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In this issue

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Medicare Advantage

MAOs more motivated to audit; 4 tips will help your in-person process

As CMS rolls out new standards for audits of Medicare Advantage organizations (MAO), providers who contract with those organizations may expect them to audit more aggressively — and also worry that the MAOs could be looking to stick them with the responsibility for government takebacks. Experts advise that practices cooperate as the regulations and their contracts require; but make sure you know your rights and take steps to protect them.

One of the major differences between fee-for-service Medicare and Medicare Advantage is the latter's risk-based payment adjustments based on patients' chronic conditions. In recent years some concerns with risk adjustment have motivated CMS and OIG to increase their investigations of these codes and claims (*PBN 12/7/20*, *3/20/23*, *10/23/23*).

Final rule ups audit risks

On Feb. 1, 2023, CMS issued a final Part C rule with bad news for MAOs as to how their audits would be conducted. For one thing, Jason L. Silberberg, partner in the health care litigation section at Frier Levitt in Pine Brook, N.J. notes, CMS abandoned the fee-for-service "adjuster" in its Risk Adjustment Data Validation, aka RADV, process, which critics say now makes determinations of overpayment value less accurate at the MAOs' expense.

More importantly, the rule allows RADV auditors to extrapolate claims — that is, apply the percentage of incorrect claims they find on a particular type of risk adjustment by the MAO from a sample of such claims to a much wider "universe" of them — which considerably increases MAOs' liability to government takebacks.

Audits under the new system are just getting underway, but MAOs have been pushing to reverse it; one of the biggest, Humana,

Holiday break

Part B News will take its scheduled break next week. Our next edition, the 2024 predictions issue, will be dated Jan. 1, 2024. In the meantime, stay tuned to the *Part B News blog* at *https://pbn.decisionhealth.com/Blogs/default.aspx* for news and updates. Best wishes for a happy holiday and a joyful new year from Richard, Roy and Julia.

is suing HHS over it (*see resources, below*). But another expected MAO response may have a more direct bearing on providers in their networks.

"It stands to reason that, as a result [of the rule], MAOs will seek to effectively downstream this liability to providers by increasing diagnosis code-related audits and clawbacks," Silberberg says.

MAO audits, frequently conducted in person at the practice, have been an annoyance for providers and an issue for their advocates for years (*PBN 5/8/17*). Their primary purpose has traditionally been to assure CMS that claims the MAO submits to them are billed and coded accurately.

Under the "unique situation" of Medicare Advantage, John W. Leardi of Buttaci Leardi & Werner LLC in Princeton, N.J., explains, "MAOs are reporting diagnosis codes they receive in claims from providers, and they're not receiving the underlying medical records every time a claim is submitted. So essentially they're taking the provider's word for it. And when Medicare wants to then audit those diagnosis codes, the medical records are the source material they want, and the only way to get the underlying medical records is [for MAOs] to go to the provider."

But with the new regulatory motivation, MAOs may want more from their audits than just to satisfy CMS' curiosity.

"If diagnoses are driving adverse audit findings against the MAO, you can bet your bottom dollar that they're going to turn around and scrutinize provider records," Leardi says. "And if there is a repayment obligation imposed upon the MAO, they're probably going to turn around and ask for some of that money back from their providers — particularly those whose records they reviewed and whose diagnoses were not supported by the medical records."

Cooperate — and accompany

Providers under contract to MAOs have to submit to their audits. That basic duty is spelled out in the Medicare Managed Care Manual, but it's also specified in their individual contracts, which may add terms as to scope and timing of access and the MAO's right to question your employees about the claims.

"[A small practice] likely doesn't have enough bargaining power to negotiate [audit] terms [in the conract]," Leardi says. "Some larger provider organizations, like hospital affiliated groups, have much more bargaining power. But [in either case] what they're probably limited to is negotiating, not the substance of the audit, but the process — how much notice you'll be given, how much time you'll have to respond [and] in what form can the records be provided."

Khaled J. Klele, partner in the health care and commercial litigation groups at the Riker Danzig firm in Morristown, N.J., has tried to get MAOs to alter their contract terms relating to audits. For example, he has sought to address how far back they can go, turnaround times, and "transparency on the auditing process — their statistical sampling [method] and how they did the extrapolation." But Klele generally finds MAOs resistant to changes, whatever the size of the client.

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4 must-dos when MAOs come around

- **Appeal to common sense.** Leardi suggests you engage the MAO and its auditors on a "common sense" basis: "You don't want an auditor showing up unannounced and demanding records while you're in the middle of a busy waiting room." Unless your relationship is unusually adversarial, this shouldn't be a tough ask.
- **Have a point person.** If the auditor wants to talk to someone, steer them to one practice person, Klele says, rather than encourage them to roam and chat up whomever they run into.
- **Have your lawyer in the room.** You almost certainly have to let the auditor grill your coders or anyone else in the chain of custody, but Leardi says there's nothing stopping you from having counsel on hand when they do.

"The idea is not to be an obstacle or to make things difficult," Leardi says. "But one thing that happens when someone is interviewing mid- or low-level employees in an organization is, sometimes information is inartfully provided — there are mistakes and misunderstandings, and something as simple as not following up on a poorly worded question can lead to suspicion or even an improper allegation being made against the provider."

You should also make sure the lawyer "understands medical coding and documentation," so they can follow what's going on, Leardi adds.

- **Don't say more than you know.** "Sometimes in this type of interview, MAO auditors will make it appear that it's very casual — but it's not," Klele says. Employees therefore "need to be very careful about how they answer questions."

Legally and ethically, you're obliged to cooperate, but Klele suggests that you tell your people that "if they're uncertain about something, they need to just say, 'I will get back to you.'" In addition to preventing the employee from rambling in an unhelpful manner, this puts the onus on the auditor to enter a correspondence stream with the employee — which you will be part of — so everything is on record and it's easier to stay on point. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- HHS/CMS, final rule, "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage…" Feb. 1, 2023: www.federalregister.gov/documents/2023/02/01/2023-01942/medicare-and-medicaid-programs-policy-and-technical-changes-to-the-medicare-advantage-medicare
- Humana v. HHS, Sept. 1, 2023: www.documentcloud.org/documents/23936080-humana_20230901_complaint

National Correct Coding Initiative

New NCCI edits skip 2024-effective codes, tie up loose ends for 2023

Despite what you might think at first glance, the latest National Correct Coding Initiative (NCCI) update isn't missing any codes. CMS did not include new procedure-to-procedure (PTP) edits or medically unlikely edits (MUE) for codes that will go into effect in 2024 in the Jan. 1, 2024, NCCI update. That means your practice can focus on implementing the new codes and guidelines without worrying about bundling edits.

For example, new CPT code **58580** (Transcervical ablation of uterine fibroid[s], including intraoperative ultrasound guidance and monitoring, radiofrequency) will replace HCPCS code **0404T** (Transcervical uterine fibroid[s] ablation with ultrasound guidance, radiofrequency), which will be deleted. CMS deleted edits featuring 0404T but didn't issue new edits for 58580.

The result is a compact code update that includes 929 new PTP edit pairs. Compare that to the Jan. 1, 2023, update, which included 41,336 new pairs (*PBN 1/9/23*).

CMS has not indicated when it will release edits for the new codes, but you might encounter bundling edits for the new services before the April 1, 2024, update. A frequently asked question about PTP edits warns you that your Medicare administrative contractor (MAC) might have its own edits and you should contact your MAC if you receive "a bundling message that says something is included in a service billed on the same day" but you can't find the edit in the current version of the NCCI edits.

CMS issued 929 new edit pairs, but 719 edits are for proprietary laboratory analysis codes that went into effect July 1. CMS also issued 62 edits for temporary hospital outpatient codes.

Focus on 147 edits for procedure codes

Make sure staff are familiar with the relatively small set of new edits for codes in the CPT manual.

CMS bundled 20 cardiac catheterization procedure codes (**93451-93568** and **93593-93598**) into five codes for percutaneous endovascular repair of pulmonary artery stenosis by stent placement (**33900-33904**). The endovascular repair codes went into effect Jan. 1, 2023. CMS gave the edits a modifier indicator of "1," so you can break the edit pair when appropriate.

You'll find seven codes for replacement of an externally accessible nephroureteral catheter (**50387**), genitourinary

procedures performed with imaging guidance (**50430-50435**) and a urography code (**74425**) into two percutaneous nephrolithotomy or pyelolithotomy lithotripsy codes (**50080-50081**), also with a modifier indicator of "1."

CMS also added edits that bundle 19 radiation therapy planning and managing codes (**77261-77318**, **77332-77336**, and **77427-77499**) into **77401** (Radiation treatment delivery, superficial and/or ortho voltage, per day). CMS gave the new pairs a modifier indicator of "0," which will stop you from unbundling the edit.

CMS creates MUEs for prolonged service codes

CMS released 208 new MUEs that will go into effect Jan. 1, 2024. The edits are dominated by HCPCS codes that became active in 2023. One notable addition applies to MUEs for the new prolonged service codes that CMS created for E/M visits in the hospital, nursing facility and home or residence settings (**G0316-G0318**). When CMS finalized the 15-minute add-on codes it also announced that it would not apply frequency limits to them (*PBN 11/10/22*). But that policy will come to an end when the new MUEs go into effect.

According to the practitioner MUE file, CMS will set an MUE of "4" for each code. The agency cites clinical data as the rationale for the limits. A treating provider will be able to report a maximum of four units of service, which amounts to 60 minutes of time past the threshold for the primary code.

CMS assigned each code an MUE adjudication indicator (MAI) of "3" to the edits, so you can appeal MUE-based denials. However, you should remind your coding and care teams that the chart must clearly support the medical necessity of the extra time when you alert them to this update. And you should expect the appeals process to be particularly tough.

CMS sets a high bar for all MUE appeals. The reviewer will check the records "to determine if the provider/supplier actually furnished units in excess of the MUE, if the codes were used correctly, and whether the services were medically reasonable and necessary," CMS explained in a FAQ on MUEs.

In addition, CMS gives reviewers the final say on time-based coding. "Our reviewers will use the medical record documentation to objectively determine the medical necessity of the visit and accuracy of the documentation of the time

(continued on p. 6)

CCI version 30.0 scorecard

Changes effective Jan. 1, 2024.

(*For more on CCI version 30.0 edits, see related story, p. 3.*)

Code range	CCI code pairs added	CCI code pairs deleted	CCI code pair revisions	MUEs added	MUEs deleted	MUEs revised
00000 – 09999	0	0	0	0	0	0
10000 – 19999	0	0	0	0	0	1
20000 – 29999	0	45	0	0	0	0
30000 – 39999	100	0	0	0	0	6
40000 – 49999	1	0	0	0	0	0
50000 – 59999	16	13	0	0	0	0
60000 – 69999	0	54	0	0	0	0
70000 – 79999	24	7	0	0	1	0
80000 – 89999	4	59	0	0	0	0
0001U – 0284U	719	1,079	2	37	13	1
90000 – 99999	2	102	0	0	15	1
0001T – 0999T	1	3,788	0	0	31	0
A0000 – V9999	62	8	0	163	9	2
Totals	929	5,155	2	200	69	11

Note: Code range is based on the comprehensive code of the edit.

Source: Part B News *analysis of CCI version 30.0 changes, www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-procedure-procedure-ptp-edits*

Benchmark of the week

5-minute interprofessional consult code maintains strong growth

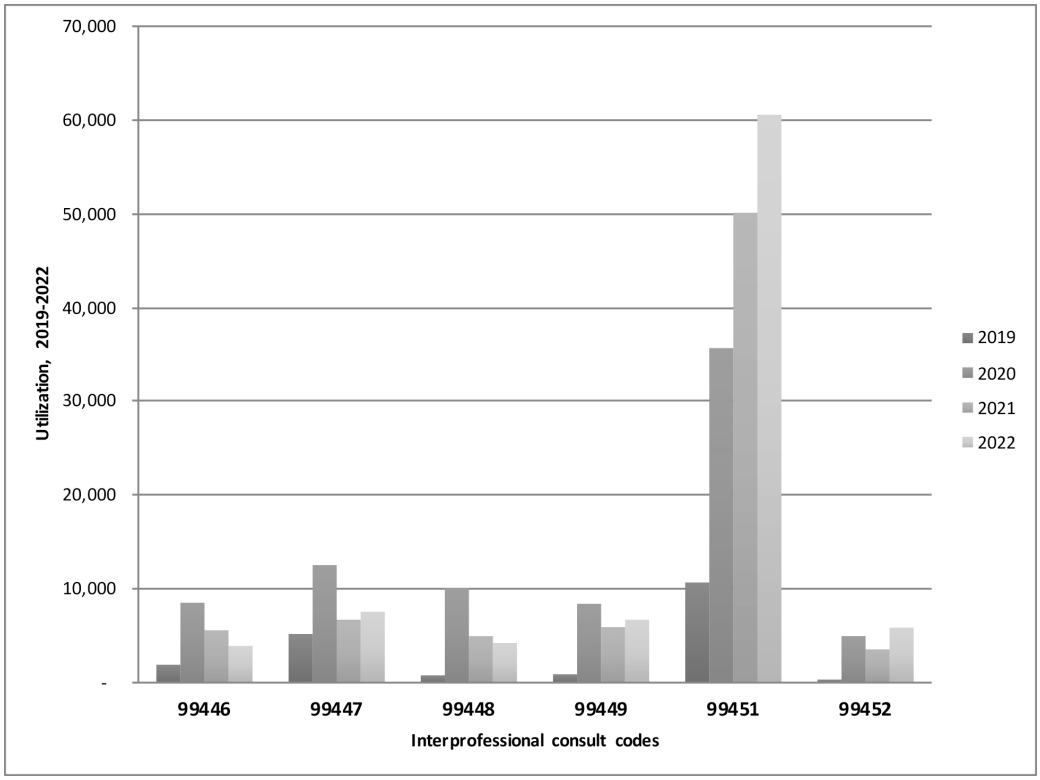
Most of the interprofessional consultation services that saw a spike in claims during the initial COVID wave returned to lower utilization, except for a glaring outlier: the most-reported interprofessional consult code **99451** continues its surging growth trajectory.

The series of six interprofessional consult codes that CMS pushed to active status in 2019 saw an almost immediate growth in claims over the course of two years (*PBN 5/16/22*). But as the chart below details, the 2021 and 2022 numbers fell sharply for most of them, according to the latest available Medicare claims data.

However, the downward spiral doesn't include big-gainer 99451 (Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time). The claims numbers more than tripled between 2019 and 2020, and then they nearly doubled from 2020 to 2022, landing at 60,613 claims and bringing in more than $1.6 million in payments in the latter year.

Much of the work on the telephone, internet or EHR consultation was performed by the psychiatric specialty, which billed for nearly 15,000 of the 99451 claims in 2022, and nurse practitioners (7,000 claims), internal medicine (5,000 claims) and cardiology (4,300 claims) also turned to the service a good amount. — *Richard Scott* (*richard.scott@decisionhealth.com*)

4-year utilization trends, interprofessional consult codes, 2019-2022



Source: Part B News *analysis of 2019-2022 Medicare claims data.*

(continued from p. 4)

spent (whether documented via a start/stop time or documentation of total time) if time is relied upon to support the E/M visit," CMS wrote in IOM 100-04, chapter 12, §30.6.7(G).

CMS has not shared any details on the factors that go into the objective determination, but it is a safe bet that an appeal will fail if the provider only documents the time and gives minimal details on the work they performed.

CMS also issued edits for monthly chronic pain care management code **G3002** and add-on code **G3003**. A new MUE of "1" plus an MAI of "2" makes sure you only report the primary 30-minute code once per day. CMS applied an MUE of "4" and an MAI of "3" to the 15-minute add-on code, which creates a limit of 60 minutes that can be appealed.

Watch for more guidance on the COVID-19 vaccine code, **90480** (Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [coronavirus disease {COVID-19}] vaccine, single dose), that debuted on Sept. 11, 2023. The code replaced six codes (**0121A-0172A**), which were deleted this year. However, the MUE file lists the deleted codes with an MUE of "1" and an MAI of "2", which means you cannot bill additional units of service. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

RESOURCES

- Medicare NCCI procedure-to-procedure edits: www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-medically-unlikely-edits
- Medicare NCCI medically unlikely edits: www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-medically-unlikely-edits
- Medicare NCCI frequently asked questions: www.cms.gov/ncci-medicare/medicare-ncci-faq-library#mue
- IOM 100-04, chapter 12, §30.6.7(G): www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf

National Correct Coding Initiative

Medicare adds guidance for appeals, revises language in 2024 NCCI manual

Remember to study the 2024 Medicare National Correct Coding Initiative (NCCI) Policy Manual while you prepare to code in the new year. The new manual, along with the new procedure-to-procedure (PTP) and medically unlikely edits (MUE), were published Dec. 1, and will go into effect Jan. 1, 2024 (*see story, p. 3*).

CMS concentrated on editorial revisions to this version of the manual. For example, throughout the manual's chapters, references to the CPT manual were replaced with the term "CPT Professional." In section Q on gender-specific procedures in Chapter I, General Coding Principles, CMS replaced the words "male" and "female" with "assigned male at birth" and "assigned female at birth."

Chapter I also contains a new warning about MUEs: "An MUE, or the lack of an MUE, does not necessarily indicate coverage status of a HCPCS/CPT code. The NCCI program does not establish medical necessity or payment policy."

For example, CMS has assigned an MUE of "6" to CPT code **99417** (Prolonged outpatient evaluation and management service[s] time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time [List separately in addition to the code of the outpatient Evaluation and Management service]). CMS does not cover the code, but private payers that have adopted the NCCI edits and cover the CPT code could use the MUE.

Introduction adds guidance on appeals, payer disputes

Don't skip the manual's introduction this year. CMS expanded the guidance on when and how to contact the NCCI contractor. New language makes it clear that practices should not contact NCCI with questions that are outside of its scope. "For example, we cannot answer questions about Local Coverage Determinations, changes to code descriptors or status indicators, or modifiers not associated with NCCI," CMS explains.

A new section on submitting appeals reminds practices that the NCCI contractor does not process appeals. You should send appeals of bundling denials to the organization that denied your claim, such as the Medicare administrative contractor (MAC) or the qualified independent contractor (QIC). The manual warns providers that it won't forward misdirected denials so sending it to the NCCI contractor could result in a missed deadline.

Finally, a new section on private payers explains that even though private payers and other federal agencies might adopt NCCI policy, neither CMS nor the NCCI contractor can help if you have a dispute with an outside organization. "If the issue you are having applies to other government, third-party, or private insurers who voluntarily choose to implement

NCCI edits, we do not have control over how those edits are applied outside of Medicare," the manual explains. — *Julia Kyles, CPC* (julia.kyles@decisionhealth.com) ■

RESOURCE

- Medicare NCCI Policy Manual: www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-policy-manual

Compliance

Be proactive about discrimination support – or risk liability

If an employee has a discrimination issue, whether it's reported or unreported, don't try to "wing it." Instead, have a process in place that makes sure both the employee and the practice are protected — and invite employees to use it.

A 2022 retaliation case against an Idaho surgery practice came to a belated conclusion in October, when a judge reduced the amount that Brianna Colo, a former surgery scheduler at Neuroscience Associates of Boise, had been awarded by a jury in a decision stemming from a discrimination case she had brought against the practice. The judge found the award had been "too speculative" as to the lost future earnings to which Colo was entitled.

But the court declined to reverse the verdict itself, as the practice had sought. Without speaking to the discrimination claim, a jury had found that Neuroscience Associates "unlawfully retaliated" against Colo under Title VII of the Civil Rights Act of 1964 and the Idaho Human Rights Act.

Colo had claimed discrimination on her job based on her gender and heritage by one of the physicians at Neuroscience Associates. The practice fired Colo after a meeting with her involving a social media post she had made, which some employees "had found inappropriate," according to her complaint. She was given to understand the matter had been settled, but the following week she was fired.

The jury appears to have accepted Colo's argument that her discussion with colleagues of her plans to report her harasser had gotten back to management and were the real reason for her dismissal, leading to the retaliation verdict.

Let them know it's there

Experts always advise a tight protocol for handling discrimination claims by employees (*PBN 6/13/22*). But sometimes practices neglect to make these protocols well-known and accessible to employees, leading to dangerous situations that can result in mishandling and legal trouble.

"When providers aren't keeping fully abreast of what's going on in their practices, they're missing opportunities to document and address legitimate issues — and they wait until they've got some 'uh oh' moment where they feel like they have to do something," says Paul D. Werner, Esq., of Buttaci Leardi & Werne in Princeton, N.J.

In such cases, even if the practice has a good reason to fire the disgruntled employee, "everything is going to get second-guessed," Werner says.

"We do a lot of on-site compliance training with health care providers — a lot of that is basic billing and that kind of stuff," Werner says. "But a big portion is how to deal with your employees — how to make sure they know there's not just an appearance of listening to them, and that you have basic straightforward documentation in place where you can say, 'If this, then that' — if a complaint comes to the supervisor, they must document it, run it up this chain [and] get back to the employee."

Offer anonymity

In addition to publicizing the availability of the complaint process, Werner advises letting employees know up front the process doesn't have to involve any supervisors — including, possibly, the object of their complaint.

"We've worked with a lot of providers to set up a compliance hotline," Werner says. "Employees can call anonymously if they like. The complaint is routed someplace other than the normal chain of command to ensure some degree of protection. Some folks route those voicemails directly to their attorneys."

The call could also go to a third-party company, like outboard human relations vendors. Joe Compagna, president of one such company, My Virtual HR Director in Plainfield, N.J., has clients specifically tell their employees that "supervisors are not trained to take complaints" so that they have to go to the vendor instead. The advantage of having professionals or counsel handle the call is that it reduces the chances of inappropriate handling of the case at a sensitive stage.

"Health care workers are well educated and reasonably good business people," Werner says. "They understand the ins and outs of what they're supposed to be doing. In my experience, if you give them clear guidance on what to do, they'll follow it because the stakes are high." (More on complaint handling at the *Part B News* blog, https://pbn.decisionhealth.com/Blogs/Detail.aspx?id=201071.) — *Roy Edroso* (roy.edroso@decisionhealth.com) ■

Ask Part B News

3 Q&As: Manage coding errors, burnish documentation, code from reports

The following series of questions and answers deliver key coding and documentation guidance on various scenarios you may encounter in your day-to-day operations. All Q&As took place during the *Advanced Specialty Coding Summit — Anesthesia*, a DecisionHealth virtual event that took place in November.

Handle errors beyond the claim correction window

Question: *What is the protocol if we discover a coding error but are now outside the window to file a corrected claim? Are we required to voluntarily refund the payment despite not being able to file a corrected claim?*

Answer: It will depend on the size of the mistake, replied Kelly Dennis, MBA, ACS-AN, CANPC, CHCA, CPMA, CPC, CPC-I, president, Perfect Office Solutions, Inc., Leesburg, Fla., during the Advanced Specialty Coding Summit — Anesthesia.

"If you are outside of that window then I think it's going to be an educational thing, unless you found that it was a huge error. If this amounts to what you consider to be a large repayment, that's where you want to involve an anesthesia-knowledgeable attorney, self-report and minimize your penalties and risk and all of that. But if you made a mistake on a couple of claims, and you're outside of that, just use it as an education [opportunity] to say we need to fix this," Dennis concluded.

Improve documentation of patient's physical status

Question: *Our providers are good at documenting relevant problems to the case but not calling out conditions specific to the physical status. Do you have any tips for getting them to improve that aspect of their documentation?*

Answer: Talk to the providers, advised Pamela Linton, CPC, CANPC, corporate coding manager, Zotec Partners, Carmel, Ind., during the event. "Just to go back to them and say the best practice for documentation is to give us that information to support what you've done. You're asking a payer in most cases to give you an extra unit, or two or three … you really need to support what you're billing."

Tips to code from the surgeon's report

Question: *Is it OK to use the surgeon's operative report when coding for the anesthesiology service or are we limited to what is documented in the anesthesia record? The anesthesiology record is handwritten and lacking in detail, which leads to vague unspecified code selections for things like diagnosis or lesion/hernia size, etc. Is there a definitive coding source that addresses whether this would be permissible or not?*

Answer: "I bet we all agree that you can use what's in the op report," began Kelly Dennis, MBA, ACS-AN, CANPC, CHCA, CPMA, CPC, CPC-I, president, Perfect Office Solutions Inc., Leesburg, Fla., during the event.

Doris Branker, CHC, CPC, CIRCC, CPMA, CPC-I, CANPC, CEMC, principal consultant, DB Healthcare Consulting & Education, Sunrise, Fla., agreed. "I think a point on that if you look at a lot of your anesthesia records they have the surgeon's name on them [which] connects the two records. I can't find a rule that says you can or can't because it says unspecified based on the documentation in the medical record, not necessarily the record that you're looking at."

Branker cautioned against using the surgeon's note when there is no obvious connection between the two charts. "But if the surgeon's operative report says it's an incarcerated hernia, but we just say hernia on our record, and that surgeon's name is there, I don't have a problem pulling it over and supporting my rationale for doing that."

Dennis reminded attendees to include that information if an auditor reviews their charts. "If you're being audited, please put that in your notes if you don't have the op report pulled over. Otherwise, we have no clue where you just got that from," she said.

You should also keep the limits of your software systems in mind, said Pamela Linton, CPC, CANPC, corporate coding manager, Zotec Partners, Carmel, Ind. "Sometimes with EMRs, the fields are limited. They just might not have enough space to give you all the detailed information. And so you would want to go to that op note," Linton said.

This is also an example of where coding and reimbursement processes intersect, Branker said. "I have it as part of my coding process … that our sources of data for diagnosis and procedure are the operative report and the associated H&P. So if … that comes into question, submit the anesthesia record and the referenced documentation that we used. Because the payer can't count what they don't see."

— *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■