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

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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?**

**AOIA**

- **Kathleen Creason, MBA**
  Executive Director
  AOIA

  **Physician Services Dept.**

- **Cynthia Penkala, CMM, CMPE, CMSCS, CPOM**
  Director, Practice Management & Education

  **Open Position**
  Manager, Physician Payer Relations

**AOA**

- **Josh Prober, JD**
  General Counsel, AOA

  **Legal Dept.**

- **Kevin Klauer, DO, EJD**
  Chief Executive Officer, AOA
  Board Member, AOIA

  **Public Policy Dept.**

- **David Pugach, JD**
  Senior Vice President, Public Policy

- **Kevin Klauer, DO, EJD**
  Chief Executive Officer, AOA
  Board Member, AOIA

  **Public Policy Dept.**

- **Raine Richards, JD**
  Director, State Government Affairs

- **Lisa Miller, MS**
  Senior Director, Regulatory Affairs & Policy Engagement

  **Legal Dept.**

- **Yolanda Doss, MJ, CHPS**
  Director, Compliance & Physician Advocacy

  **AOA**
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….
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

*Includes all sources of funds: Public and private payers, out-of-pocket consumer spending, etc.

SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group
Healthcare Spending: Where did the money go?

- Hospital care: 32%
- Physician and clinical services: 19%
- Other spending: 21%
- Prescription drugs: 8%
- Nursing facilities and retirement homes: 8%
- Government administration and net cost of insurance: 7%

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?

- 37% Private Health Insurance
- 27% Medicare
- 22% Medicaid
- 14% Out-of-Pocket

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:
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
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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.
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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.
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.
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.
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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

• 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

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

*Consolidated Health Services
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

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

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

File an Appeal
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

DEFENSIVE

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 physician's effort when deciding a course of treatment.

- **Medical Necessity** involves *substantiating* that the patient's condition and the required 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
Somatic dysfunction is identified on the physical examination by one or more elements of TART:

- Tissue texture changes
- Positional asymmetry
- Range of motion alterations
- E.g., tenderness (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!