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Practice Management Tips and Tools – "We Cannot Tell You How to Bill for That!"

Whether trying to determine what caused a claim denial or the policy coverage requirements are for a new service, there is nothing more frustrating than hearing *"We cannot tell you how to bill for that"* from an insurance customer service representative. If the representative can't tell us what the policies are, how do we figure them out? This Timely Topic provides tips and resources for finding policies that affect your practice.

The Language of Healthcare

First, it is important to understand the language of healthcare—the coding. Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding system (HCPCS) codes and modifiers are used to communicate what services were rendered. International Classification of Diseases, 10th Edition, Clinically Modified (ICD-10-CM) codes are used to communicate why services were necessary. It is essential to have the current year's information available, either in book or electronic format. Each year these code sets are revised to reflect necessary updates in the industry. Coding guidelines along with chapter introductions, code descriptions and other parenthetical notes provide vital information on how to use the codes within each code set. When submitting a claim, follow the coding rules that were/are in place at the time the service is provided.

ICD-10-CM updates are effective every year on October 1st. This latest update includes some revision to the coding guidelines and 360 new codes, 142 deleted codes and 226 revised codes. The ICD-10-CM code set and coding guidelines can be downloaded at no cost from the Centers for Medicare & Medicaid Services (CMS) website. Publications (both print and electronic) with additional information are also available for purchase from various sources.

CPT and HCPCS updates are effective on January 1st each year. The American Medical Association has released the 2018 edition of CPT. 2018 CPT has 170 new codes, 82 deleted codes, and 60 revised codes. 2018 CPT includes some significant changes in anesthesia, including 5 new codes and 5 deleted codes. The Centers for Medicare & Medicaid Services (CMS) will release the 2018 edition of HCPCS later this year.

If you do not have the resources current for this year, you may not have vital information affecting your coding, billing and payment.

ASA Resources include the Relative Value Guide®, the CROSSWALK® and the Reverse CROSSWALK®. Many payers reference these ASA resources when developing payment and clinical policies. Like CPT, HCPCS and ICD-10-CM, these resources are updated annually and are essential components in the anesthesiology and pain medicine practice's toolkit. In addition, use ASA's online resources to stay up to date with key practice management

topics: Practice Guidance Resources, Quality reporting, MACRA, Quality Improvement and other Practice Management information.

Payer Policy and Where to Find It

Once you have the foundational tools of the trade, the next step is to look at payer policy. All Medicare policy is published and easily accessible on line through Internet Only Manuals, the Medicare Coverage Database, and an expansive website with articles, transmittals, notifications, etc. As discussed in a previous Timely Topic, the Medicare Coverage Database can be used to stay abreast of all Medicare policy updates or to research specific topics. The Internet Only Manuals are the operational manuals used by CMS and its contractors to govern services, benefits, payment processing, quality management and program administration. Anesthesiology is specifically discussed the Medicare Claims Processing Manual, Chapter 12, Sections 50 and 140. CMS manuals are updated with some frequency so it is best to refer to the on-line version rather than rely on an older printed copy – with the caveat that the rules in play are those that were in effect on the date that a service was provided. CMS also has developed specific coding policy as described in the National Correct Coding Initiative Policy Manual for Medicare Services and covered in previous Timely Topics.

It is important to note that these policies apply specifically to traditional Medicare programs (Part A and Part B). While Medicare Managed Care plans (Part C), Medicaid, and other payers may reference the Medicare policies, they are not required to fully adopt them.

Each payer can develop its own policies for payment, coding and clinical coverage. While some may align closely with Medicare policies, others can differ significantly. Medicaid is an example of both of these scenarios, as we discussed in The Silent M in CMS Packs a Big Punch. Medicaid programs in each of the 50 states and six U.S. territories is responsible for developing its own policies and resources, so states vary widely in all areas of Medicaid payment and coding policy. Each state and territory also maintains it's own references and webpage so the best resources for your Medicaid program are found on your state's Medicaid website. When looking for Medicaid policies, some of the keywords/resources to look for on the state Medicaid program's website are:

- provider manual
- billing manual
- reimbursement manual
- provider notices
- physician fee schedule
- anesthesia fee schedule
- anesthesia guideline

Commercial and other third party payers also develop their own policies. While they often reference Medicare policy, they may or may not align closely with Medicare in how claims will be processed. Most payers will include their clinical, coding and payment policies in the Provider section of their websites. Some payers may still provide paper copies of policy manuals and policy change notices, but many only provide this information online. Provider-Payer contracts often include a clause that holds the provider subject to all existing and future policies as published by the payer and will refer to these policies in the event of a claims dispute.

I've Found the Policies – What's Next?

Take steps to identify which payers have the greatest impact in your practice and then research the policies developed by those payers. Understanding the applicable policies can help identify key elements in billing, coding, and clinical services requirements for your practice. Use the information to update operational processes, improve documentation and educate providers and team members as needed. Check back with your payers at least quarterly to identify any changes that may affect your practice. By following these steps, you will be able to identify "how to bill" and other information to help smooth your claims and payment processing.

This Timely Topic is the first in a series of "Practice Management Tips & Tools" focused on helping anesthesia and pain practices develop and enhance toolkits to address billing, coding and other payer related issues. Future topics in the series will include medical necessity, denial management, and appeals.