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!

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**Medicare Point of Service**

**The Medicare POS (Point of Service) is an option for Medicare beneficiaries that involves a blend of traditional Medicare and managed care options. It combines some features of Medicare Part A (hospital insurance), Part B (medical insurance), and provides a level of flexibility in choosing healthcare providers. Let us break down the key intricacies of how the Medicare POS works:**

**1. Overview of Medicare POS:**

**Medicare POS is a hybrid model primarily available through Medicare Advantage plans (Part C). It is a managed care model that allows beneficiaries to access care in-network as well as out-of-network providers, with varying costs.**

**2. In-Network vs. Out-of-Network:**

* **In-Network Care: When beneficiaries use in-network providers, the costs are usually lower, and the plan pays a larger portion of the cost.**
* **Out-of-Network Care: Beneficiaries can also see out-of-network providers, but it will usually result in higher costs. You might have to pay higher co-pays, coinsurance, or even the full cost of services.**

**3. Referral Requirement:**

* **In the case of a Medicare POS plan, a primary care physician (PCP) typically plays a vital role. For access to specialists, you may be required to get a referral from your PCP.**
* **If you go outside the network for care without a referral, your plan may not cover the cost or may only cover part of the cost.**



**4. Flexibility:**

**One of the key features of a POS plan is the flexibility it offers beneficiaries. If you prefer to see a specialist or provider outside of the plan’s network, you still have the option to do so, although at a higher cost than using in-network services.**

**5. Costs and Coverage:**

* **Premiums: The cost of the Medicare POS plan may include premiums, and these can vary depending on the insurer and plan options.**
* **Co-pays/Co-insurance: The plan may have different co-pays and co-insurance rates based on whether you receive care in-network or out-of-network.**
* **Deductibles and Out-of-Pocket Costs: You may be responsible for deductibles, and there could be a maximum out-of-pocket limit which helps cap your expenses each year.**

**6. Eligibility:**

**To be eligible for a Medicare POS plan, a beneficiary must be eligible for Medicare, which includes those sixty-five or older or those with certain disabilities.**

**7. Medicare Advantage and POS:**

* **Medicare POS is typically found in Medicare Advantage Plans (Part C) that incorporate managed care. These plans offer the benefit of Medicare’s Part A and Part B coverage along with extra benefits like vision, dental, and wellness programs.**
* **POS vs HMO/PPO: Medicare Advantage plans may include POS options alongside other models like HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization). Compared to HMO, POS plans offer more flexibility in seeing out-of-network providers, though it often comes at a higher cost.**

**8. Impact on Out-of-Pocket Costs:**

* **In-network care will result in the lowest out-of-pocket costs, while out-of-network care can result in higher co-payments or even full responsibility for the bill, depending on the terms of the plan.**
* **Some POS plans may offer a balance between the flexibility of a PPO and the cost-saving features of an HMO.**

**9. Choosing Providers:**

**In a Medicare POS plan, you will have the freedom to select healthcare providers, but it is important to keep track of whether they are in-network or out-of-network to manage your   
costs efficiently. The plan may have a list of preferred providers or facilities.**

**10. Prescription Drug Coverage:**

**Some POS plans may also include prescription drug coverage (Medicare Part D), which means that medications will be covered if you adhere to the plan’s network guidelines.**

**Conclusion:**

**The Medicare POS plan offers a unique balance of flexibility and cost control. Beneficiaries enjoy the ability to go outside of the plan’s network if needed, but this may come at a higher cost. Like any other health plan, it is important to fully understand the costs, the referral process, and the benefits provided to ensure that you make the most of your Medicare POS option.  
  
  
  
  
 Vijila P V CRCP**

**How To Avoid Down code Payment in E & M Service**

**In Evaluation and Management service, sometimes insurance pay Downcode payment as they are not agreeing the level of service we billed. Usually commercial payer BCBS, UHC etc. pay the payment and possibly applying the recoup as level of service not met. It’s one of the main impacts for low collection. When billing for (E/M) services, it is crucial to ensure that your medical documentation is comprehensive, accurately reflects the complexity of the patient encounter, and clearly supports the chosen E/M code level. Here are some key strategies to help prevent down coding:**

**Key Strategies to Prevent Downcoding:**

**Thorough Documentation**

**• Comprehensive Patient Information: Clearly document all relevant patient information, including the chief complaint, past medical history, social history, review of systems, and medications.**

**• Detailed Examination Findings: Include detailed physical examination findings, noting both pertinent positive and negative observations.**

**• Medical Decision-Making Process: Provide a comprehensive medical decision-making process, including the rationale for the chosen treatment plan.**

**• Time Documentation: Record the time spent with the patient, especially if you are using time-based coding.**

**Accurate Code Selection**

**• Understand E/M Code Criteria: Familiarize yourself with the criteria for each E/M code level based on the 2021 E/M guidelines, including Medical Decision Making (MDM) or total time spent.**

**• Correct Code Usage: Select the code that most accurately reflects the complexity of the patient encounter. Avoid "upcoding" by claiming a higher level of service than what is documented.**

**Stay Informed About Updates**

**• Keep Updated with Guidelines: Stay up to date with the latest E/M coding guidelines and changes from the American Medical Association (AMA) and payers.**

**• Payer-Specific Rules: Be aware of payer-specific coding rules and policies to ensure compliance.**

**Appealing Denials**

**• Review Denial Reasons: If a claim is downcoded, carefully review the denial reason and prepare a strong appeal with supporting documentation from the medical record. It’s more important that we are adding the clear reason to substantiate the level we billed.**

**• Communicate with Payers: Contact the payer to discuss the claim and provide clarification if needed.**

**What to Avoid**

**• Incomplete Documentation: Failing to document all necessary details could lead to downcoding as the insurance company may not have enough information to justify the chosen code.**

**• Unbundling Codes: Avoid submitting multiple codes for components of a single service that should be billed with a single code.**

**• Generic Documentation: Using vague or non-specific language in your notes can lead to misunderstandings and potential downcoding.**

**• Ignoring Payer Guidelines: Not adhering to specific coding rules set by the insurance company can result in denials and downcoding.**

**By following these strategies, you can effectively avoid downcoding and ensure that your E/M services are properly reimbursed. If you encounter any issues, don't hesitate to appeal and provide detailed documentation to support your case. Staying informed and maintaining thorough records will go a long way in preventing downcoding and ensuring smooth interactions with insurance companies.**

 **Prakash V CRCP**

**Payer Policies for Medical Necessity**

**Payer policies for medical necessity refer to the guidelines and criteria used by insurance companies, government programs (like Medicare and Medicaid), and other healthcare payers to determine if a medical service, procedure, or treatment is appropriate, justified, and covered under a given healthcare plan.**

**Here is a breakdown of the key aspects:**

**1. Definition of Medical Necessity**

* **Medical Necessity typically refers to services, procedures, or treatments that are appropriate, necessary, and consistent with the diagnosis, level of care, and standards of medical practice.**
* **The service must be provided for the purpose of diagnosing, treating, or preventing an illness, injury, or condition.**
* **The procedure should be performed in the least restrictive, least invasive manner available.**



**2. Payer Policies and Criteria**

* **Payer guidelines specify what constitutes "medically necessary" in the context of a specific insurance plan.**
* **Policies may include specific diagnostic criteria, procedural codes (such as CPT or ICD codes), and evidence-based standards.**
* **For services to be covered, they must meet both the clinical guidelines and the payer’s specific policy on what is deemed medically necessary.**
* **Examples of payer types include commercial insurers (e.g., Blue Cross, Aetna), government programs (e.g., Medicare, Medicaid), and Health Maintenance Organizations (HMOs).**

**3. Common Medical Necessity Criteria**

* **Clinical Appropriateness: The treatment or service should be consistent with accepted medical practice, recognized by the medical community as effective.**
* **Cost-Effectiveness: The treatment or service should be cost-effective compared to alternatives.**
* **Clinical Evidence: The procedure should have clinical evidence supporting its benefit for a specific condition.**
* **Frequency and Duration: Policies often specify limits on how often a service or procedure can be performed or how long a treatment can continue to qualify as medically necessary.**

**4. Appeals Process**

* **If a claim is denied due to medical necessity, patients or providers can appeal the decision. This often involves submitting additional clinical documentation or evidence that supports the necessity of the treatment.**

**5. Variability Across Payers**

* **Different payers may have different policies, and what is deemed medically necessary for one payer may not be covered under another.**
* **Government Programs (Medicare/Medicaid): These programs have strict guidelines based on federal and state regulations. Services must be deemed necessary and follow specific treatment protocols.**
* **Private Insurers: They may adopt similar guidelines but often incorporate broader criteria, considering factors like the patient's overall health, evidence-based practices, and the availability of treatments.**

**6. Examples of Common Denied Medical Necessity Claims**

* **Experimental or Investigational Treatments: If a treatment is not widely accepted or supported by evidence as effective for the condition, it may not be considered medically necessary.**
* **Non-Covered Services: Some services may not be covered at all by specific insurers (e.g., cosmetic surgery, certain alternative therapies).**
* **Out-of-Network Providers: If the healthcare provider is out-of-network, the treatment may not be covered as medically necessary under the payer’s plan.**

**7. Documentation**

* **Clinical Documentation: Clear, comprehensive, and accurate documentation from healthcare providers is critical. This includes medical records, diagnostic test results, and the physician’s reasoning for the necessity of a treatment or service.**
* **Pre-authorization: Some services require pre-authorization from the payer to confirm that the service will be covered. Pre-authorization often involves submitting medical records and other information that demonstrate the medical necessity of the proposed treatment.**

**8. Factors Affecting Medical Necessity Determination**

* **Clinical guidelines from professional medical associations (e.g., the American Medical Association, National Comprehensive Cancer Network) often inform payer policies.**
* **Technology Assessments: Payers may review studies on recent technologies to determine their effectiveness and safety before deciding whether to cover them.**
* **Patient’s Health History: The patient’s specific health history and needs are always considered in determining whether a treatment is medically necessary.**

**9. Challenges and Considerations**

* **Disputes over what constitutes medical necessity can be complex, as different payers may interpret medical evidence and guidelines differently.**
* **Providers and patients often need to work closely with payers to ensure that treatments are approved and covered, especially for high-cost or specialized care.**

**In summary, payer policies for medical necessity serve as a framework to determine what treatments and services are covered under a healthcare plan. They are based on medical guidelines, cost-effectiveness, and the documented needs of the patient.**

**Uma V - CRCP**