THE CHENNAI CHAPTER OF AAHAM American Association of Healthcare Administrative Management

Chennai Connexions

Issue 15, Aug 2019 www.aahamchennai.org | e-Newsletter

Editorial

Chennai Connexions has been a great tool that connects all our local members. Each issue covers issues and update from the industry experts.

This issue talks about some of the important updates that would affect most of us. We welcome you to contribute articles to the newsletter and share your knowledge and expertise with all the other members.

We hope you find this edition useful. Happy reading!

Do you have an article for the next edition of Chennai Connexions? Please send it to secretary@aahamchennai.org!

What can you find in this edition?

Payor	Subject	Update	Applicable CPT	Effective date	Reference link
Cigna	Duplex Scan to Evaluate for Carotid Artery Stenosis	New medical coverage policy, Duplex Scan to Evaluate for Carotid Artery Stenosis (0542), to review duplex scans for carotid artery stenosis screening for medical necessity	93880	DOS beginning July 15, 2019	https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm_0542_coveragepositioncriteria_duplex_scan.pdf
Cigna	Spinal fusion related services	Three new coverage policies to require precertification for spinal fusion related codes	22532 - 22859 20930 - 20938	DOS beginning August 23, 2019	https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm_0527_coveragepositioncriteria_cervical_fusion.pdf https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm_0303_coveragepositioncriteria_lumbar_fusion_degenerative_conditions.pdf https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm_0118_coveragepositioncriteria_recombinant_human_bone_morphoge
Cigna	Daily Routine and Supplies in Outpatient Settings	Current edits has been updated for to deny claims for routine supplies provided in an outpatient setting. Routine supplies are included in the facility fee and are not separately reimbursable. This aligns with our Facility Routine Services, Supplies and Equipment (R12) reimbursement policy	NA	Claims processed on or after July 15, 2019	https://cignaforhcp.cigna.com/public/content/pdf/resourceLibrary/medical/ccr-not-payable-reason-codes.pdf
Cigna	Facility Evaluation and Management (E&M)	Updated list of inclusive Facility Routine Services, Supplies and Equipment (R12) reimbursement policy and deny claims for evaluation and management (E&M) services billed by a facility on a UB claim form. Only the E&M code will be denied. All other services on the claim will be reimbursed according to the terms of the customer's benefit plan and the facility's Agreement. **Note:** Outpatient facilities, including oncology clinics, urgent care facilities, behavioral health care, emergency rooms, Veterans Affairs Medical Centers, and Maryland are excluded from this update	NA	Claims processed on or after July 15, 2019	https://cignaforhcp.cigna.com/public/content/pdf/resourceLibrary/medical/ccr-not-payable-reason-codes.pdf
Cigna	Intraoperative Neurophysiological Monitoring (IONM) Studies	- Current edits has been updated for facility Routine Services, Supplies and Equipment reimbursement policy (R12), and deny claims for intraoperative neurophysiological monitoring (IONM) studies and associated electrodiagnostic studies when billed with Place of Service (POS) codes 11 and 15. - POS code 11 is used to bill for services in an office setting. POS code 15 is used to bill for services provided in a mobile unit. IONM services are only reimbursable when provided in the same location where the surgery is being performed; i.e., an operating room setting.	NA	Claims processed on or after July 15, 2019	https://cignaforhcp.cigna.com/public/content/pdf/resourceLibrary/medical/ccr-not-payable-reason-codes.pdf
Cigna	Genetic Testing for Reproductive Carrier Screening and Prenatal Diagnosis (0514)	Genetic Testing for Reproductive Carrier Screening and Prenatal Diagnosis (0514) medical coverage policy to review sequencing-based non-invasive prenatal testing for medical necessity	81420, 81507, and 0009M	DOS beginning July 15, 2019	https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm_Future/mm_0514_coveragepositioncriteria_genetic_testing_repro_carrier_prenatal.pdf
Cigna	Pneumatic Compression Devices and Compression Garments (0354)	In alignment with our current Pneumatic Compression Devices and Compression Garments (0354) medical coverage policy, we will deny pneumatic pump claims billed with International Classification of Diseases (ICD-10) code I87.1 as not medically necessary. Additionally, we will deny claims billed with Healthcare Common Procedure Coding System (HCPCS) code E0676 as experimental, investigational, and unproven (EIU) for any indication in the home setting.	E0676	DOS beginning July 15, 2019	https://cignaforhcp.cigna.com/public/content/pdf/coveragePolicies/medical/mm_Future/mm_0354_coveragepositioncriteria_lymphedema_pumps_and_sleeves.pdf

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DENIALS – AN OVERVIEW

According to American Medical Association (AMA) 25-30 % of total health care expenditures are direct transaction costs and inefficiencies associated with "claims management revenue cycle"

Substantial amount of resources are utilized while managing the basics of the claim revenue cycle

- Lack of payment transparency
- Inaccurate or unfair payment
- Administrative hassle
- Payment reconciliation and claim follow-up

According to recent estimates, gross charges denied by payers has grown to an alarming 15 to 20 % of all claims submitted

The average cost of reworking a claim is $25 according to the Healthcare Financial Management Association

As many as 65 % of claim denials are never worked resulting in an estimated 3 % loss of revenue

Roughly 67 % of all denials are appealable

Accurate claims payment is also measured as part of the insurer report card, with the following results.

Insurer	Aetna	Anthem	Cigna	HCSC	Humana	Regence (BCBS)	UHC	Medicare
Contracted fee schedule match rate								
Match Rate	96.69	91.64	97.46	92.60	97.92	85.21	98.13	99.66

Thiru

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Steps to Achieve Clean Claims Submission

The claims have to be revisited, denials have to be identified, appropriate action has to be taken and the claim cycle begins again. There is a substantial time and resource utilization in doing the submission process all over again. Hence, it is very, very important to get maximum number of claims paid at the first submission.
The average percentage of claims that get paid at the first submission determines the clean claim percentage. It is ideal to keep this percentage high for running a profitable surgery center where resources are tight and time spend is crucial. So how do you ensure optimum percentage of clean claims and build a continuous process?

Some common process deficiencies include:

- Registration errors
- Insurance verification not performed
- Charge entry errors
- Referrals and pre-authorization not processed
- Duplicate billing
- Lack of medical necessity documentation
- Documentation to support claim not included
- Code bundling — editing system or modifier issues

Here are the steps that will help ensure clean claims submissions

1) Ensure correct and updated patient information on claims.
 Information to verify- patient demographic information, policy information and medical information.
2) Verify patient eligibility and benefits at-least two days prior to the date of service.
 Information to verify- primary, secondary and if applicable tertiary insurances,

policy effective dates, in-network/ out-of-network benefits entitlement, services or procedure coverage, co-pays and deductibles.
3) Procedure authorization at-least five days prior to the date of service.
 Information to verify- type of procedure, checking with carriers if a certain scheduled procedure requires a prior authorization and verifying if the procedure is covered under the patient plan type.
4) Follow carrier specific coding guidelines.

- Information to verify- CPT and ICD compatibility, submission process- paper based or electronic. Create carrier specific Local Coverage Determination (LCD) guidelines to verify coding compatibility.
- During the bill generation process, edits are conducted for national and local coverage determinations. Correct Coding Initiative edits are also applied for the following:

- Bundling & Unbundling
- Age or gender
- Local carrier regulations
- Payer-specific editing
- Physician Quality Reporting System and nationwide

5) Ensure correct modifier usage.

- Information to verify- application of correct modifier, appending the modifier on the correct procedure. Create customized National Correct Coding Initiative (NCCI) edits guideline to determine modifier usage.
- You need to know the answers to these questions: What modifiers do the payers accept? Should you use a – 50 modifier for a bilateral procedure, or a combination of –RT and –LT? If their software does not recognize a modifier, it could lead to rejected claims.

6) Undertake quality checks prior to submission.

- Information to verify- Examine each claim for demographic, coding, submission errors prior to submission.
- We need to understand what a payer will cover and what they won’ t. Do they cover screening exams, and if so, how often? Do they apply payment reductions when multiple procedures are performed in the same session?

7) Detailed medical documentation.

- Payers are notorious for denying claims for medical necessity or delaying payment for review of medical records. It is important to monitor their patterns of behaviour and develop processes to preempt reimbursement delays by providing concise, supportive notes in designated claim segments
- Information to verify- case history, need of service documentation, procedure documentation, patient medication history. If required by carriers, medical documents act as supplemental records for claims processing.

8) Avoid duplicate claims

- Increasingly, more healthcare services are bundled into a single package, Aiken says. Paying close attention to this could prevent the wasted time of duplicate billings that aren' t necessary.

- For example, lab profiles with multiple tests don' t always qualify for separate reimbursements, or an all-encompassing rate may cover a minor procedure as well as the pre- and post-procedure visits," she says. " In these cases, a combined payment is often received."

Thiru