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The Enlighten Newsletter

July 2015

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Inside This Issue

Advize Health's Enlighten Newsletter

We are pleased to present you with the latest rendition of the Enlighten Newsletter – written by CPCs for CPCs. In this issue, we discuss Transitional Care Management, ICD-10, fraud waste and abuse facts, long-term effects from snoring, PHI, tobacco cessation counseling for medicare beneficiaries, and more.

We hope you enjoy this month's newsletter, and we invite you to stay tuned for more exciting news coming from Advize Health this year!

How to Code Transitional Care Management

Transitional Care Management (TCM) codes are used to report patients who are transitioning from inpatient hospital, observation, skilled nursing/nursing facility, or rehabilitation to the patients' normal community settings such as their home, domiciliary, rest home or assisted living settings.

The patient's transition to a normal community setting is not the only requirement of the TCM Services. The health care professional must accept care of the patient, without any gap and post discharge. Furthermore, they need to take responsibility for the patients care, and the patient's condition (medical /or psychosocial) must be of moderate or high complexity medical decision making.

TCM begins when the patient is discharged from an inpatient facility setting, and continues for the next 29 days.

The services include a face-to-face visit within the time frame required (as specified by CPT), as well as a non-face-to-face service as appropriate for the condition of the patient. The non-face-to-face services are provided either by the physician, other qualified health care professional and/or licensed clinical staff under the direction of the physician overseeing the patient.

Interactive contact must be made between the patient and caregiver within the two business days following discharge. As noted in the CPT codes, the contact may be in the following form: direct contact, telephone, or electronic. This communication must be an exchange of information and appropriate medical direction between the parties to be considered successful. If unsuccessful attempts are made, TCM codes may NOT be billed.

Non-face-to-face services provided by clinical staff, under direction of the physician or other qualified health care professional, and may include:
- Communication by direct contact with the patient, family members, guardian, or care taker, surrogate decision makers, and/or other professionals regarding aspects of the patients care
- Communication with home health agencies and other community services utilized by the patient
- Provide education to support self-management, independent living, and activities if daily living
- Assessment and support for treatment regimen adherence and medication management
- Identification of available community and health resources
- Facilitating access to care and services needed by the patient and/or family

Non-face-to-face services provided by the physician or other qualified health care provider may include:
- Obtaining and reviewing the discharge information (ex. discharge summary, as available, or continuity of care documents)
- Reviewing need for or follow-up on pending diagnostic tests and treatments
- Interaction with other qualified health care professionals who will assume or reassume care of the patient's system specific problems
- Education of patient, family, guardian, and/or care giver
- Establishment or reestablishment of referrals and arranging for needed community resources
- Assistance in scheduling any required follow-up with community providers and services

One face-to-face visit is required. During the face-to-face visit, the provider will perform a medication reconciliation, and plan for or coordinate care for services that the patient may need. They can utilize community agencies such as: Home Health nursing visits.

TCM codes are determined largely by medical decision making and the date of the first face-to-face visit. As described in the TCM codes the patient's problem must be of Moderate or High Medical Decision Making. You can find more info on MDM in the Documentation Guidelines (1995 or 1997).

You may look at the CPT requirements for performing these TCM services and find yourself overwhelmed. We suggest you break it down step by step and create an office policy and procedure. Performing these services is vitally important to improving Quality in your patient's life, improving their ability to safely stay out of the hospital in a more comfortable home environment.

You Be the Coder

The Advanced Beneficiary Notice of Non-coverage (ABN)

A 67 year old Medicare patient comes into the office for a cosmetic skin procedure. The following day the billing office staff checked and found the reason for service was not medically reasonable as per the Local Coverage Determination. The patient had not been made aware prior to having the procedure performed. No Advance Beneficiary Notice was issued or signed.

The Billing staff member explained to the Provider stating we performed a service that Medicare will not cover, and we didn't get an ABN. The Provider instructs his staff to send the claim to Medicare, and if it is denied collect the payment from the patient. Is this a proper billing and collection process?

Answer on page 5.

Enl*i*ght-10-ment:
An Overview of the Genitourinary System

The genitourinary system includes the reproductive and the urinary excretion organs. These are grouped together because of their proximity to each other.

The structure of the urinary tract includes the kidneys; two ureters, which are the tubes leading from the kidney to the bladder and the urethra, which is the tube leading from the bladder to the exterior of the body. The anatomy differs between men and women.

In the female, the urethra is between one or two inches long, and exits the body between the clitoris and the vagina. The internal reproductive organs include the vagina, uterus, ovaries, and fallopian tubes, and it is designed to carry out several functions such as reproduction.

Breasts are also included in this chapter, but only female breasts develop, this occurs during puberty; female sex hormones (estrogen) promotes breast development.

In the male, the urethra is about eight inches long and opens at the end of the penis. The urethra also provides an exit for the semen during the ejaculation. The internal genital organs include the testes, the epididymis, ductus deferens, and the ejaculatory duct. Associated glands include the prostate and seminal bulbo-urethral glands.

Components of the Urinary System

Kidney
Ureter
Bladder
Urethra

Diseases of the Genitourinary System

Combinations

Along with the detailed anatomy for this chapter there are some very detailed codes that combine disease process with symptoms. Some examples are:

N02.1 Recurrent and persistent hematuria with focal and segmental glomerular lesions
N06.7 Isolated proteinuria with diffuse crescentic glomerulonephritis
N30.01 Acute cystitis with hematuria

Laterality
Although we are dealing with anatomy that has laterality, the only codes in this chapter that specify right and left are in category N60 for breast cysts. It will be required to document which breast (right or left) or if both breasts are affected by the disease or condition.
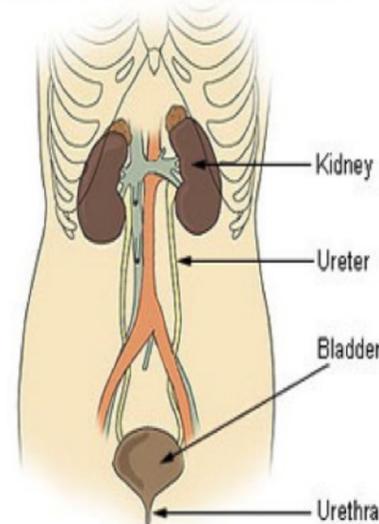
Guidelines
The small amount of guidelines for this chapter all pertain to Chronic Kidney Disease (CKD) and parallel the guidelines from ICD-9. CKD is coded using category N18, all codes in this category require a 4th character. The 4th character is representative of the stage of CKD, for example: N18.3 is CKD, stage 3 (moderate).

Tabular specific guidelines instruct to code first any associated diabetic CKD (E08.22, E09.22, E10.22, E11.22, E13.22) or hypertensive CKD (I12.-,I13.-). Also use an additional code to identify kidney transplant status, if applicable (Z94.0). N18.6 for end stage renal disease has an additional use additional code note to identify dialysis status (Z99.2).

Tabular guidelines always take precedence over the general guidelines posted in the front of the manual.

Expanded Codes

As with other chapters in ICD-10 the Genitourinary System chapter has been expanded to include a specific section involving Intraoperative and postprocedural complications. Some examples from category N99 are:

N99.110 Postprocedural urethral stricture, male meatal
N99.520 Hemorrhage of other external stoma of urinary tract

N99.821 Postprocedural hemorrhage and hematoma of a genitourinary system organ or structure following other procedure.

ICD-10 also will require that physicians identify the symptoms of Menopause.

ICD-9
627.2 Symptomatic Menopausal or female climacteric sates.

ICD-10
N95.1 Menopausal and female climacteric states

Use additional code for associated symptoms, such as:
N95.1 Insomnia
R45.4 Irritability

Use caution when looking up some of the conditions for this chapter as the Alphabetic Index does not always lead you directly to the correct combination code. Remember even though laterality abounds in ICD-10 it is not applied to many genitourinary codes. Consider yourself enlight10'd!

Compliance 101

primarily for medically unnecessary—but expensive— power wheelchairs, that she then used to support her fraudulent bills to Medicare and Medi-Cal."- The Department of Justice

Compliance Corner

True or False: The Privacy Rule requires the return or destruction of all protected health information (PHI) at the termination of a business associate agreement contract where feasible or permitted by law.

Answer on page 6.

Fraud, Waste and Abuse Fact

Owner of Medical Equipment Supply Company convicted for $3.5 Million Medicare and Medi-Cal Fraud Scheme

"The evidence at trial demonstrated the then-owner of a Medical Supply company, paid illegal kickbacks to patient recruiters in exchange for patient referrals. The evidence further showed that the accused paid kickbacks to physicians for fraudulent prescriptions,

You Be the Coder Answer

Answer: No

Rationale: If you do not issue an ABN when required by Medicare, or if the ABN is invalid, you cannot bill the beneficiary for the service.

When billing Medicare for items/ service that are non-covered, and/or not reasonable and necessary append the appropriate HCPCS modifier. Why is it necessary to append a modifier to a claim that will deny with or without the modifier? Doing so demonstrates your compliance and understanding of the CMS rules.
- **GY**: Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit.
- **GZ**: Item or service expected to be denied as not reasonable and necessary.

Tobacco Cessation Counseling For Medicare Beneficiaries

WHO IS COVERED

A beneficiary who:

1. Uses tobacco and has been diagnosed with a recognized tobacco-related disease or exhibit symptoms of such or;

2. Uses tobacco (regardless of whether they have signs or symptoms of tobacco-related disease);

3. Is competent and alert at the time that counseling is provided; and,

4. Whose counseling is furnished by a qualified physician or other Medicare-recognized practitioner. (May be provided incident-to)

FREQUENCY

- Medicare will cover two attempts per 12-month period.
- Each attempt may include four counseling sessions; total of eight.
- Beneficiaries are eligible for subsequent sessions 11-months after the first session

CODES (TIME DRIVEN)

ASYMPTOMATIC	SYMTOMATIC	TIME
G0436: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes	99406: Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	4-10 minutes
G0437: Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes	99407: Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes	11+ minutes

Diagnosis ICD-9 vs. ICD-10	
305.1 Nondependent tobacco use disorder **V15.82** History of tobacco use, presenting hazards to health	**Z72.0** Tobacco use NOS **F17.200-F17.299** Nicotine dependence • Cigarettes, chewing tobacco, other, unspecified • Uncomplicated, in remission, with withdrawal, other nicotine disorders, unspecified nicotine disorders **Z87.891** Personal history of nicotine dependence

DOCUMENTATION

Documentation should support beneficiary history relating to tobacco use and the time spent counseling. If the beneficiary is symptomatic documentation should support the condition adversely affected by tobacco use or the condition being treated with a therapeutic agent whose metabolism or dosing is affected by tobacco use.

Compliance Corner Answer

True

The Realities of Snoring and its Long-Term Effects

Snoring is often laughed about, but it is no joking matter.

Chronic loud snoring, waking up choking or gasping for air, and cessation of breathing while sleeping for short periods of time are common symptoms of a condition called **obstructive sleep apnea**. Sleep apnea affects nearly 22 million Americans, and according to the Cleveland Clinic, "At least 80% of people experiencing obstructive sleep apnea go undiagnosed." What's the risk? Should this common "ailment" be so swiftly brushed aside?

Sleep apnea occurs when tissue in the back of the throat collapses and obstructs the airway, decreasing the amount of oxygen delivered to your organs. When the blood-oxygen level drops low enough, the body suddenly wakes up. This can happen hundreds of times a night. There are serious side effects if it is left untreated, such as headaches, depression, stroke, congestive heart failure, heart attack, hypertension, and death.

Often people don't realize they are experiencing episodes of non-breathing, therefore we enlist the help of your partner. Please encourage your loud snoring loved one to see their Doctor if they experience these or similar symptoms.

What can you expect when you visit the doctor? They may schedule you for a Polysomnography (PSG), also called a sleep study. The test will be performed at an accredited facility, which may be affiliated with a hospital or may be under the direction and control of a physician (MD or DO). Facilities are accredited through the American Academy of Sleep Medicine (AASM) as a sleep disorder center, or a laboratory for sleep-related breathing disorders through the Joint Commission.

Yes, you will have to spend the night! The sleep study is performed while the patient is fully asleep. PSG provides continuous monitoring for six or more hours, observing sleep cycles, and the bodies reactions to the cycles. This monitoring identifies disruptions in the sleep pattern. The study records and measures the brain waves, blood oxygen levels, heart and breathing rates, and eye movement during the test. Normally sleep cycles in a night switch between non-REM (Non-rapid Eye Movement), and REM (Rapid Eye Movement) about every 90 minutes, therefore experiencing 4-6 sleep cycles. *Expect a follow up appointment to discuss the results of your test.*

If you are diagnosed with obstructive sleep apnea, your provider may order and arrange for you to get fitted for a continuous positive airway pressure (CPAP) machine. CPAP is a mask that is worn at night while asleep and helps to keep your airway open. Patients do say it may take some time to get used to this accessory, but it is a life saving valuable piece of equipment that should be worn as per your provider's recommendations.

Resources:
American Medical Association. Professional Edition Current Procedural Terminology (CPT). 2014.http://oig.hhs.gov/oei/reports/oei-05-12-00340.asp
http://www.mayoclinic.org/tests-procedures/poly-somnography/basics/definition/prc-20013229
http://sleepfoundation.org/sleep-disorders-problems/rem-behavior-disorder/history
http://nih.gov/news/health/apr2010/nhlbi-08.htm
www.aasmnet.org/Resources/PDF/NGSpoly.pdf

Our Business Model

Advize Health is represented by a staff of experts who perform coding and billing audits for payers, in both private and public sectors, and have a range of certifications: RN, RHIT, CPC, CPC-H, CPC-I, CCS-P, CIRCC, CPCO, CPMA, CEMC, CHC and CFE.

Project-Focused Approach
We offer straightforward healthcare review services with a focus on clear and frequent communication.

Delivery of Clear ROI
The "Standard Audit" is customized during the contracting phase to ensure services and value to the client are a perfect fit.

Responsive
Our proprietary auditing solution enables us to process claims quickly and accurately through our proven case management system.

Low Costs
There are no fixed fees. Our pricing is determined on a cost-per-claim review to deliver greater value and a lower cost.

No Startup Fees
We do not charge for new client startup or for obtaining data.

Typical Recoveries
Our new pricing model provides a return of between $4 and $8.50 for every dollar spent.

Immediate Project Launch
We will begin reviewing and assessing records within four days of receiving your data.

Certified Auditors
Our auditors are fully trained and are Certified Professional Coders (CPC) and/or Physician Based Certified Coding Specialists (CCS-P).

Experience
Our highly skilled team of experts has been performing coding and billing audits for an average of 15 years each.

Customer Service
Our solution allows clients 24/7 access to view project reports, check status, and review individual provider or claim results.

Adaptable
Other services - such as Custom Reporting, Fraud Identification, and Provider Inquiry Management - are provided at competitive rates.

Visit our website at advizehealth.com to learn more about our auditing and advisory services.

CONTACT US FOR A PILOT

Explore your options, risk-free, by requesting our proof-of-concept option. Send us a sample set of your claims and we will process them at no cost to you in order to prove our value.

To find out how Advize Health can help you save time and money, improve productivity, reduce billing errors and minimize the risk of future overpayments, please call Jeanmarie Loria at 407.583.7379.

http://advizehealth.com

Medical Record Reviews
Audits
Consulting
Training

Advize Health provides cost-effective and efficient medical record review services to identify inconsistent documentation between clinical records and claim payment data. Our expert team of experienced healthcare professionals has extensive knowledge in auditing, coding and claims recovery, enabling us to deliver valuable results and increased savings to healthcare providers.

Advize Health produces an honest and credible medical record review that fully explains how the codes are determined, down to the actual elements within the medical record. By using Advize Health's services, you can reduce expenses and improve Medical Loss Ratios, allowing you to concentrate on providing high-quality healthcare and improving your bottom line.

For more information about Advize Health, please visit advizehealth.com

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