Billing, Coding, & Calculating Fees: Finding Success

Janet McCarty
Director of Private Health Plan Reimbursement
American Speech-Language-Hearing Association
Direct Line: 301-296-5674
jmccarty@asha.org

Agenda

- **BILLING:** Learn how to bill for your services
- **CODING:** Learn the codes that describe the services you provide. Use these codes to communicate with health plans
- **CALCULATING FEES:** Learn how to determine fees for your services

BILLING: Superbills

- Use a Superbill (Billing, Coding, Charges)
- List ICD-10 and CPT codes used most often in your practice
- Provide patient information
- Assign a diagnosis (ICD-10 code)
- Assign a treatment (CPT code)
- Provide provider information
- Total Charges: _____

ICD-10 & CPT Codes

- **ICD-10** (International Classification of Diseases) codes describe the diagnosis: **R48.8** (Other symbolic dysfunction)

- **CPT** (Current Procedural Terminology) codes describe procedures performed: **92521** (Evaluation of speech fluency)

Filing A Claim & Using a Superbill

- Clinician decides whether patient or provider files claims
- If the patient files, you will need to provide a bill with CPT & ICD-10 codes, charges, and supporting documentation
- If you have a signed agreement with the health plan, you may need to file the claim
- ASHA provides a model SLP superbill on the ASHA website

Review Patient's Policy

- Are audiology or speech-language services covered?
- Claim decisions are based on contract wording. Is coverage clear or vague?

Filing A Claim

Be sure to obtain patient permission to supply the health plan with relevant documentation

Contact the Health Plan or Provider Relations

- What is your provider status?
- Is your setting recognized (private practice, university clinic)?
- Do you need a provider #?
- What documentation is necessary?
- Pre-authorization needed?

National Provider Identifiers (NPIs)

- The NPI is the health care provider identification system adopted by the U.S. Department of Health and Human Services as part of the implementation of HIPAA. All health care providers that are considered covered entities under HIPAA, and those who file claims electronically or use a clearinghouse to bill insurance, are required to apply for an NPI. All other health care providers are eligible to receive an NPI if they desire.
- Audiologists and speech-language pathologists can apply online for their NPI, free of charge, at: https://nppes.cms.hhs.gov/NPPES/Welcome.do
- ASHA's information on NPI: http://www.asha.org/practice/reimbursement/hipaa/NPI.htm

Billing Policies

Q. Can I waive co-payments?

A. Usually not. Payers view the routine waiver of patient payments as a breach of contract. Medicare/Medicaid co-pay waivers are not allowed and are viewed as false claims.

Q. Can I offer a sliding scale?

A. Yes. Be sure to have a defined policy and procedure for consistent administration. Have a written policy that establishes guidelines for determining a patient's indigency. Contact local welfare clinics to learn the community standard. Medicare/Medicaid allows for limited documented indigency.

Examples of Health Care Provider Fraud

- Billing for services not performed
- Falsifying a patient's diagnosis to justify tests
- Upcoding, or billing for a more costly service than the one performed
- Unbundling, or billing for each stage of a procedure as if it were separate

Coding

Support your coding decisions with patient history, physician referral information, evaluation results, and other documentation that supports your professional judgment as to the cause of the patient's condition and required treatment.

ICD-10 Coding

- Determine a diagnosis based on test results and assign a diagnostic code
- Assign the best, or most appropriate diagnostic code
- Be able to support the assigned code

Code the Highest Degree of Specificity

Code to the highest degree of specificity.

That means use the code with the most characters in that family of codes.

- Don’t code R41.84
- Do code R41.841

Primary or Secondary Diagnosis?

- **Primary Diagnosis**: Condition chiefly responsible for the visit (reason you are seeing the patient)

(Also known as “treatment diagnosis.”)

- **Secondary Diagnosis**: Co-existing conditions, symptoms, or etiology

Your diagnosis is the primary diagnosis. The medical diagnosis, if available, is the secondary diagnosis. Example: assign a primary diagnosis of R47.89 for speech deficits for a child with cleft palate, and the secondary diagnosis of Q37.4 for cleft palate.

Unspecified vs. Other: What's the Difference?

- Always use "other." Avoid "unspecified."
- Codes designated as **"unspecified" indicate that there is insufficient information** in the medical record to assign a more specific code.
- Codes designated as **"other" indicate that sufficient documentation exists** to assign a diagnosis, but no code exists for the specific condition.

Coding Normal Results

- Many payers will not reimburse for evaluation results reported “within normal limits.”
- When coding an uncertain diagnosis (“suspected,” “to be ruled out”), code the condition as if it existed.
- When testing produces a normal result, report the sign & symptom or chief complaint as the primary diagnosis.

Excludes1 and Excludes2 Rules

- **Excludes1** indicates that the codes excluded should never be used at the same time as the code above the “Excludes1” notation. An “Excludes1” notation is used when two conditions cannot occur together, such as the congenital form of a condition versus an acquired form of the same condition.

For example, code H93.25 for central auditory processing disorder (CAPD) has an “Excludes1” note that prevents clinicians from coding it with F80.2 for mixed receptive-expressive language disorder.

- **Excludes2** indicates codes that may be listed together because the conditions may occur together, even if they are unrelated. When an “Excludes2” notation appears under a code, it is acceptable to use both the code and the excluded code together.

Code First Rules

- "Code first" or "Use additional codes"
  - R13.11 Dysphagia, oral phase
  - Code first, if applicable, dysphagia following cerebrovascular disease, I69.XXX

“Use additional code(s)”

Q90 Down syndrome

Use additional code(s) to identify any associated physical conditions and degree of intellectual disabilities (F70-F79)

- Q90.0 Trisomy 21, nonmosaicism (meiotic nondisjunction)
- Q90.1 Trisomy 21, mosaicism (mitotic nondisjunction)
- Q90.2 Trisomy 21, translocation
- Q90.9 Down syndrome, unspecified
- Trisomy 21 NOS

Developmental or Organic?

Q. Are there different diagnosis codes for speech-language deficits that are developmental in nature versus deficits that are due to physiological conditions?

A. Yes. Organic-based speech, language, or swallowing problems, like those related to cleft palate and cerebral palsy, are coded typically in the **R00–R99** (ICD-9-CM 784) series of codes.

For example, the code for oral phase dysphagia is R13.11. The code for dysarthria of speech (not related to a cerebrovascular accident) is R47.1, which may be descriptive of the speech of a child who has cerebral palsy.

Developmental or Organic?

- For a child with **language deficits** related to an **organic** or medical condition, **code R48.8** (other symbolic dysfunctions) is often used by SLPs to describe the deficit.
- When there is an underlying medical condition contributing to the speech or language deficit, this information should also be included on the claim.

Developmental or Organic?

- For a child with **no related medical condition** but who has speech-language deficits, use **code F80.2** (ICD-9-CM ode 315.32), mixed receptive-expressive language disorder, for example.

- There are additional codes in each of these code series.

CPT Coding Procedures

- Use CPT codes to describe the service or treatment.
- Choose the CPT procedure code that best describes the services.
- Don’t unbundle codes.

Example: Don’t provide an additional CPT procedural code for oral motor activities if providing speech treatment under CPT **92507 or 92526**. Those codes include oral motor activities as a component of the code.

What codes can be combined?

- The **National Correct Coding Initiative** (NCCI, or more commonly, CCI) is an automated edit system to control specific Current Procedural Terminology (CPT) code pairs that can be reported on the same day.
- Used for Medicare and Medicaid claims, but private payers may also use.
- SLP-related code pairs that are **not** listed here are not subject to CCI restrictions and **can be billed on the same day without a modifier**.
- http://www.asha.org/Practice/reimbursement/coding/CCI-Edit-Tables-SLP/

The CPT Process

- Owned by the American Medical Association (AMA)
- ASHA's Health Care Economics Committee proposes new codes
- Multiple-step process for approving new codes
- Collaboration with related organizations

The CPT Process

- The AMA Relative Value Committee “values” the procedure, or new code, and makes a recommendation to CMS (Centers for Medicare/Medicaid)
- CMS revalues the procedure taking into account: work, time involved, professional liability, equipment & supplies; then assigns reimbursement

CALCULATING FEES

- Health care providers have some flexibility when setting private fees.
- Clinicians can choose a pricing philosophy, and then gather available charge information to establish a fee schedule and negotiate health care contracts.

Choosing A Pricing Philosophy

- **Market-driven approach**: Known as UCR (usual, customary, reasonable) ties medical pricing to industry trends in local communities; assumes patients are price-sensitive.
- **Relative value approach**: Fees are tied to “worth” of a procedure and considers skill, time, risk. Medicare Physician Fee Schedule uses the relative value method.

Compare Your Fees

- Compare your fees with the **Medicare Physician Fee Schedule**
- Use the fee data from **ASHA's Milliman report**

(The Milliman fee data cannot be directly shared beyond ASHA members, but can be used as a reference for negotiating rates.)

- **National Fee Analyzer**; https://www.optum360coding.com/Product/45873/

Calculating Fees: WARNING

Setting prices in collusion with colleagues is illegal. **Avoid price-fixing**, such as discussing fees with local providers.

Understanding Fee Data

- National Fee Analyzer provides charge data at:

50th percentile: 50% of charges are below this rate; 50% of charges are at or above this rate.

75th percentile: 75% of charges are below this rate; 25% of charges are at or above this rate.

- National Fee Analyzer - uses actual provider **charge data**
- Milliman data - average **allowed charges** for services

Calculating the Medicare Reimbursement Rate

- Example:

CPT 92507 (Treatment of speech, language, voice disorder):

Professional Work	1.30
Practice Expense	0.88
Malpractice	0.05
Total RVUs	2.23

2016 CF of $35.8279 X 2.23 = **$79.90**

Fee Data Comparisons

CPT 92523 (Speech & Language Evaluation)

Optum 50th percentile:	$410.31
Optum 75th percentile:	$565.65
Medicare rate:	$195.98
Milliman data:	$146.49 to $171.13

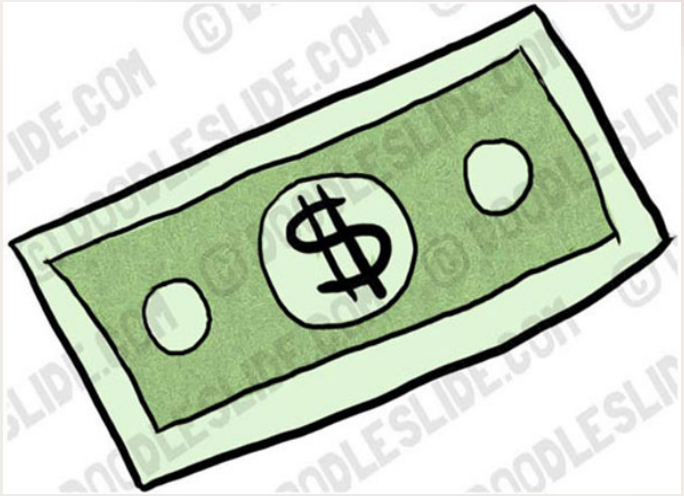
Fee Data Comparisons

CPT 92507 (Speech, language, voice…treatment)

Optum 50th percentile:	$107.41
Optum 75th percentile:	$148.07
Medicare rate:	$79.90
Milliman data:	$74.55 to $80.79

Establishing Fees

Establishing fees takes care. Fees that are too high will lead to disputes with patients and payers. Fees that are too low will result in inadequate reimbursement.



Negotiating Better Reimbursement Rates

5 – Step Process

Negotiating Better Reimbursement Rates

Step 1

Determine the most common CPT codes

-Codes that account for 75% of your total practice charges

-Record the # of times you provided the service over 12-month period (CPT 92557: frequency 500)

Negotiating Better Rates

Step 2

Determine your top payers

-Focus on 3-4 payers = bulk of your reimbursement

-Medicare/Medicaid use established fee schedules and do not negotiate

Negotiating Better Rates

Step 3

Determine your reimbursement for each code

-Note how much each payer allows for each code on your list

-Calculate each payers' reimbursement as a % of Medicare's fee schedule

Calculate Payer Rate As A % of Medicare Rate

CPT	Medicare Allowed Amt.	Health Plan Rate	Payer Payment as a % of Medicare
92507	$80.79	$85.00	105%

Negotiating Better Rates

Step 4

Review your fees for each code

-Calculate your fees as a percentage of Medicare's rates

-Update your fee schedule annually

Calculate Your Fees As A % of Medicare's Rate

CPT	Medicare Allowed Amt.	Your Current Fee	Your fee as a % of Medicare
92507	$80.79	$95.00	117%

Negotiating Better Rates

Step 5

Organize and analyze the data

-Compare rates between plans

-If payer reimburses in full, may mean your fees are too low. Plan may be willing to pay more.

-Consider raising fees or standardize all your fees at some % of Medicare, say 120%

Negotiating Better Rates

Organize & analyze the data

-Is one plan's rates lower, or is one code paid at a much lower % of Medicare than others?

-Establish target reimbursement rates for your negotiations, say 120% of Medicare

Health Plan Contracts

Health plans would have you believe that all terms and conditions in health plan contracts are carved in stone. That is not true. **Health plan contract language can and should be negotiated** under some circumstances. All providers are cautioned against blindly signing health plan contracts concerning rates, charges, reimbursement or network participation on the assumption that you have no choice. (Kevin S. Little)

Negotiating a Contract: Summary

Preparing for negotiating includes:

- gathering available average charge data
- knowing your practice and operating costs
- knowing how to track reimbursement patterns
- knowing standard billing codes and payment policy
- understanding negotiating strategies
- awareness of new payment models

Develop An Action Plan

- Negotiate individual fees: **Your first contact might be Provider Relations rep**, then the Contracting Manager
- Drop the plan: Rates too low, no longer accept patients. Patients may find another provider, or complain to their employer.
- Close to new patients if you don’t want to drop a health plan completely.

Move to Alternative Payment Models

Payers are moving away from fee-for-service (FFS) health care services to value-based payment models that incentivize providers on quality, outcomes, and cost containment. In the near future it is likely that your practice will feel the impact as **some of the risk is shifted to you, the provider.** For example:

1. **Accountable Care Organizations** (ACOs) are groups of doctors, hospitals, and other health care providers, who come together to give coordinated care.
2. **Bundled payment,** or **episode-based payment,** is a single *payment* for all *care* to treat a patient with a specific illness or condition.
3. **Patient Centered Medical Home** - patient treatment is coordinated through their primary care physician to ensure they receive necessary care when and where they need it.

Coding Examples

Let’s look at some patient cases and code the service and diagnosis.

Coding Example

Case: Patient seen for bedside swallowing assessment. What codes would be used?

- ICD-10 code: **R13.11** (dysphagia, oral phase)
- CPT code: **92610** (evaluation of oral/pharyngeal swallow function)

Coding Example

Case: An SLP sees a child for articulation treatment due to cleft palate. What ICD10 code should be assigned?

R47.89 (other speech disturbance) is the first listed code, or primary diagnosis;
Q37.5 (cleft of the hard and soft palate with unilateral cleft lip) is the second listed code, or secondary diagnosis

Coding Example

Case: An SLP evaluates a patient who suffered a CVA, and determines dysarthria. The type of CVA is noted in the medical record as nontraumatic subarachnoid hemorrhage. What is the ICD10 code?

I69.022 (dysarthria following nontraumatic subarachnoid hemorrhage)

Resources

Who to contact at ASHA if you have questions?

reimbursement@asha.org will get you to the right person!

Resources

ASHA's website has many reimbursement resources. Check it out.

Billing and Reimbursement

- Coding For Reimbursement
- Medicare
- Medicaid
- Private Health Plans
- Health Care Reform

http://www.asha.org/practice/