

Maryland AAHAM E / M Updates & Denial Prevention

July 28, 2021

Presented By:
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Your Speaker



Kem Tolliver holds dual Bachelor of Science degrees in Healthcare Administration and Organizational Management; Summa Cum Laude and Magna Cum Laude respectively. Certifications include: Certified Medical Practice Executive (CMPE), Certified Professional Coder (CPC) and Certified Medical Office Manager (CMOM).

Kem is the co-author of, “Revenue Cycle Management: Don’t Get Lost in the Financial Maze” published by MGMA® ISBN: 978-1-56829-677-7. Medical practices managed by Kem have received MGMA® “Better Performing Practice” distinctions in the areas of Accounts Receivable and Collections. In a desire to lead, Kem served on the Board of Directors of MD MGMA as the Chair of the Practice Management Committee, Chair of the Government Affairs Committee. She received MD MGMA’s 2016 Outstanding Service Award and was the 2018 State of Maryland ACMPE Certification Rep.

She has been instrumental in collaborating with MedChi The Maryland State Medical Society on member practice improvements and to provide testimony and guidance on healthcare legislation within the Maryland General Assembly. Kem served as a member of Maryland’s 2018 General Assembly House of Delegates – Health & Government Operations Prior Authorization special session workgroup.

Kem provides state-wide risk management training programs for Medical Mutual Insurance policy holders. She serves as a SME for: Henry Health start-up behavioral-telehealth app, Ability Networks-An Inovalon Company and Zane Networks. She was an Adjunct Professor of Revenue Cycle at Catonsville Community College.

Ms. Tolliver is the President of PG County, MD chapter of AAPC, co-Founder of Prince George’s County Practice Manager’s Association and serves on the Novitas JL Carrier Advisory Committee.

From 2017-2018, Kem served on the Board of Directors for Laurel Regional Hospital. She was a Mentor for the Prince George’s County Public School’s 2018 PTECH Health Innovation Program. Kem served on the Totally Linking Care-Maryland Advisory Council and was a faculty member for Beyond the Exam Room.

The State of Maryland Governor’s awarded Kem with Volunteer Service Certificate for 2015-2018. Nexus Health, Fort Washington Medical Center nominated her for the 2016 Community Health Award. Kem was awarded the Heart to Hand, Inc. 2019 Heart of Gold Award for 501 (c) (3) community based public health medical practice leadership.

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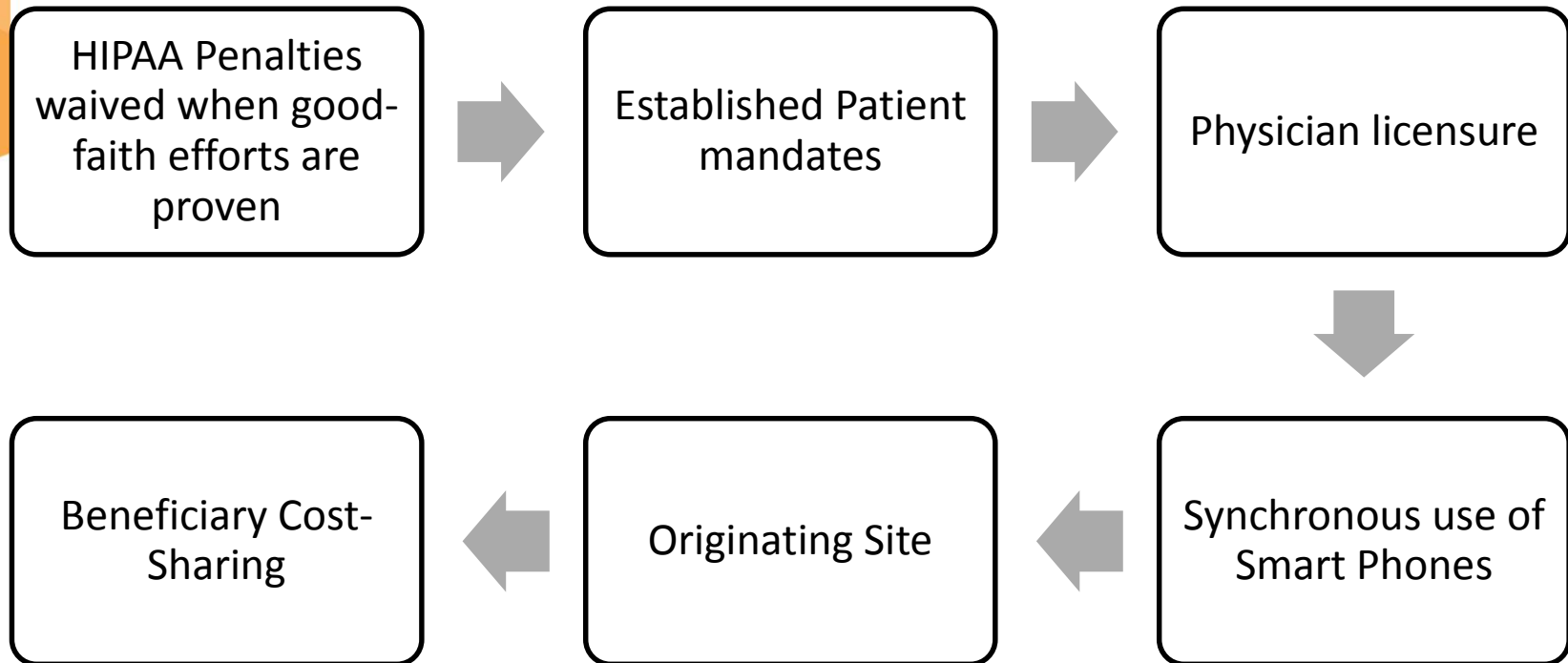
Learning Objectives

1. CMS Final Rule Updates
2. E / M Updates
3. Fee Schedule Management
4. Denial Management Terms & Definitions
5. Achieving Clean Claims
6. Assess Types of Denials
7. Mapping denials to RCM model

CMS 2021 Final Rule Highlights and E / M Updates

Temporary Telehealth Waivers

Expires with the end of the Public Health Emergency



Public Health Emergency was renewed on July 20, 2021

2021 Evaluation & Management Highlights



History & Exam

- **REMOVED FROM E/M SCORING**
- May now be collected and documented by Ancillary staff/care team; Provider must review

Examination

- **REMOVED FROM E/M SCORING**
- Continue to document to demonstrate medical necessity

Medical Decision Making (MDM)

- Elements **MUST** be addressed during the encounter
- Amount of and/or complexity of data reviewed
- Number and complexity of problems addressed

Time

- Removal of more than 50% of time spent on counseling and/or care coordination

These changes only apply to CPT codes 99211-99205

Selecting the Level of E/M Service

Select the appropriate level of E/M services based on the following:

- The level of the medical decision making (MDM) as defined for each

service; **or**

- The total time for E/M services performed on the date of the encounter.



2021 Time Calculations on the DOS

Preparing to see the patient (e.g. review of tests)

Obtaining and/or reviewing separately obtained history

Performing a medically appropriate examination and/or evaluation

Counseling and educating the Patient/family/caregiver

Ordering medications, tests, or procedures

Referring and communicating with other health care professionals (when not separately reported)

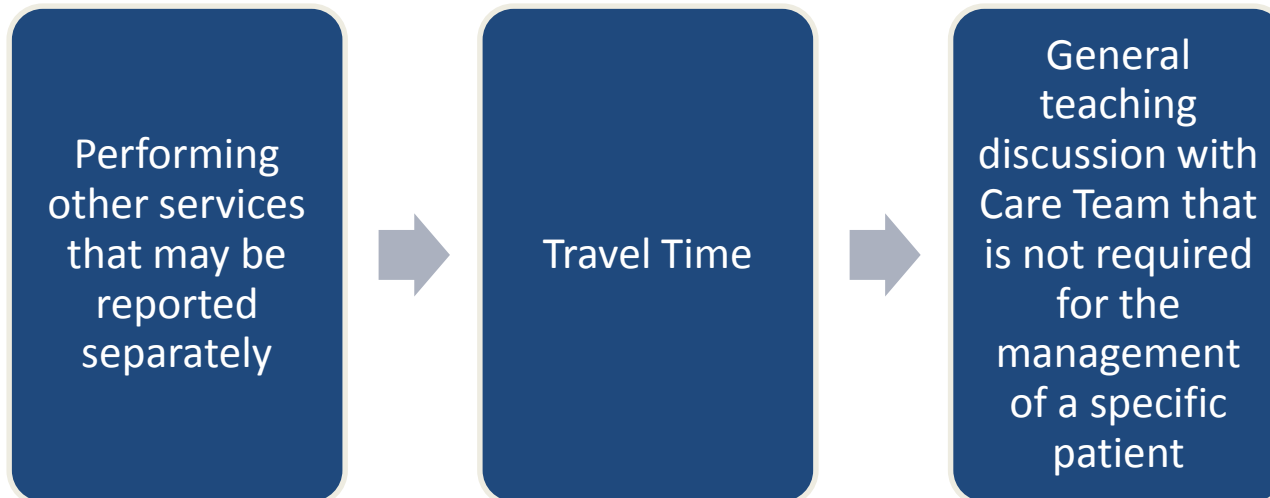
Documenting clinical information in the electronic or other health record

Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver

Care coordination (not separately reported)

New Time Counting Exclusions

Posted by AMA in March 2021 –
Retroactively Effective January 1, 2021



Recent MDM Clarifications

**Posted by AMA in March 2021 –
Retroactively Effective January 1, 2021**

**(1) PRESENTING
PROBLEMS & RISK**

(2) ANALYZED

(3) UNIQUE TEST

**(4) ORDERING
TESTS**

(5) DISCUSSION

**(6) INDEPENDENT
HISTORIAN**

(7) SDOH

<https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf>

2021 Conversion Factor

CONVERSION FACTOR (CF)					
2016	2017	2018	2019	2020	2021
\$35.80	\$35.89	\$35.99	\$36.04	\$36.09	\$32.4085
Increase	Increase	Increase	Increase	Increase	DECREASE

NEW!!
\$34.8931

Anesthesia Conversion Factor	
2020	2021
\$22.20	\$19.9631

Final 2021 E&M Code Changes

<u>New Pt CPT</u>	<u>Work RVU</u>	<u>2019 Time</u>	<u>2021 Time</u>	<u>MDM</u>
99201	Deletion of CPT code			
99202	0.93	20 min	15-29 min	Straight-Forward
99203	1.6	30 min	30-44 min	Low Complexity
99204	2.6	45 min	45-59 min	Moderate Complexity
99205	3.5	60 min	60-74 min	High Complexity
<u>Estab. Pt CPT</u>	<u>Work RVU</u>	<u>2019 Time</u>	<u>2021 Time</u>	<u>MDM</u>
99211	0.18	5 min	7-14 min	None
99212	0.7	10 min	15-29 min	Straight-Forward
99213	1.3	15 min	30-44 min	Low Complexity
99214	1.92	25 min	45-59 min	Moderate Complexity
99215	2.80	40 min	60-74 min	High Complexity

2021 RVU Updates

CPT Code	2020 RVU	2021 RVU	Increase %
99201	0.48	Deleted	N/A
99202	0.93	0.93	0%
99203	1.42	1.6	13%
99204	2.43	2.6	7%
99205	3.17	3.5	10%
99211	0.18	0.18	0%
99212	0.48	0.7	46%
99213	0.97	1.3	28%
99214	1.5	1.92	28%
99215	2.11	2.8	33%

Medicare Physician Fee Schedule (MPFS)

New patient	2018 Rate	2019 Rate	2020 Rate	2021 rate	Difference Between 2020 vs 2021
99201	\$51.99	\$47.70	\$53.97	DELETED	
99202	\$86.77	\$79.38	\$88.71	\$79.99	(\$8.72)
99203	\$124.43	\$112.57	\$124.97	\$122.23	(\$2.74)
99204	\$188.16	\$170.64	\$189.40	\$182.60	(\$6.80)
99205	\$236.10	\$214.40	\$238.67	\$240.73	\$2.06
Established patient					
99211	\$25.44	\$23.69	\$27.55	\$26.20	(\$1.35)
99212	\$51.11	\$46.94	\$53.53	\$62.90	\$9.37
99213	\$83.92	\$77.09	\$87.12	\$99.87	\$12.75
99214	\$123.44	\$112.80	\$125.75	\$141.54	\$15.79
99215	\$166.00	\$151.08	\$168.31	\$197.38	\$29.07
	<i>Source: Medicare Administrative Contractor – Novitas Solutions Jurisdiction L</i>				

Accessing the Medicare Fee Schedule



Medicare Administrative Contractor



Novitas JL MAC Fee Schedule Access

Check our local Medicare fee schedules using the following steps:

- www.novitas-solutions.com
- Select: Part B: Physicians & other healthcare professionals
- Accept Terms and Conditions
- Select: Fee Schedules
- Select: Search & Download Fee Schedules

Localities for Jurisdiction L (JL)

Locality #	State	Fee Schedule Area	Counties
01	DC	DC + MD/VA Suburbs	District of Columbia, Alexandria City, Arlington
01	MD	Baltimore / Surrounding Counties	Anne Arundel, Baltimore, Baltimore City, Carroll, Harford, Howard
99	MD	Rest of State	All Other Counties EXCEPT Montgomery and Prince George's

Medicare Part B [Change to A]

- JL Home
- Novitasphere Portal
- Appeals
- CERT
- Claims
- Contact Us
- Education & Training
- Electronic Billing-EDI
- Enrollment
- Evaluation & Management
- Frequently Asked Questions
- Fee Schedules
- Home (All Fees)
- Search & Download Fee Schedules
- Flu, Pneumonia, and Hep B Fees
- Local Contractor Pricing
- Forms Catalog
- Join our E-mail Lists
- Medical Policy / LCDs
- Medical Review
- News & Publications
- Self-Service Tools
- Specialties / Services

Physician's Fee Schedule Code Search & Downloads

Search using a single code

Procedure Code No Modifier

Date Of Service

State

Locality

Download the complete Fee Schedule

Year

State

Locality

File type

Results

Procedure Code	91300	State	District of Columbia	Modifier	No Modifier
Effective Date	01-01-2021	Locality	DC Metro & MD/VA suburbs (01)	Description	Sarscov2 vac 30mcg/0.3ml im

Please click on the icon for a description of any field or indicator

Fee Schedule Amount

Participating Provider	0.00
Non-Participating Provider	0.00
Limiting Charge Amount	0.00

When performed in a facility setting

Participating Provider	0.00
Non-Participating Provider	0.00
Limiting Charge Amount	0.00

Status Indicators

FEEDBACK

Need Help?

SOLUTIONS

Print

Medicare Part B [Change to A]

- JL Home
- Novitasphere Portal
- Appeals
- CERT
- Claims
- Contact Us
- Education & Training
- Electronic Billing-EDI
- Enrollment
- Evaluation & Management
- Frequently Asked Questions
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- Join our E-mail Lists
- Medical Policy / LCDs
- Medical Review
- News & Publications
- Self-Service Tools
- Specialities / Services

Physician's Fee Schedule Code Search & Downloads

Search using a single code

Procedure Code: 0001A No Modifier

Date Of Service: 3/16/2021

State: District of Columbia

Locality: DC Metro & MD/VA suburbs (01)

Search Clear

Download the complete Fee Schedule

Year: 2021

State: Choose a state...

Locality: Choose a locality...

File type: PDF

Download

Results

Procedure Code	0001A	State	District of Columbia	Modifier	No Modifier
Effective Date	01-01-2021	Locality	DC Metro & MD/VA suburbs (01)	Description	Adm sarscov2 30mcg/0.3ml 1st

Please click on the icon for a description of any field or indicator

Fee Schedule Amount

Participating Provider	0.00
Non-Participating Provider	0.00
Limiting Charge Amount	0.00

When performed in a facility setting

Participating Provider	0.00
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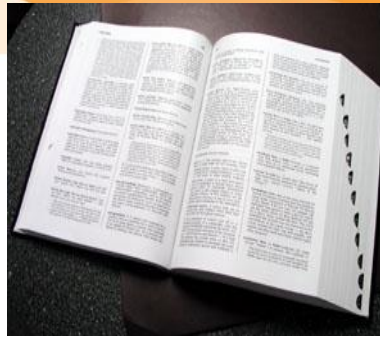
FEEDBACK

Need Help?

Denial Prevention



Definitions



Accounts Receivable

- Amounts in A/R are outstanding balances due payable to the organization. This can include balances due from patients as well as from insurers.

Allowable Amount

- The maximum contracted amount that is paid by a health insurance company for a covered service.

Appeal

- Request for reconsideration and review for a claim which was not paid.

Assignment of Benefits

- The process that a beneficiary turns over payment of services to another organization on their behalf; thereby removing them from the medical billing process.

Definitions



Balance Billing

- Occurs when a patient is billed for the balance between the providers charge amount and the payers allowed amount.

Charge Description Master

- Comprehensive list of CPT/HCPCS codes and description of services charges for healthcare.

Claim Adjustment Reason Codes (CARC)

- Communication of why a claim or services was paid differently than it was billed.

Claim Control Number (CCN)

- 14-digit number assigned to each claim in the Medicare system. All numbers in sequence serve a purpose.

Claim Adjustment Reason Codes (CARC)

6 The procedure/revenue code is inconsistent with the patient's age.
Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Start: 01/01/1995 | Last Modified: 07/01/2017

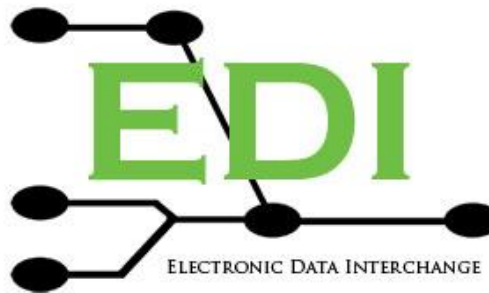
29 The time limit for filing has expired.

Start: 01/01/1995

22 This care may be covered by another payer per coordination of benefits.

Start: 01/01/1995 | Last Modified: 09/30/2007

Definitions



Code Set 270

- Query sent by providers for patients healthcare benefits info to insurance.

Code Set 271

- Response from insurance back to provider on patients benefits info.

Code Set 835

- Electronic Remittance Advice (ERA) from Payer to Provider.

Code Set 837

- Electronic submission of healthcare claims from provider to insurance.

Definitions



Timely Filing

- The amount of time granted to submit a claim after the date of service.

Unbundling

- Billing individually for CPT/HCPCS codes that should be included in a code set.

Utilization Review

- Criteria used by insurance companies to compare health status with care to reduce improper payments and utilization of resources.

Virtual Payments

- Payment method that replaces checks & EFTs with a credit card. Usually includes a finance fee that is subtracted from the allowable amount.

Playing the GAME



Achieving CLEAN CLAIMS



**Subscriber ID# /
Group #**

**Patient Name,
DOB & Gender**

**Subscriber's
Name, DOB,
Relation to
Patient**

Date of Service

**Place of Service
Code**

Modifier

**Rendering
Provider NPI#**

**Correct
Taxonomy Code**

Tax ID#

Common Denial Types



Administrative
Denials



Clinical Denials

Denial Types

Hard Denials

Denied for No pre-authorization/Referral

Denied as not financially responsible

Denied as not a covered service

Denied charge/procedure as bundled

Denied for untimely submission

Soft Denials

Denied pending receipt of medical records

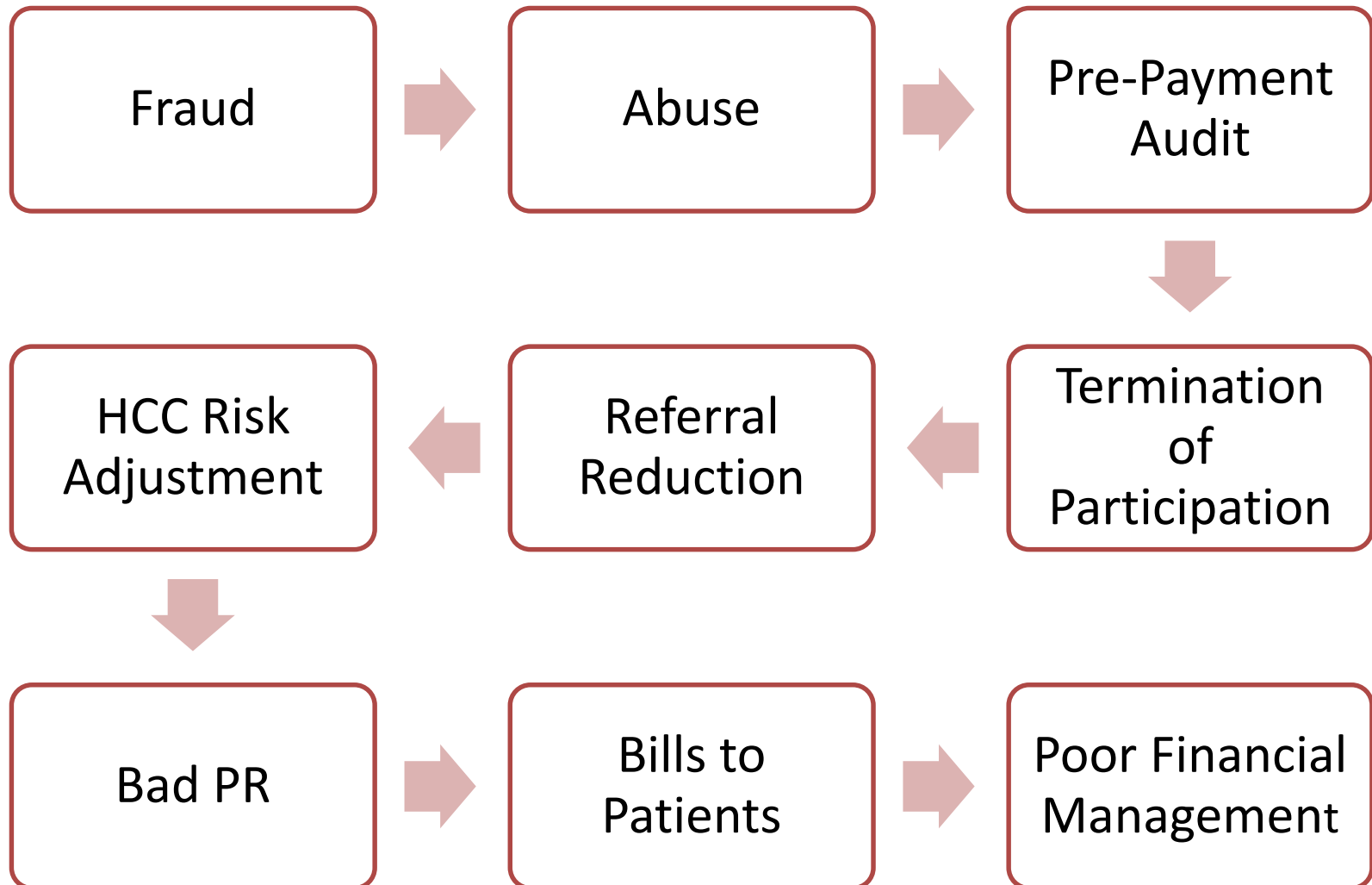
Denied due to missing/inaccurate data

Denied due to coding issues

Denied due to demographic information

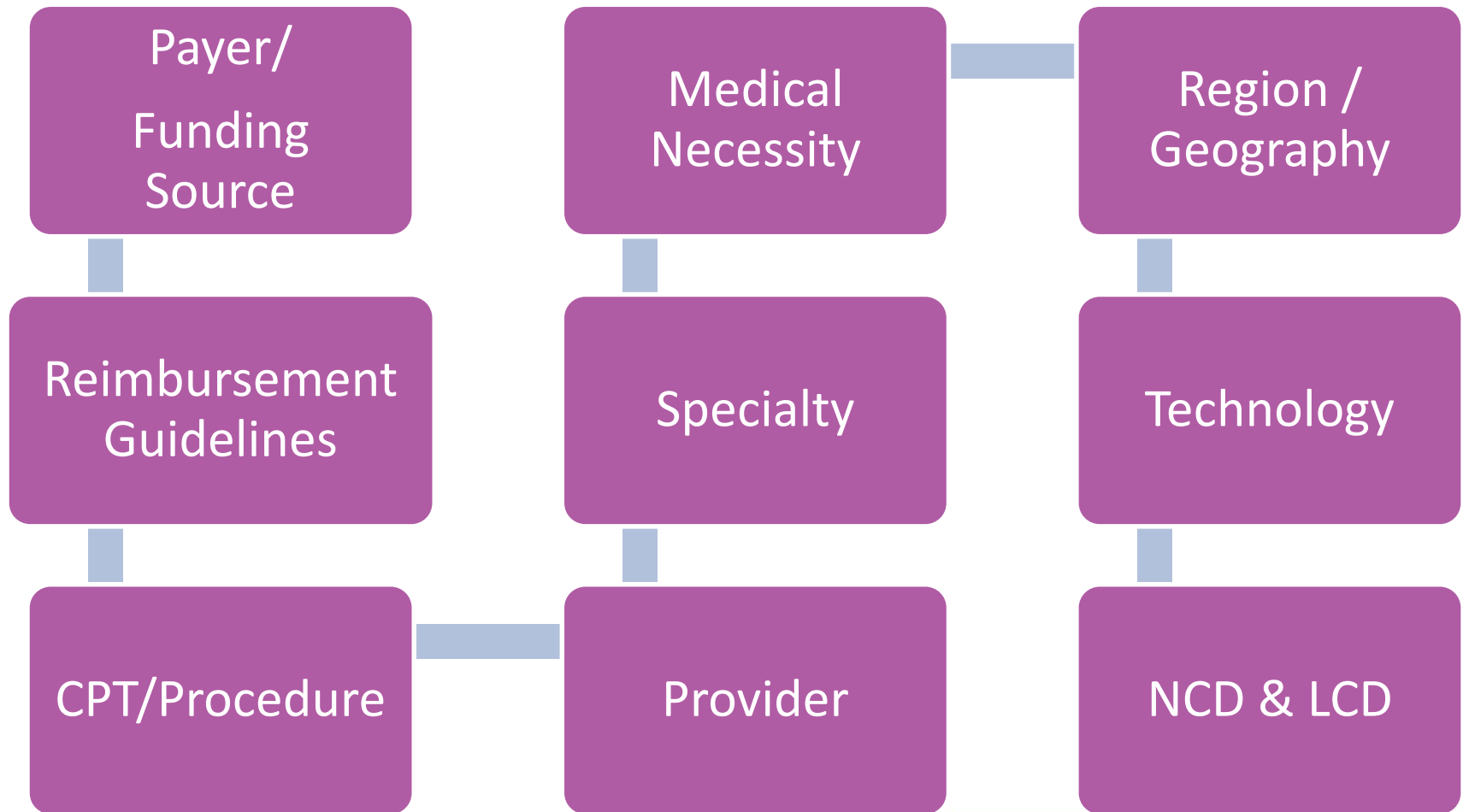
Denied secondary payment pending receipt of EOB from primary insurance

Risks as a Result of Denials

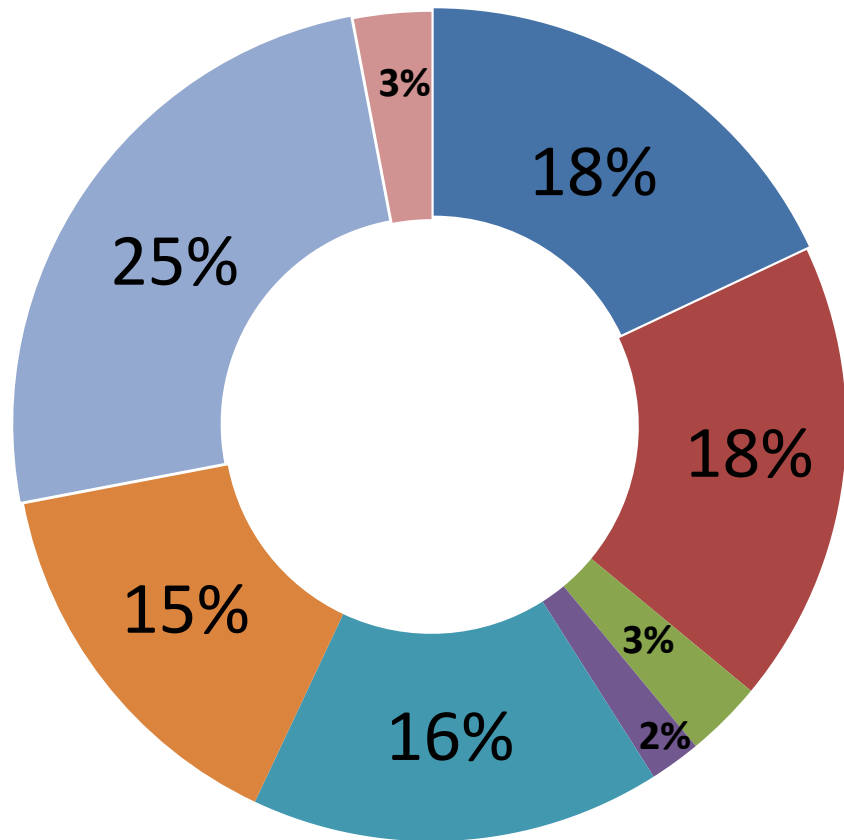


Proactive Approach

Categorize Denials to Take Action



Categorize Denials to Take Action



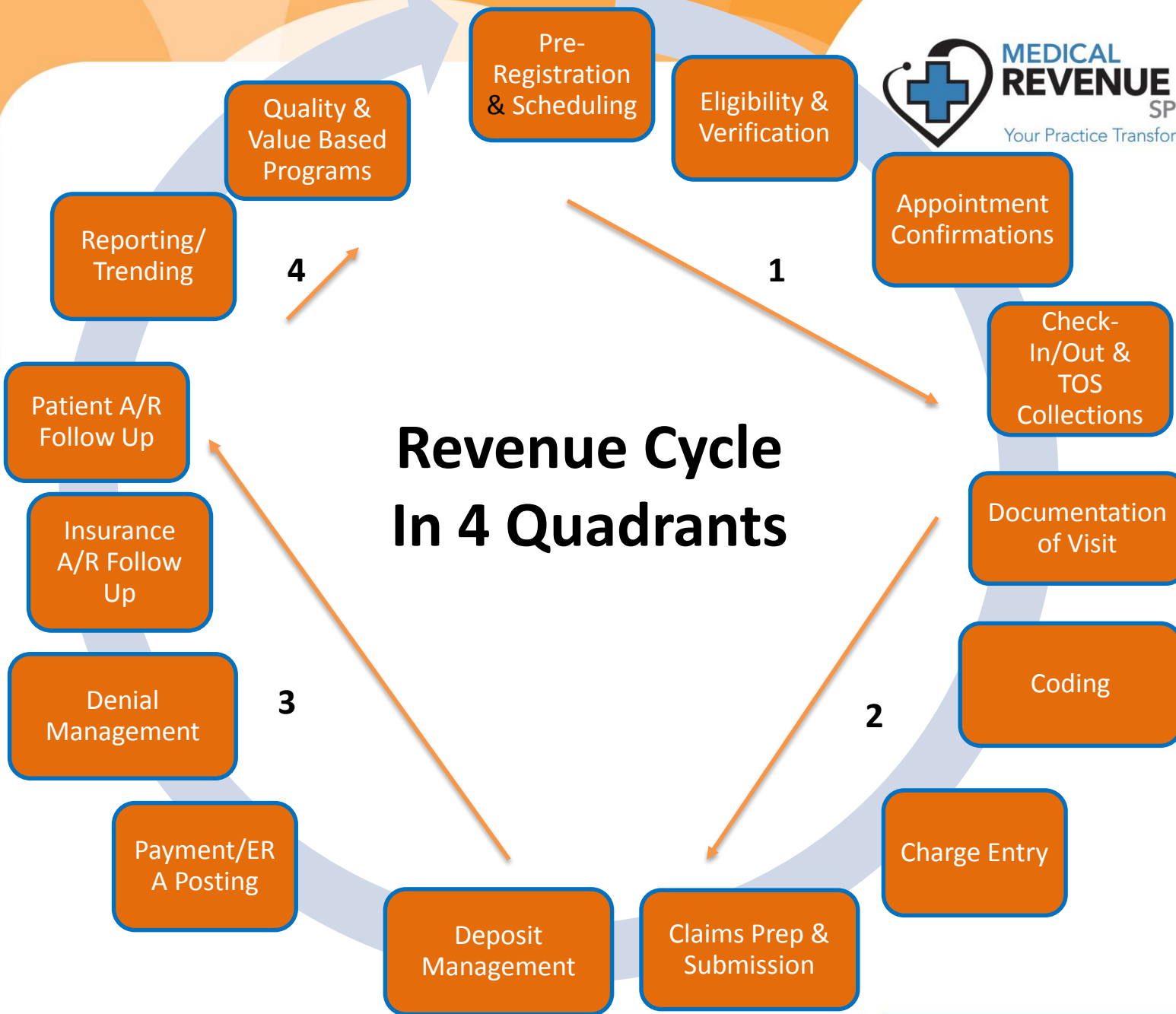
- Patient Registration
- Utilization Review
- Documentation & Coding
- Charge Capture
- Claim Submission Issues
- Contract Management
- Claim Follow up
- Underpayment

Revenue Cycle Management Mapping to Denial Prevention

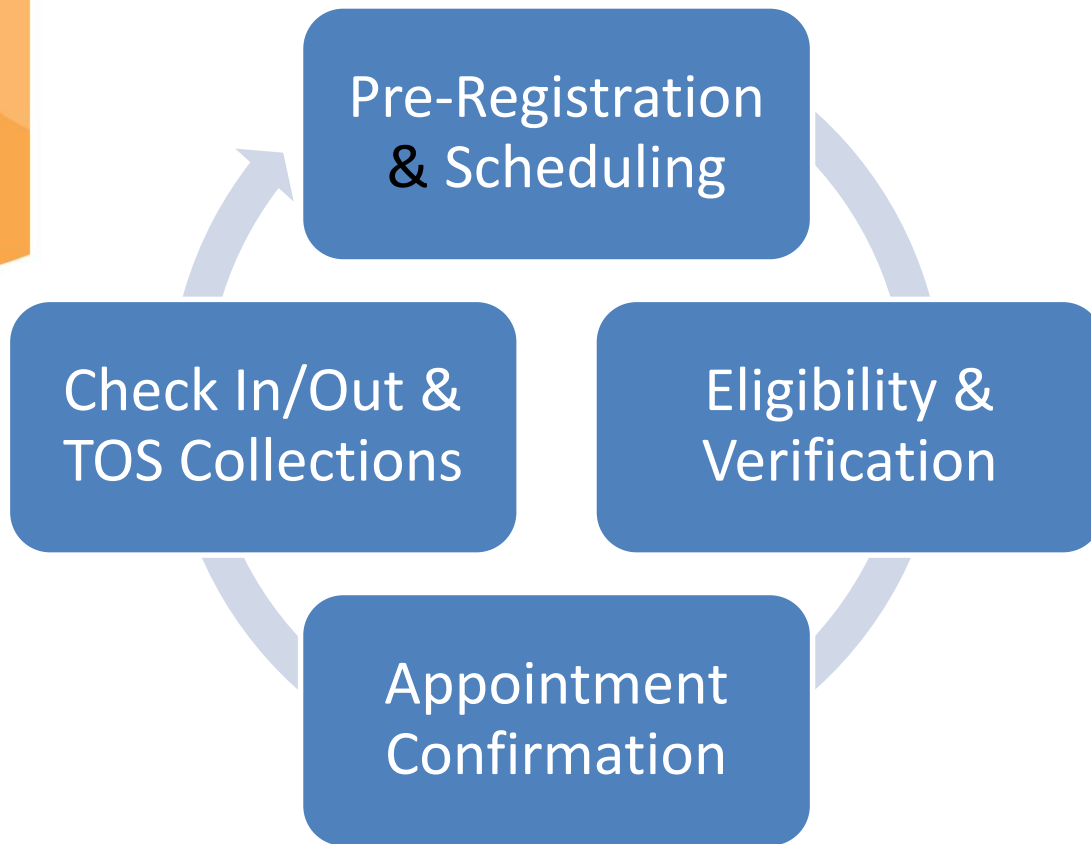




Revenue Cycle In 4 Quadrants



1st Quadrant – Patient Access



Out of Network

Missing PCP

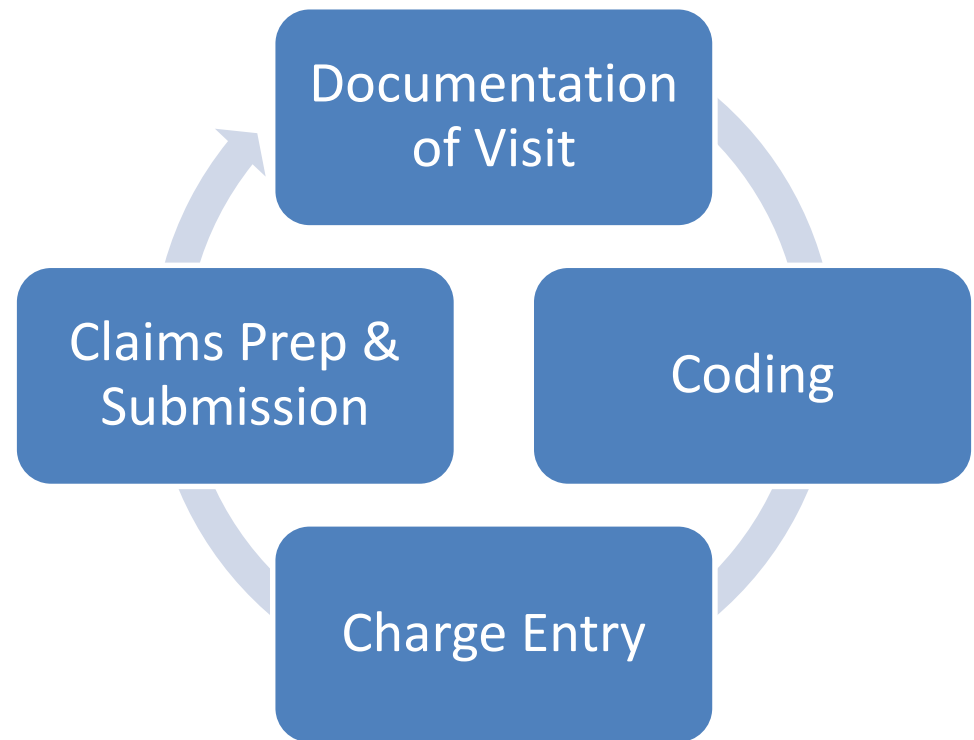
Patient not covered

2nd Quadrant – Mid Cycle

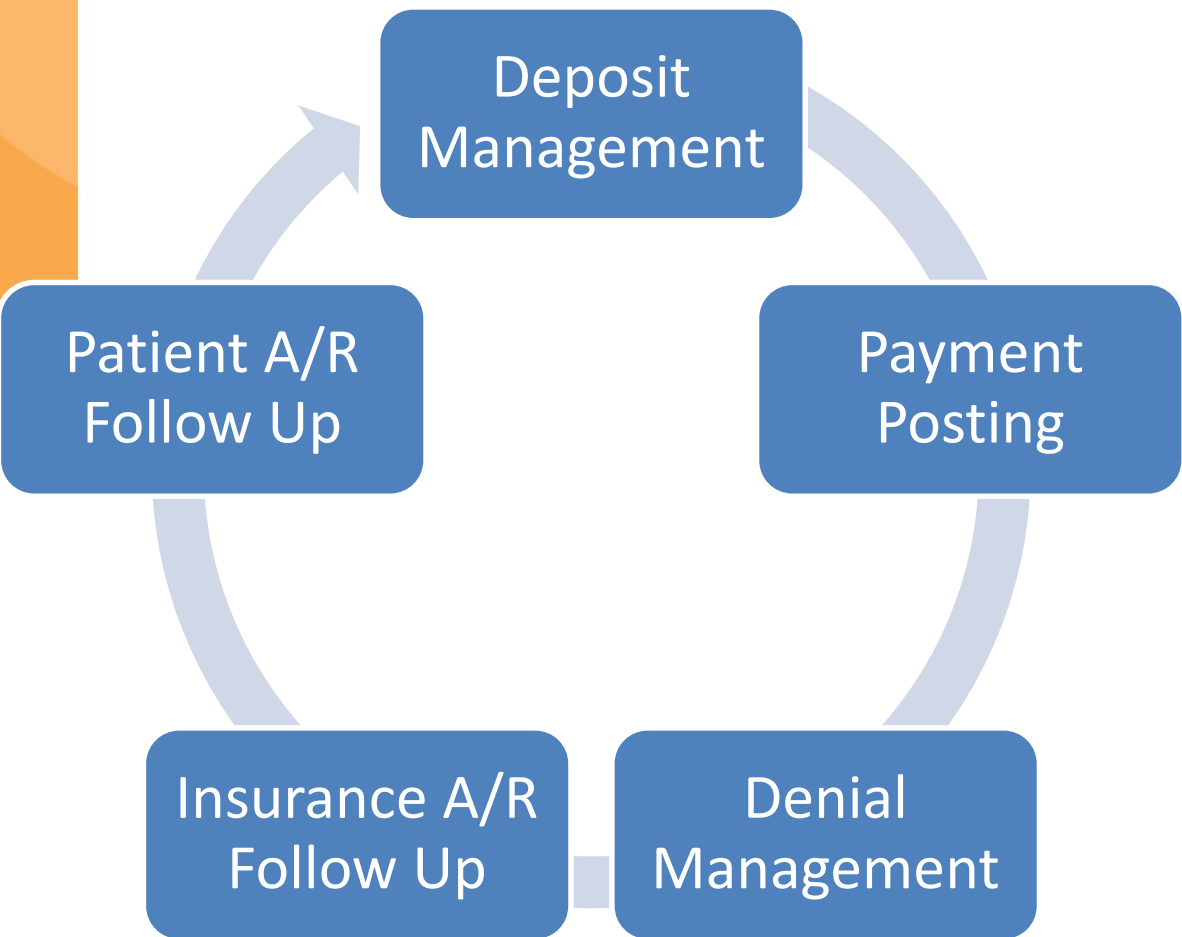
Improper DX
Sequencing

Not medically
necessary

Incorrect
Modifier Usage



3rd Quadrant – Back End



Invalid Denial

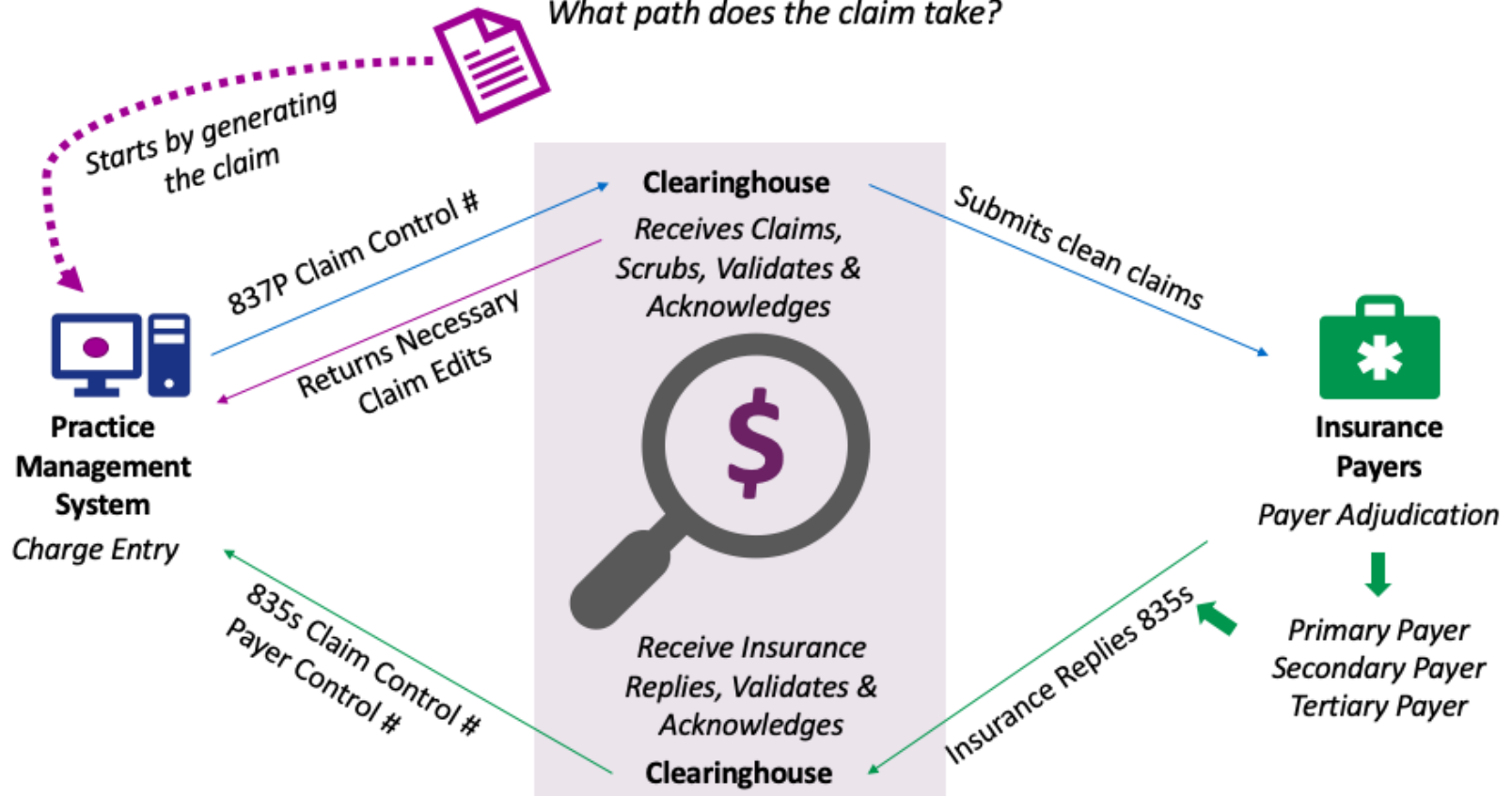
Previously Paid

Duplicate claim

Clearinghouse or Add on Platform Value Proposition

Clearinghouse Interface Flow

What path does the claim take?



Denial Reduction Strategies

Communication



Communication

- Essential to prevention of denial
- Vital to submitting clean claims
- Review policies and procedures of insurance companies
- Dedicated team members
- Build necessary relationships



Education

- Training and/or experience
- Cross-train coders and billers
- Current with the latest rules, regulations, appeal rights, and critical timelines
- Keep current reference materials/resources

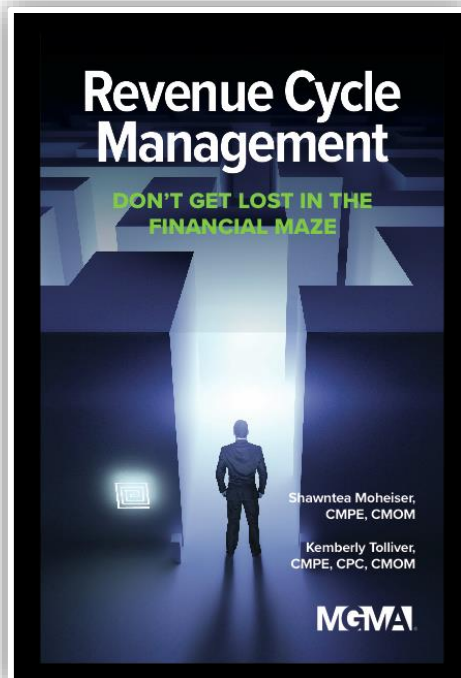


Accountability

- Dedicate specific staff member
- Set Goals
- Shared Reporting
- Regularly scheduled meeting
- Rewards

Connect with Kem

Co-Author of MGMA's
"Revenue Cycle Management:
Don't Get Lost in the Financial Maze"



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Thank You!



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