
KMC
U
UNIVERSITY
Coding and MORE!
Presented by:
Kathy Weidner, MCS-P, CPCO, CCPC, CCCA

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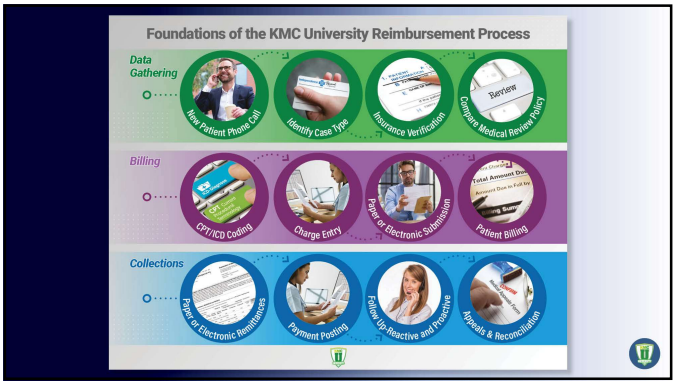
Foundations of the KMC University Reimbursement Process
Data Gathering
New Patient Phone Call
Identify Case Type
Insurance Verification
Review
Compare Medical Review Policy
Billing
CPT/ICD Coding
Charge Entry
Paper or Electronic Submission
Patient Billing
Collections
Paper or Electronic Remittances
Payment Posting
Follow-Up-Reactive and Proactive
Appeals & Reconciliation

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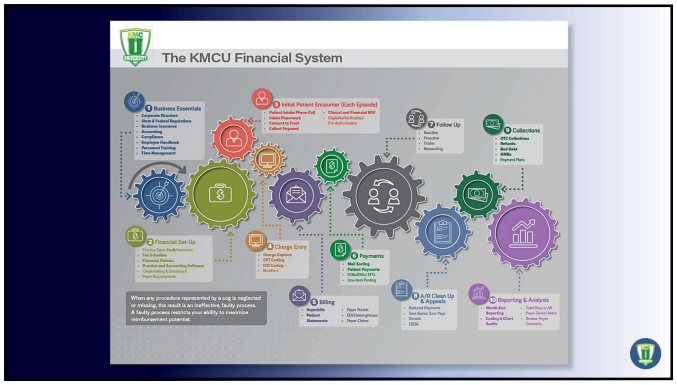
The KMCU Financial System

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Please Note!
- The views and opinions expressed in this presentation are solely those of the author, Kathy Weidner
- Kathy and/or KMC University does not set practice standards
- We offer this only to educate and inform
- Medicare information provided today is available in the public domain

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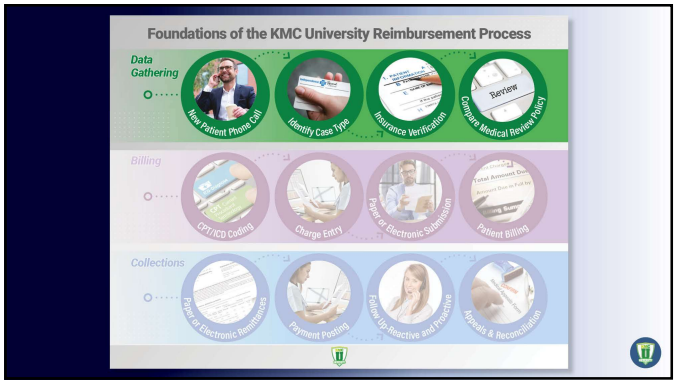
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Most Significant Compliance Risks We See
- Lack of understanding of the Big Four Steps to compliance as we see it
- Lack of differentiating medical necessity from clinical appropriateness
- Disconnecting from the rules of billing because "I'm the Provider of Service" not the biller
- The attitude that the rules don't apply to me because I run a cash practice
- And, by the way, I don't keep up with the rules because I'm too busy but I try to belong to

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What We Call
"The Big Four"
WANT
NEED
MUST
HAVE

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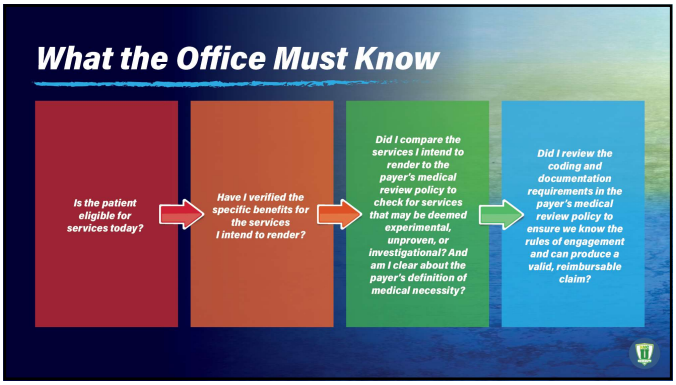
What the Office Must Know
Is the patient eligible for services today?
Have I verified the specific benefits for the services I intend to render?
Did I compare the services I intend to render to the payer's medical review policy to check for services that may be deemed experimental, unproven, or investigational? And am I clear about the payer's definition of medical necessity?
Did I review the coding and documentation requirements in the payer's medical review policy to ensure we know the rules of engagement and can produce a valid, reimbursable claim?

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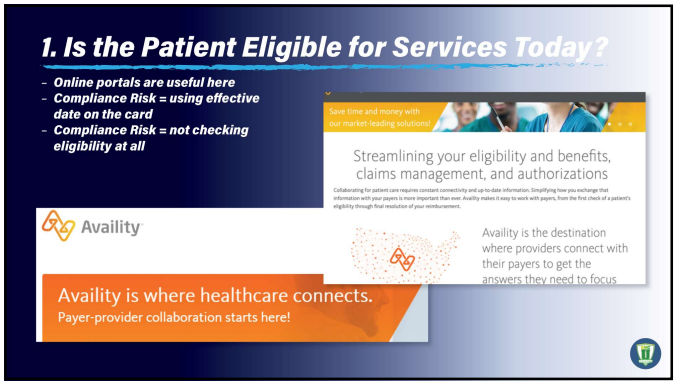
1. Is the Patient Eligible for Services Today?
- Online portals are useful here
- Compliance Risk = using effective date on the card
- Compliance Risk = not checking eligibility at all
Availity
Streamlining your eligibility and benefits, claims management, and authorizations
Availity is the destination where providers connect with their payers to get the answers they need to focus
Availity is where healthcare connects.
Payer-provider collaboration starts here!

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Eligibility: A Compliant Outcome
- The correct payer is billed
- Verification of the patient identity is completed
- Basic information needed to further the next steps is gathered
A good process
produces good results.
Nick Saban

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2. Have I verified the specific benefits for the services I intend to render?
TRUST
BUT
VERIFY

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Benefit Verification: A Compliant Outcome
- Services are clarified as covered or not covered
- Patient financial obligations are made clear
- Benefit verification leads to Medicare Review Policy comparison
A good process
produces good results.
Nick Saban

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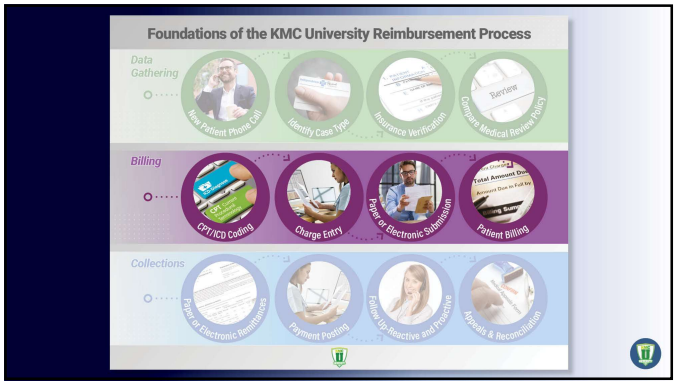

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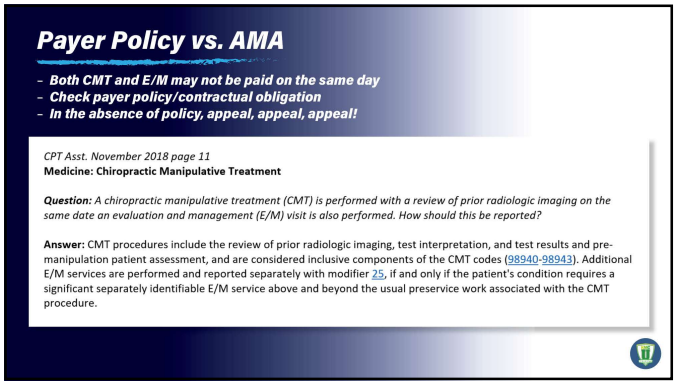

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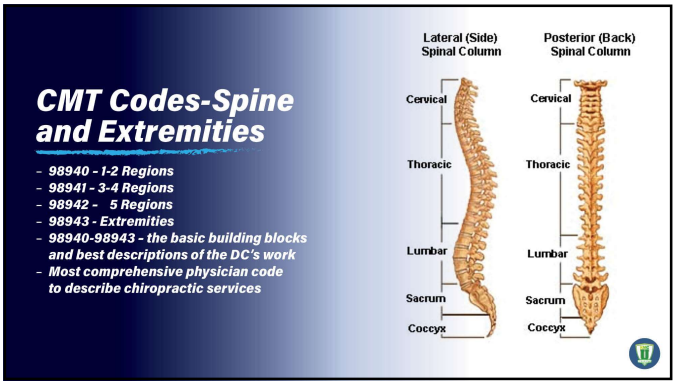

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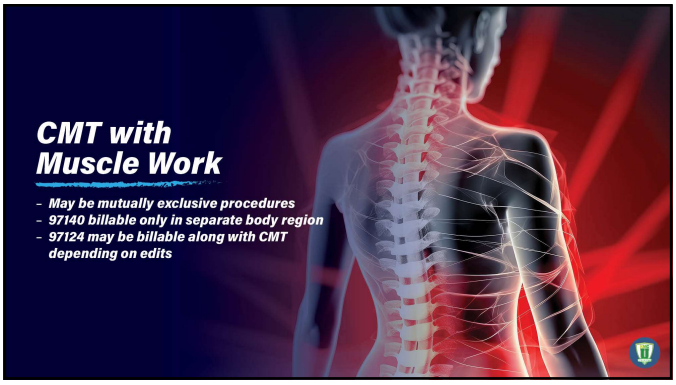

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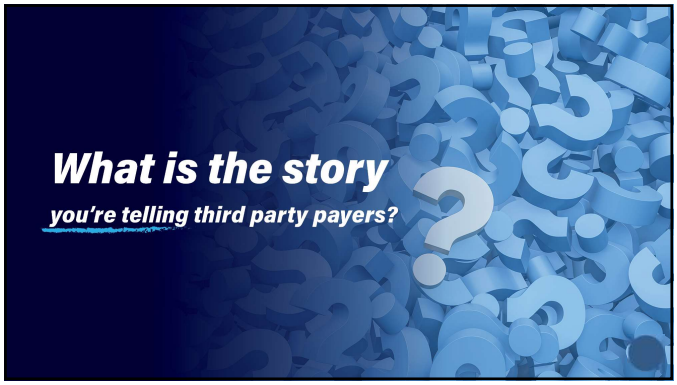

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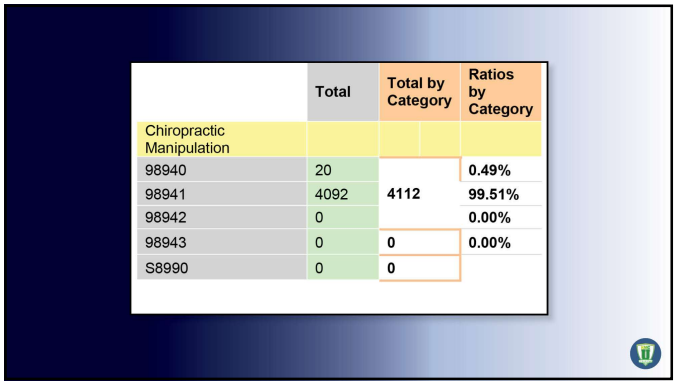

	Total	Total by Category	Ratios by Category
Chiropractic Manipulation			
98940	20		0.49%
98941	4092	4112	99.51%
98942	0		0.00%
98943	0	0	0.00%
S8990	0	0	

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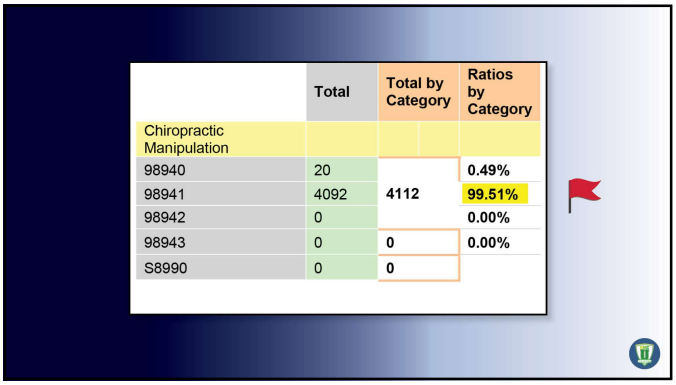

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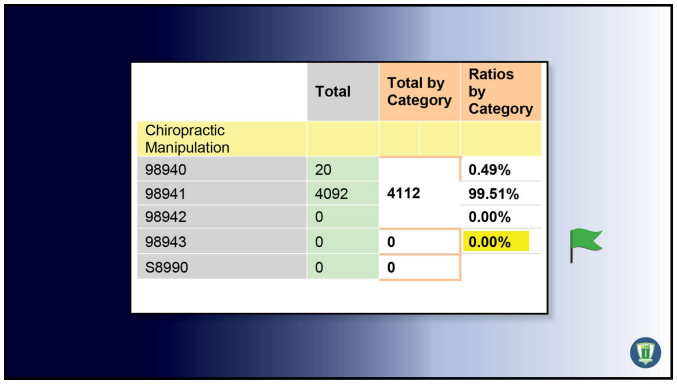

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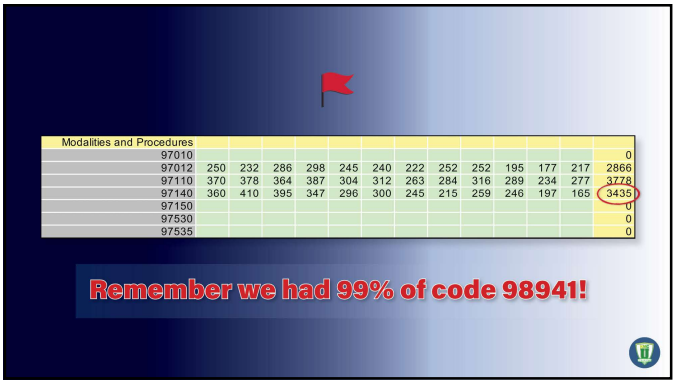

Modalities and Procedures													
97010													0
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97110	370	378	364	387	304	312	263	284	316	289	234	277	3778
97140	360	410	395	347	296	300	245	215	259	246	197	165	3435
97150													0
97530													0
97535													0

Remember we had 99% of code 98941!

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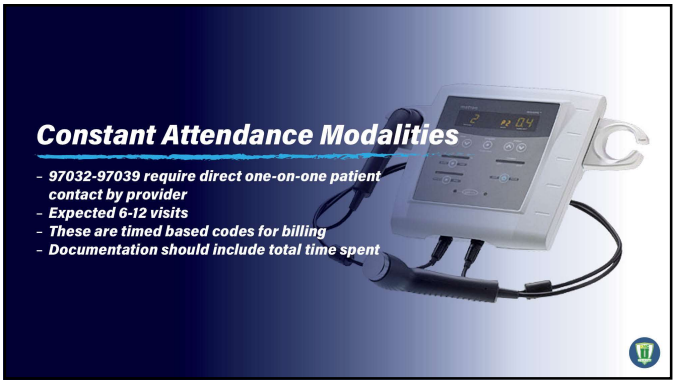

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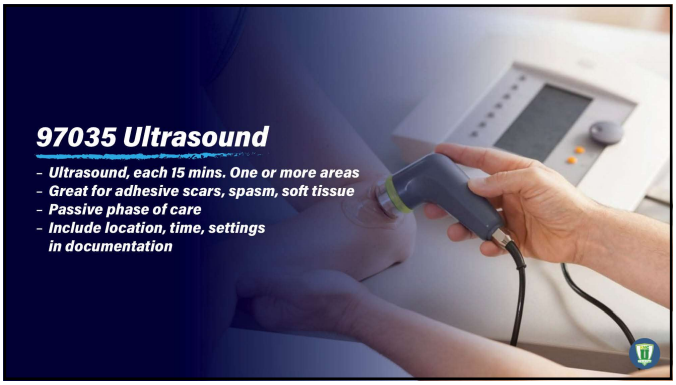

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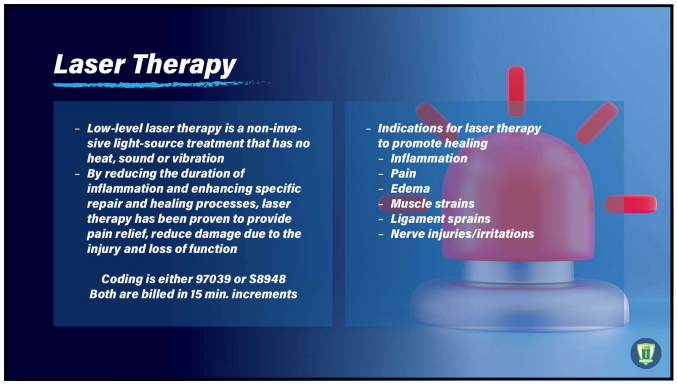

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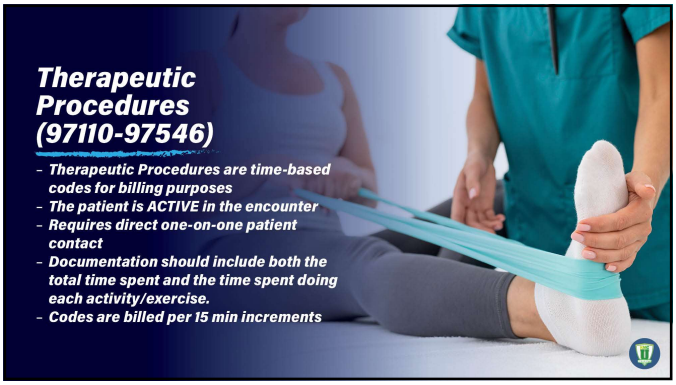

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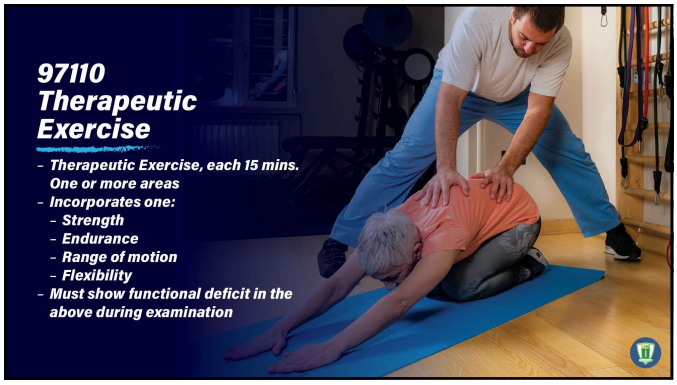

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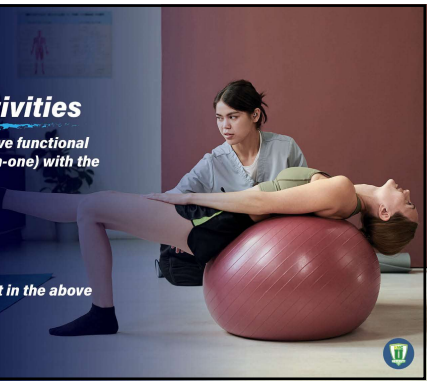
97530 Therapeutic Activities

- Dynamic activities to improve functional performance, direct (one-on-one) with the patient (15 minutes)
- Incorporates two or more:
  - Strength
  - Endurance
  - Range of motion
  - Flexibility
- Must show functional deficit in the above during examination



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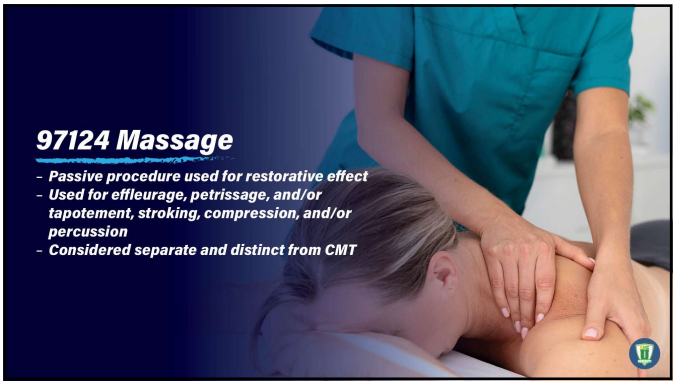
97124 Massage

- Passive procedure used for restorative effect
- Used for effleurage, petrissage, and/or tapotement, stroking, compression, and/or percussion
- Considered separate and distinct from CMT



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97140 Manual Therapy

- Includes soft tissue and joint mobilization, manual traction, trigger point therapies, passive range of motion, and myofascial release.
- With CMT - must be in a separate body region
- May require a -59 or X? modifier

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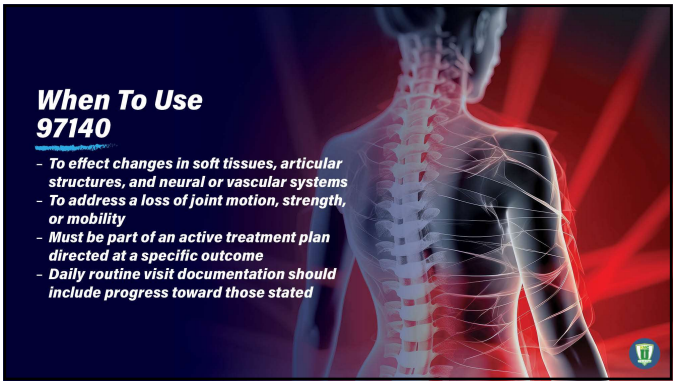
When To Use 97140

- To effect changes in soft tissues, articular structures, and neural or vascular systems
- To address a loss of joint motion, strength, or mobility
- Must be part of an active treatment plan directed at a specific outcome
- Daily routine visit documentation should include progress toward those stated



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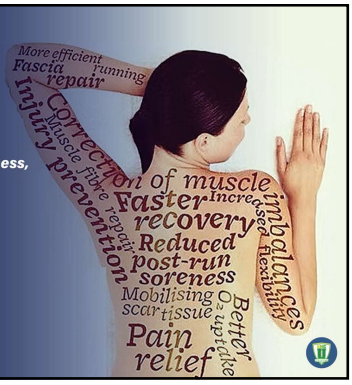
When to Use 97124

- Used to improve muscle function, stiffness, edema, muscle spasms or reduced joint motion
- When treatment is friction based, relaxation type massage that is less specific than 97140



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Muscle Therapies

- The National Correct Coding Initiative is a CMS program that prevents improper payment for procedures that should not be submitted together
- Use the -59 modifier to indicate that - YES, these services were both performed today AND - they should BOTH be paid today

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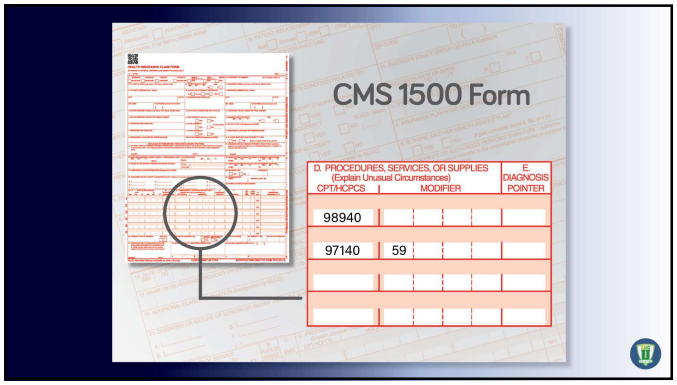

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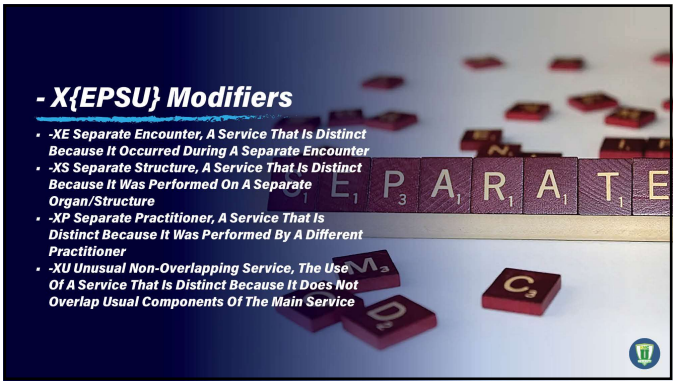

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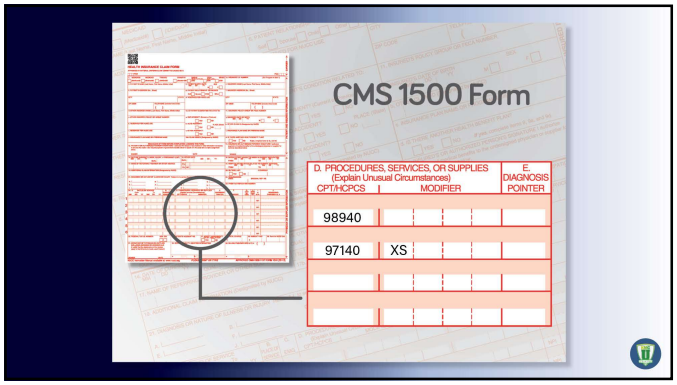

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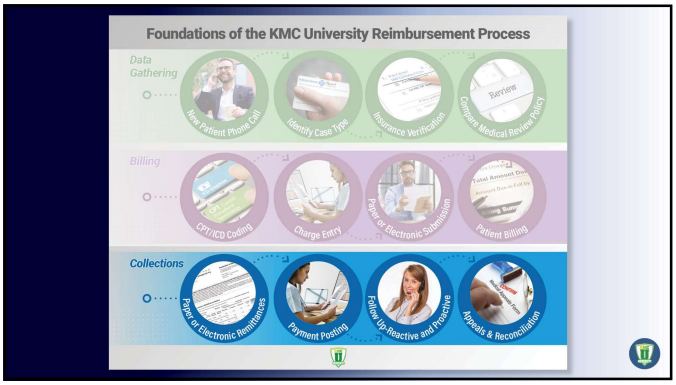

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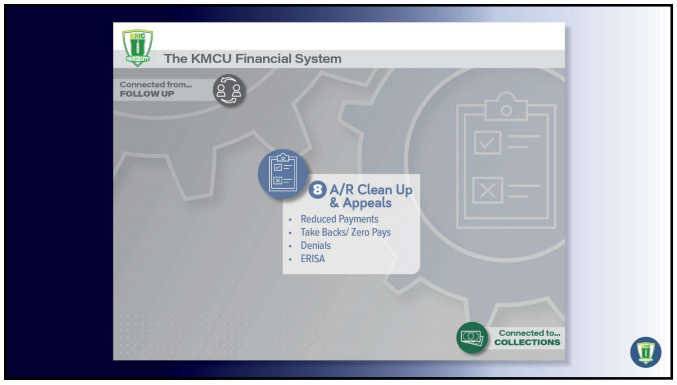

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When Might an Appeal Be Necessary?

- An entire claim is denied
- A partial claim (line item) is denied
- There is an underpayment on one or more items or services according to the policy guidelines or provider contract

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Appeals Process

- Determine Reason for Denial
- Investigate the Issue—is the Provider at fault or is the Payer at fault?
- Review the process for appeals as outlined by the payer (e.g., Medicare has its own unique appeals process)
- Gather supporting information and file the appeal
- Do not delay the process—the clock is ticking
- Medicare appeals process has five stages… some differ

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Medicare Appeals Processes Have 5 Levels

- LEVEL 1 — Medicare Administrative Contractor (MAC) Redetermination
- LEVEL 2 — Qualified Independent Contractor (QIC) Reconsideration
- LEVEL 3 — Office of Medicare Hearings and Appeals (OMHA) Decision
- LEVEL 4 — Medicare Appeals Council (Council) Review
- LEVEL 5 — U.S. District Court Judicial Review

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Payer Appeals Draft Template Letters

Appeals Letter Templates

Contents

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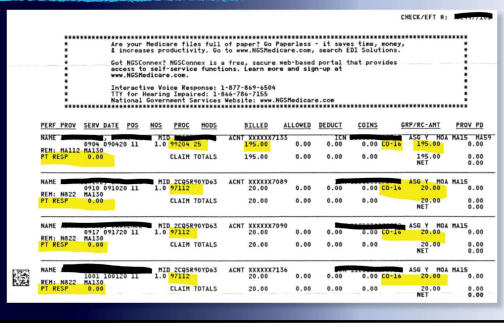
Part B-What's Missing Here?



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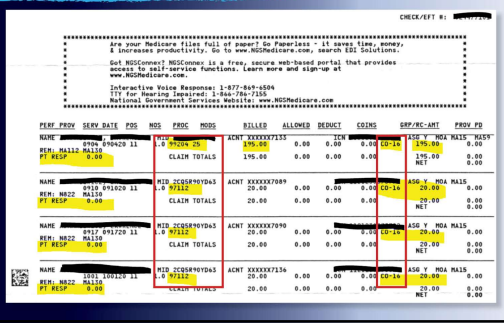

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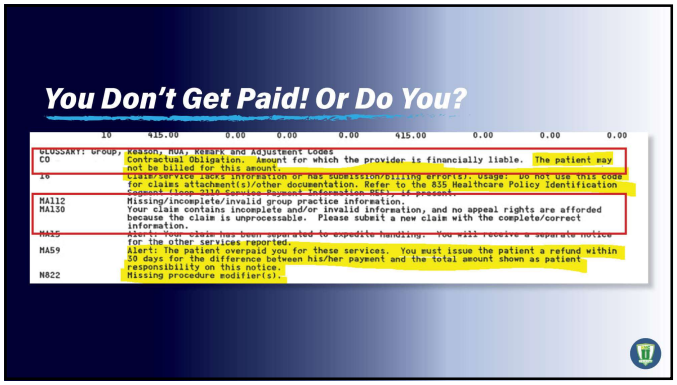

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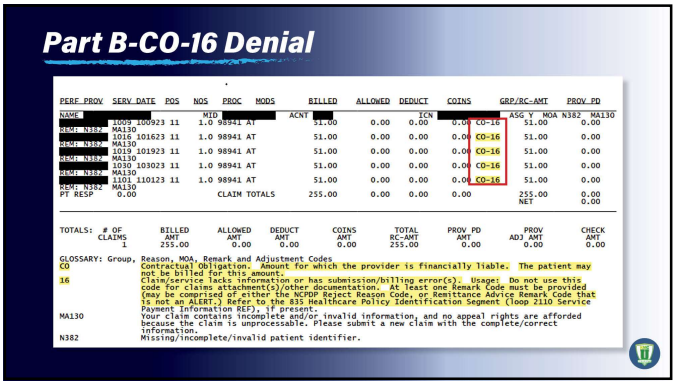

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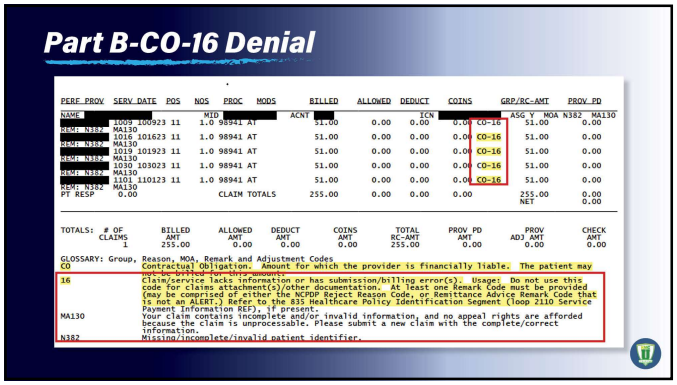

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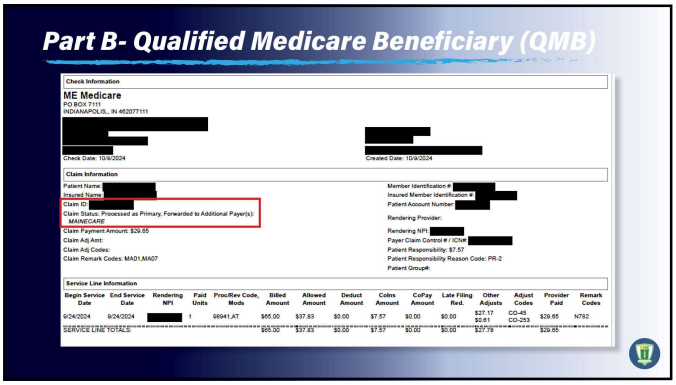

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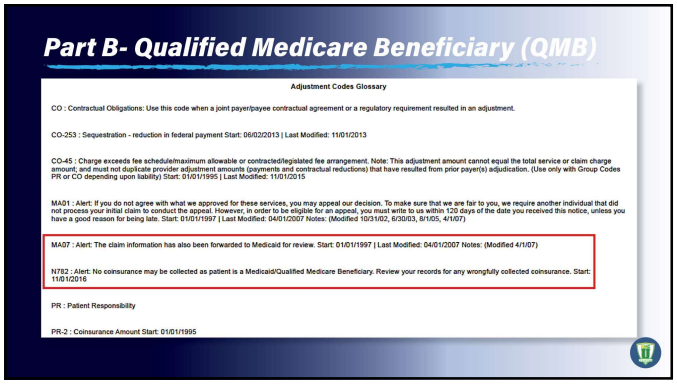

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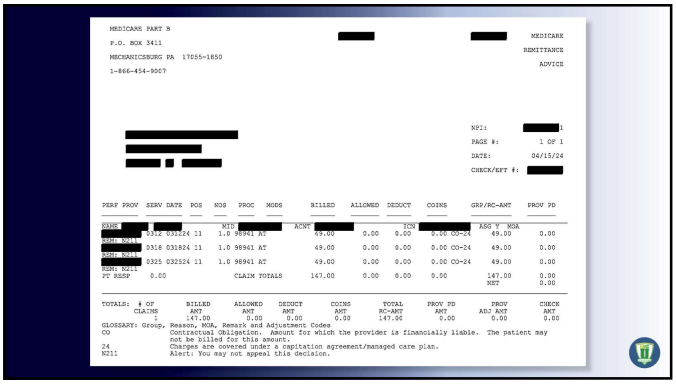

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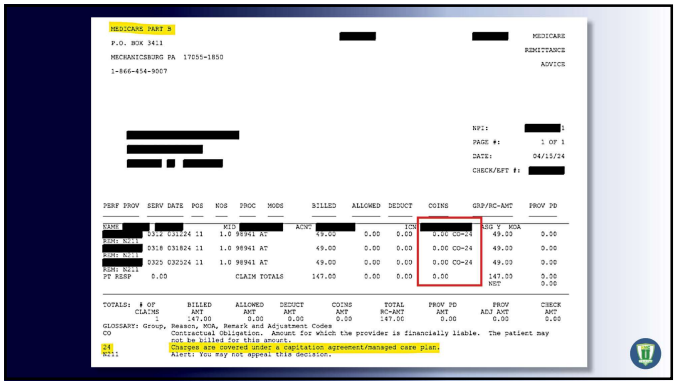

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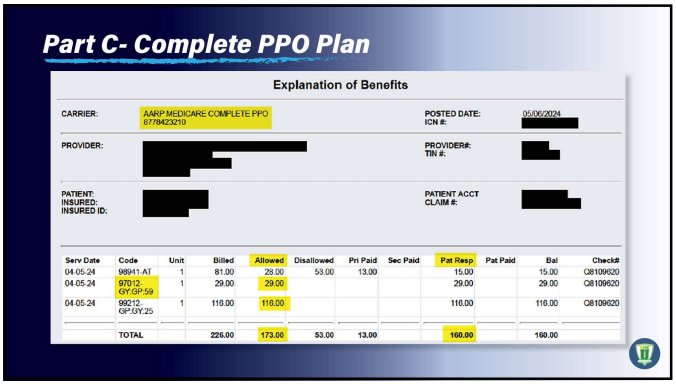

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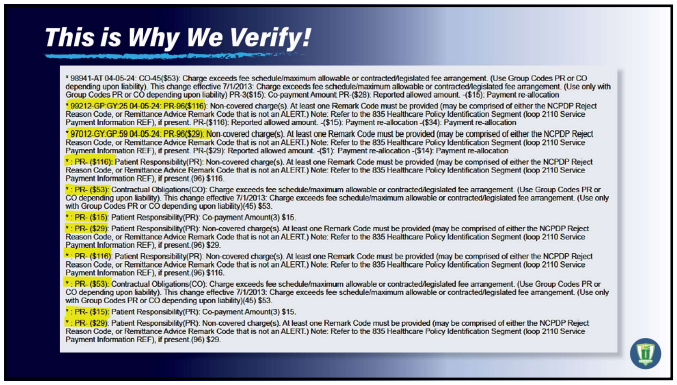

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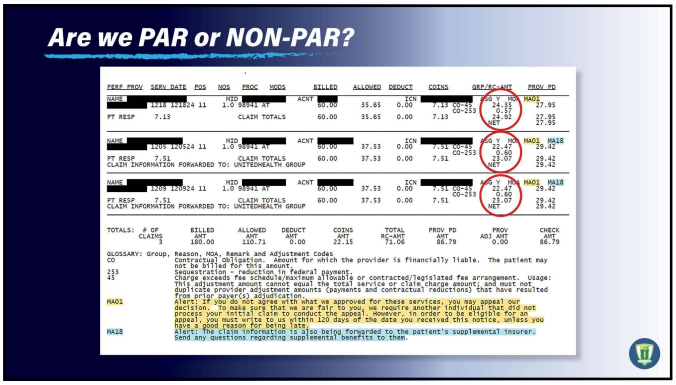

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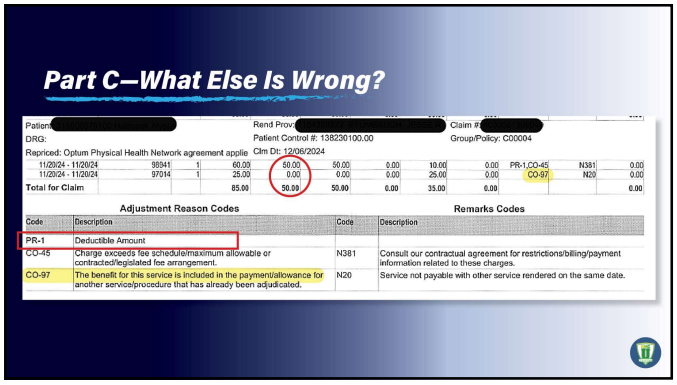

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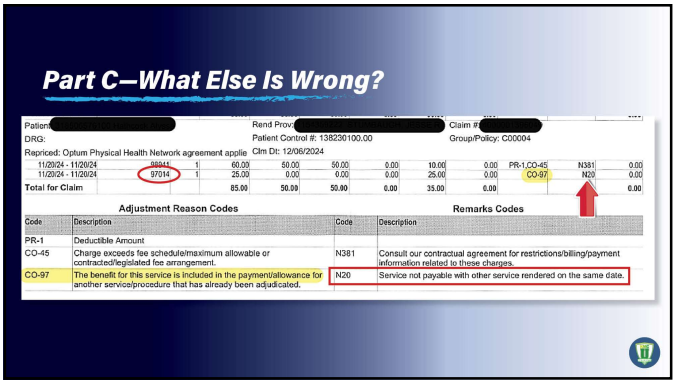

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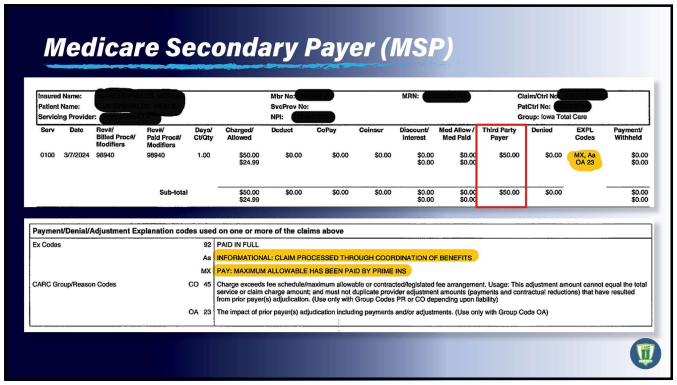

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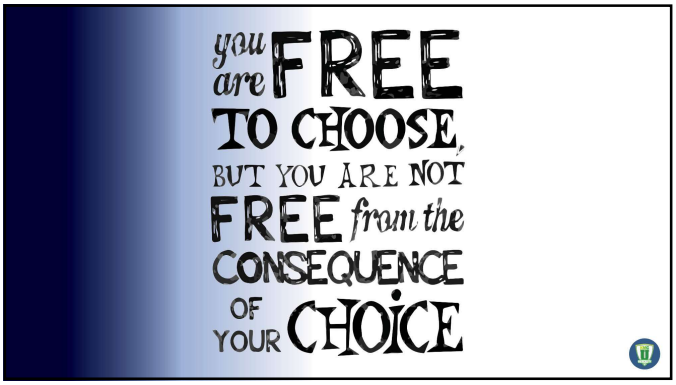

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