  - Unnecessarily lengthy notes

On MAC’s radar

Each exam should be unique for that DOS

Resources

Guide to Coding & Documentation: OMT



https://store.osteopathic.org/

AOA Resources

Practice Management webinars www.osteopathic.org/PM-webinars

Learn more tips for managing your practice with these on-demand webinars.

- **Evaluation and Management Scoring**: Michael Warner, DO, discusses how providers can score an evaluation and management service based on documentation.

- **Documentation & Coding: What auditors look for**: Susan Carbone, MBA, provides tips for improving your practice's documentation and coding.

- **Is my E/M supported with OMT? Documentation Guidelines**: Susan Carbone, MBA, provides the documentation guidelines with examples of what is needed to bill for an E/M visit on the same day as an OMT.

AOA Resources

ADVOCACY IN ACTION

AOA works to reduce administrative burden and protect patient care

- Prior Authorization
- Modifier-25
- Prepayment Clinical Validation

Questions & Answers

Physician Services Department

312-202-8194

physicianservices@osteopathic.org

Discussion & Questions

Thank You!