Chapter 7
Visit Charges and Compliant Billing

Chapter 8
Health Care Claim Preparation and Transmission
Visit Charges and Compliant Billing

Learning Outcomes

After studying this chapter, you should be able to:

1. Explain the importance of properly linking diagnoses and procedures on health care claims.
2. Describe the use and format of Medicare’s Correct Coding Initiative (CCI) edits.
3. Discuss types of coding and billing errors.
4. Explain major strategies that help ensure compliant billing.
5. Discuss the use of audit tools to verify code selection.
6. Describe the fee schedules that physicians create for their services.
7. Compare the usual, customary, and reasonable (UCR) and the resource-based relative value scale (RBRVS) methods of determining the fees that insurance carriers pay for providers’ services.
8. Describe the steps used to calculate RBRVS payments under the Medicare Fee Schedule.
9. Identify the three methods most payers use to pay physicians.
10. Discuss the calculation of payments for participating and non-participating providers, and describe how balance billing regulations affect the charges that are due from patients.
Although physicians have the ultimate responsibility for proper documentation, correct coding, and compliance with billing regulations, medical insurance specialists help ensure maximum appropriate reimbursement by submitting correct, accurate health care claims. The process used to generate claims must comply with the rules imposed by federal and state laws as well as with payer requirements. Correct claims help reduce the chance of an investigation of the practice for fraud and the risk of liability if an investigation does occur.

Compliant Billing

In the medical billing process, after patients' encounters, physicians prepare and sign documentation of the visit. The next step is to post the medical codes and transactions of the patient's visit in the practice management program (PMP) and to prepare claims.

Correct claims report the connection between a billed service and a diagnosis. The diagnosis must support the billed service as necessary to treat or investigate the patient's condition. Payers analyze this connection, called code linkage, to decide if the charges are for medically necessary services. Figure 7.1 on page 206 shows a completed health care claim that correctly links the diagnosis and the procedure. Review the information on the lower left of the claim to see the diagnosis codes and the procedure codes. This chapter covers basic information about billing; Chapter 8 presents the mechanics of preparing and sending claims.

Knowledge of Billing Rules

To prepare correct claims, it is important to know payers' billing rules that are stated in patients' medical insurance policies and in participation contracts. Because contracts change and rules are updated, medical insurance specialists also rely on payer bulletins, websites, and regular communications with payer representatives to keep up to date.
FIGURE 7.1 Example of a Correct Health Care Claim Showing the Linkage Between the Diagnosis and the Billed Service

In this chapter, basic claim compliance is discussed. Chapters 9 through 13 cover the specific rules for these types of payers:

- Chapter 9 Private Payers/Blue Cross and Blue Shield
- Chapter 10 Medicare
- Chapter 11 Medicaid
- Chapter 12 TRICARE and CHAMPVA
- Chapter 13 Workers’ Compensation and Disability
Medicare Regulations: The Correct Coding Initiative

The rules from the Centers for Medicare and Medicaid Services (CMS) about billing Medicare are published in the Federal Register and in CMS manuals such as the Medicare Carriers Manual and Coverage Issues Manual (see Chapter 6 and the CMS website). Especially important for billing is Medicare's national policy on correct coding, the Medicare National Correct Coding Initiative (CCI). CCI controls improper coding that would lead to inappropriate payment for Medicare claims. It has coding policies that are based on:

- Coding conventions in CPT
- Medicare's national and local coverage and payment policies
- National medical societies' coding guidelines
- Medicare's analysis of standard medical and surgical practice

CCI, updated every quarter, has many thousands of CPT code combinations called CCI edits that are used by computers in the Medicare system to check claims. The CCI edits are available on a CMS website, as shown in Figure 7.2 on page 208. CCI edits apply to claims that bill for more than one procedure performed on the same patient (Medicare beneficiary), on the same date of service, by the same performing provider. Claims are denied when codes reported together do not “pass” an edit.

CCI prevents billing two procedures that, according to Medicare, could not possibly have been performed together. Here are examples:

- Reporting the removal of an organ both through an open incision and with laparoscopy
- Reporting female- and male-specific codes for the same patient

CCI edits also test for unbundling. A claim should report a bundled procedure code instead of multiple codes that describe parts of the complete procedure. For example, since a single code is available to describe removal of the uterus, ovaries, and fallopian tubes, physicians should not use separate codes to report the removal of the uterus, ovaries, and fallopian tubes individually.

CCI requires physicians to report only the more extensive version of the procedure performed and disallows reporting of both extensive and limited procedures. For example, only a deep biopsy should be reported if both a deep biopsy and a superficial biopsy are performed at the same location.

Organization of the CCI Edits

CCI edits are organized into the following categories:

- Column 1/column 2 code pair edits
- Mutually exclusive code edits
- Modifier indicators

Column 1/Column 2 Code Pairs

In the CCI column 1/column 2 code pair edits, two columns of codes are listed. Most often, the edit is based on one code being a component of the other. This means that the column 1 code includes all the services described by the column 2 code(s), so the column 2 code(s) cannot be billed together with the column 1 code for the same patient on the same day of service. Medicare pays for the column 1 code only; the column 2 code(s) are considered bundled into the column 1 code.

EXAMPLE:

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>27370</td>
<td>20610, 76000, 76003</td>
</tr>
</tbody>
</table>
If 27370 is billed, neither 20610, 76000, nor 76003 should be billed with it, because the payment for each of these codes is already included in the column 1 code.

**Mutually Exclusive Code Edits**  
CCI mutually exclusive code (MEC) edits also list codes in two columns. According to CMS regulations, both services represented by these codes could not have reasonably been done during a single patient encounter, so they cannot be billed together. If the provider reports both codes from both columns for a patient on the same day, Medicare pays only the lower-paid code.

**EXAMPLE**

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>50021</td>
<td>49061, 50020</td>
</tr>
</tbody>
</table>

This means that a biller cannot report either 49061 or 50020 when reporting 50021.
Modifier Indicators  In CPT coding, modifiers show particular circumstances related to a code on a claim. The CCI modifier indicators control modifier use to “break,” or avoid, CCI edits. CCI modifier indicators appear next to items in both the CCI column 1/column 2 code pair list and the mutually exclusive code list. A CCI modifier indicator of 1 means that a CPT modifier may be used to bypass an edit (if the circumstances are appropriate). A CCI modifier indicator of 0 means that use of a CPT modifier will not change the edit, so the column 2 codes or mutually exclusive code edits will not be bypassed.

EXAMPLE
Flu vaccine code 90656 includes bundled flu vaccine codes 90655 and 90657–90660. It has a CCI indicator of 0. No modifier will be effective in bypassing these edits, so in every case only CPT 90656 will be paid.

Other Government Regulations
Other government billing regulations are issued by the Office of Inspector General (OIG; see Chapter 2). Annually, as part of a Medicare Fraud and Abuse Initiative, the OIG announces the OIG Work Plan for the coming year. The Work Plan lists projects for sampling particular types of billing to determine whether there are problems. Practices study these initiatives and make sure their procedures comply with billing regulations. When regulations seem contradictory or unclear, the OIG issues advisory opinions on its OIG website. These opinions are legal advice only for the requesting parties, who, if they act according to the advice, cannot be investigated on the matter. However, they are good general guidelines for all practices to follow to avoid fraud and abuse.

The OIG website also has:
- Audit reports that summarize OIG findings after problems are investigated.
- The List of Excluded Individuals/Entities (LEIE), a database that provides information about excluded parties, as shown in Figure 7.3. If employees, physicians, or contractors have been found guilty of fraud, they may be

**FIGURE 7.3** OIG Excluded Parties Website Home Page
Thinking it Through — 7.1

1. What type of code edit could be used for the following rule?

Medicare Part B covers a screening Pap smear for women for the early detection of cervical cancer but will not pay for an E/M service for the patient on the same day.

2. An OIG fraud project found that during one month in a single state, there were 23,000 billings for an E/M service with the modifier –25 reported with one of these CPT-4 codes: 11055, 11056, 11057, and 11719, and with HCPCS code G0127 (trimming of dystrophic nails).

Look up the descriptors for the CPT codes. Do you think the procedures appear to be simple or complicated?

Why do you think that this billing combination continues to be under scrutiny by CMS?

excluded from work for government programs, and their names appear on the LEIE. An OIG exclusion has national scope and is important because knowingly hiring excluded people or companies is illegal.

Private Payer Regulations

CCI edits apply to Medicare claims only. Private payers, however, develop code edits similar to the CCI. Although private payers give information about payment policies in their contracts, handbooks, and bulletins, the exact code edits may not be released. At times, their claim-editing software does not follow CPT guidelines and bundles distinct procedures or does not accept properly used modifiers. In such cases, medical insurance specialists must follow up with the payer for clarification and possible appeal of denied claims (see Chapters 9 and 14).

Compliance Errors

Health care payers often base their decisions to pay or deny claims only on the diagnosis and procedure codes. The integrity of the request for payment rests on the accuracy and honesty of the coding and billing. Incorrect work may simply be an error, or it may represent a deliberate effort to obtain fraudulent payment. Some compliance errors are related to medical necessity; others are a result of incorrect code selection or billing practices.

Errors Relating to Code Linkage and Medical Necessity

Claims are denied for lack of medical necessity when the reported services are not consistent with the diagnosis or do not meet generally accepted professional medical standards of care. Each payer has its own list of medical necessity edits. In general, codes that support medical necessity meet these
conditions:

- The CPT procedure codes match the ICD-9-CM diagnosis codes.
  
  EXAMPLE
  A procedure to drain an abscess of the external ear or auditory canal should be supported by a diagnosis of disorders of the external ear or an ear carbuncle or cyst.

- The procedures are not elective, experimental, or nonessential.
  
  EXAMPLE
  Cosmetic nasal surgery performed to improve a patient’s appearance is typically excluded. However, a cosmetic procedure may be considered medically necessary when it is performed to repair an accidental injury or to improve the functioning of a malformed body member. A diagnosis of deviated septum, nasal obstruction, acquired facial deformity, or late effects of facial bone fracture supports medical necessity for cosmetic nasal surgery.

- The procedures are furnished at an appropriate level.
  
  EXAMPLE
  A high-level Evaluation and Management code for an office visit (such as 99204/99205 and 99214/99215) must be matched by a serious, complex condition such as a sudden, unexplained large loss of weight.

Errors Relating to the Coding Process

These coding problems may cause rejected claims:

- **Truncated coding**—using diagnosis codes that are not as specific as possible
- Mismatch between the gender or age of the patient and the selected code when the code involves selection for either criterion
- **Assumption coding**—reporting items or services that are not actually documented, but that the coder assumes were performed
- Altering documentation after services are reported
- Coding without proper documentation
- Reporting services provided by unlicensed or unqualified clinical personnel
- Coding a unilateral service twice instead of choosing the bilateral code
- Not satisfying the conditions of coverage for a particular service, such as the physician’s direct supervision of a radiologist’s work

Errors Relating to the Billing Process

A number of errors are related to the billing process. These are the most frequent errors:

- Billing noncovered services
- Billing overlimit services
- Unbundling
- Using an inappropriate modifier or no modifier when one is required
- Always assigning the same level of E/M service
- Billing a consultation instead of an office visit
- Billing invalid/outdated codes
- Either **upcoding**—using a procedure code that provides a higher reimbursement rate than the correct code—or **downcoding**—using a lower level code. Some physicians downcode to be “safe,” especially E/M codes.
- Billing without proper signatures on file
Strategies for Compliance

Sending claims that generate payment at the highest appropriate level is a critical goal, but regulations can be unclear or can even conflict with each other. Compliant billing can be a difficult and complex assignment; the strategies discussed in this section are helpful.

Carefully Define Bundled Codes and Know Global Periods

To avoid unbundling, coders and medical insurance specialists must be clear on what individual procedures are contained in bundled codes and what the global periods are for surgical procedures (see Chapter 5). Many practices use Medicare’s CCI list of bundling rules and global periods for deciding what is included in a procedure code; they inform their other payers that they are following this system of edits. If the payer has a unique set of edits, coders and billers need to have access to it.

Benchmark the Practice’s E/M Codes with National Averages

Comparing the evaluation and management codes that the practice reports with national averages is a good way to monitor upcoding. Medical coding consulting firms as well as CMS and other payers have computer programs to profile average billing patterns for various types of codes. For example, reporting only the top two of a five-level E/M code range for new or established patient office visits would not fit a normal pattern and might appear fraudulent.

Use Modifiers Appropriately

CPT modifiers can eliminate any impression of duplicate billing or unbundling. Modifiers –25, –59, and –91 are especially important for compliant billing.

Modifier –25: Significant, Separately Identifiable Evaluation and Management (E/M) Service by the Same Physician on the Same Day of the Procedure or Other Service

When a procedure is performed, the patient’s condition may require the physician to perform an evaluation and management (E/M) service above and beyond the usual pre- and postoperative care associated with that procedure. In this case, modifier –25 is appended to the evaluation and management (E/M) code reported with the procedure code. The modifier –25 says that this was a significant, clearly separate E/M service by the same physician on the same day as the procedure. Note that a different diagnosis does not have to be involved.

EXAMPLE

An established patient is seen in a physician’s office for a cough, runny nose, and sore throat that started five days ago. During examination, the patient also reports right and left earaches. The physician performs an expanded problem-focused history and examination with a medical decision making of low complexity. The physician also examines the patient’s ear and performs earwax removal from the left and right ears. The patient is discharged home on antibiotics with the following diagnoses and procedures: common cold, impacted cerumen, and removal of impacted cerumen.

CPT codes on the claim are 99213–25 (covers office visit portion) and 69210 (covers removal of impacted cerumen).
Modifier –59: Distinct Procedural Service

Modifier –59 is used to indicate a procedure that was distinct or independent from other services performed on the same day. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries).

EXAMPLE

A physician performs a simple repair (2.5 centimeters in size) of a superficial wound to the right arm and also performs a partial thickness skin debridement of another site on the same arm.

CPT codes on the claim are 12001 (covers the repair of the superficial wound) and 11040–59 (covers skin debridement).

Modifier –91: Repeat Clinical Laboratory Test

Modifier –91 should be appended to a laboratory procedure or service to indicate a repeat test or procedure performed on the same day for patient management purposes. This modifier indicates that the physician or provider had to perform a repeat clinical diagnostic laboratory test that was distinct or separate from a lab panel or other lab services performed on the same day and that it was performed to obtain medically necessary subsequent reportable test values. This modifier should not be used to report repeat laboratory testing due to laboratory errors, quality control, or confirmation of results.

EXAMPLE

A patient undergoing chemotherapy for lung carcinoma has a CBC with automated platelet count performed prior to receiving chemotherapy. The patient has a very low platelet count and receives a platelet transfusion. The automated platelet count is repeated after the transfusion to determine that the platelet count is high enough for the patient to be sent home.

CPT codes on the claim are 85027 (covers automated CBC with automated platelet count) and 85049–91 (covers repeat automated platelet count).

In general, clarify coding and billing questions with physicians, and be sure that the physician adds any needed clarification to the documentation. Use the information from claims that are denied or paid at a lesser rate to modify procedures as needed.

Be Clear on Professional Courtesy and Discounts to Uninsured/Low-Income Patients

Professional Courtesy

Professional courtesy means that a physician has chosen to waive (not collect) the charges for services to other physicians and their families. Although this has been common practice in the past, many federal and state laws now prohibit professional courtesy. The routine waiver of deductibles and copays is unlawful because it results in false claims and violates antikickback rules.

Many physician practices study the OIG’s Compliance Program Guidance for Individual and Small Group Physician Practices (see Chapter 2) and then consult with an attorney to clarify their professional courtesy arrangements. The resulting guidelines should be explained to the administrative staff in the practice’s billing policies and procedures.
Discounts to Uninsured and Low-Income Patients

Many physician practices consider ability to pay when they bill patients. Under OIG guidelines, physicians may offer discounts to their uninsured and low-income patients. The practice's method for selecting people to receive discounts should be documented in the compliance plan and in its policies and procedures information.

Maintain Compliant Job Reference Aids and Documentation Templates

Many medical practices develop job reference aids, also known as cheat sheets, to help in the billing and coding process. These aids usually list the procedures and CPT codes that are most frequently billed by the practice. Some also list frequently used diagnoses with ICD codes.

Job reference aids can help select correct codes, but their use may also lead to questions about compliance. Are codes assigned by selecting those on the aid that are close to patients' conditions rather than by researching precise codes based on the documentation?

If these aids are used, these guidelines should be followed:

- Job reference aids should be dated, to be sure that current codes are in use, and reissued every year with updated codes.
- The job reference aid for CPT E/M codes must contain all the codes in a range. For example, if the E/M office visit codes are included, all ten codes should be listed (five levels each for both new and established patients).
- An aid for ICD-9-CM codes should be presented in one of two ways: (1) The aid should have only the ICD categories (three-digit numbers) to speed the code selection process, and the manual should be reviewed for the proper usage and highest degree of specificity. (2) If three-, four-, and five-digit codes are listed, the complete range should be shown, not one or two codes from the group. For example, if heartburn is to be listed, the complete range of symptoms involving the digestive system (787.0–787.99) should be shown, with the correct level of specificity shown as well.

Thinking it Through — 7.2

1. Medical necessity must be shown for emergency department visits for physicians' patients. If a four-year-old wakes at 3 A.M. with an earache and a temperature of 103°, in what order should the following diagnosis codes be listed to show the urgent reason for an emergency department visit with the child's pediatrician: 381.00, 780.6, 388.71?

2. The following diagnosis and procedure codes were rejected for payment. What is the probable reason for the payer's decision in each case?

   A. 881.1
   B. V50.3, 69090
   C. 054.79, 69145
   D. V70.0, 80050, 80053
Many practices also list CPT and ICD-9-CM codes on the office’s encounter form. In some cases, these are the only codes listed; in others, these standard codes are shown next to the accounting codes the practice uses. Encounter forms, like job reference aids, must not preselect from various codes in a range. Instead, all the code possibilities should be listed so that it is clear that all have been considered before the code is checked on the encounter form.

Some physician practices have paper or electronic forms called documentation templates to assist physicians as they document examinations (see Chapter 2). The template prompts the physician to document the review of systems (ROS) that was done and to note medical necessity. Like other forms used in medical coding, these templates must be compliant and must clearly record the work done.

## Audits

Monitoring the coding and billing process for compliance is done either by the practice’s compliance officer or by a staff member who is knowledgeable about coding and compliance regulations. The responsible person establishes a system for monitoring the process and performing regular compliance checks to ensure adherence to established policies and procedures.

An important compliance activity involves audits. An audit is a formal examination or review. An income tax audit is performed to find out if a person’s or a firm’s income or expenses were misreported. Similarly, compliance audits judge whether the practice’s physicians and coding and billing staff comply with regulations for correct coding and billing.

An audit does not involve reviewing every claim and document. Instead, a representative sample of the whole is studied to reveal whether erroneous or fraudulent behavior exists. For instance, an auditor might make a random selection, such as a percentage of the claims for a particular date, or a targeted selection, such as all claims in a period that have a certain procedure code. If the auditor finds indications of a problem in the sample, more documents and more details are usually reviewed.

### External Audits

In an external audit, private payers’ or government investigators review selected records of a practice for compliance. Coding linkage, completeness of documentation, and adherence to documentation standards, such as the signing and dating of entries by the responsible health care professional, may all be studied. The accounting records are often reviewed as well.

Payers use computer programs of code edits to review claims before they are processed. This process is referred to as a prepayment audit. For example, the Medicare program performs computer checks before processing claims. Some prepayment audits check only to verify that documentation of the visit is on file, rather than investigating the details of the coding.

Audits conducted after payment has been made are called postpayment audits. Most payers conduct routine postpayment audits of physicians’ practices to ensure that claims correctly reflect performed services, that services are billed accurately, and that the physicians and other health care providers who participate in the plan comply with the provisions of their contracts.

In a routine private-payer audit, the payer’s auditor usually makes an appointment in advance and may conduct the review either in the practice’s office or by taking copies of documents back to the payer’s office. Often, the auditor requests
the complete medical records of selected plan members for a specified period. The claims information and documentation might include all office and progress notes, laboratory test results, referrals, X-rays, patient sign-in sheets, appointment books, and billing records. When problems are found, the investigation proceeds farther and may result in charges of fraud or abuse against the practice.

Internal Audits

To reduce the chance of an investigation or an external audit and to reduce potential liability when one occurs, most practices’ compliance plans require internal audits to be conducted regularly by the medical practice staff or by a hired consultant. These audits are routine and are performed periodically without a reason to think that a compliance problem exists. They help the practice determine whether coding is being done appropriately and whether all performed services are being reported for maximum revenue. The goal is to uncover problems so that they can be corrected. They also help:

• Determine whether new procedures or treatments are correctly coded and documented
• Analyze the skills and knowledge of the personnel assigned to handle medical coding in the practice
• Locate areas where training or additional review of practice guidelines is needed
• Improve communications among the staff members involved with claims processing—medical coders, medical insurance specialists, and physicians

Internal audits are done either prospectively or retrospectively. A prospective audit (also called a concurrent audit), like a prepayment audit, is done before the claims are sent. Some practices audit a percentage of claims each day. Others audit claims for new or very complex procedures. These audits reduce the number of rejected or downcoded claims by verifying compliance before billing.

Retrospective audits are conducted after the claims have been sent and the remittance advice (RA) has been received. Auditing at this point in the process has two advantages: (1) The complete record, including the RA, is available, so the auditor knows which codes have been rejected or downcoded, and (2) there are usually more claims to sample. Retrospective audits are helpful in analyzing the explanations of rejected or reduced charges and making changes to the coding approach if needed.

Auditing Tools to Verify E/M Code Selection

As explained in Chapter 5, the key components for selecting evaluation and management codes are the extent of the history documented, the extent of the examination documented, and the complexity of the medical decision making. The 1995 and the 1997 versions of the CMS/AMA Documentation Guidelines for Evaluation and Management Services reduce the amount of subjectivity in making judgments about E/M codes, such as one person’s opinion of what makes an examination extended. They do this by describing the specific items that may be documented for each of the three key E/M components. They also explain how many items are needed to place the E/M service at the appropriate level.

The documentation guidelines have precise number counts of these items, and these counts can be used to audit as well as to initially code services. The audit double-checks the selected code based on the documentation in the patient medical record. The auditor looks at the record and, usually using an auditing tool such as that shown in Figure 7.4, independently analyzes the
### Figure 7.4 Example of Evaluation and Management Code Assignment Audit Form

<table>
<thead>
<tr>
<th>General Multi-system Exam</th>
<th>Single Organ System Exam</th>
</tr>
</thead>
</table>

#### General Multi-system Exam

<table>
<thead>
<tr>
<th>Number of Diagnoses or Treatment Options</th>
<th>1-5 elements (PROBLEM FOCUSED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 elements</td>
<td>EXPANDED PROBLEM FOCUSED</td>
</tr>
</tbody>
</table>

#### Single Organ System Exam

| ≥ 2 elements from 6 areas/systems OR ≥ 12 elements from at least 2 areas/systems | FOCUSED |
| ≥ 2 elements from 5 areas/systems | COMPREHENSIVE |

#### General Multi-system Exam

<table>
<thead>
<tr>
<th>Risk of Complications and/or Morbidity or Mortality</th>
<th>Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
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</table>

#### Single Organ System Exam

<table>
<thead>
<tr>
<th>Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>

#### Examinations

<table>
<thead>
<tr>
<th>Examination</th>
<th>Duration of Visit</th>
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#### Numbers and Complexity of Data to Be Reviewed

<table>
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<tr>
<th>Data to Be Reviewed</th>
<th>Points</th>
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#### Checking for Relevant Medical Care

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<th>Relevant Medical Care</th>
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#### Summary

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#### Exception

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#### Case Example

<table>
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#### Figure 7.4 Example of Evaluation and Management Code Assignment Audit Form (continued on next page)
### OUTPATIENT, CONSULTS (OUTPATIENT, INPATIENT & CONFIRMATORY) AND ER

<table>
<thead>
<tr>
<th>New/Consults/ER</th>
<th>Established</th>
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<td></td>
</tr>
<tr>
<td>If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.</td>
<td></td>
</tr>
</tbody>
</table>

#### History
- PF = Problem focused
- EPF = Expanded problem focused
- ER = Face-to-face in outpatient setting
- C = Comprehensive

#### Examination
- D = Detailed
- L = Low
- M = Moderate
- H = High

#### Complexity of medical decision
- SF = Straightforward
- ER: L = Expanded problem focused in outpatient setting
- ER: M = Moderate
- ER: H = High

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#### INPATIENT

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<td>If a column has 2 or 3 circles, draw a line down the column and circle the code OR draw a line down the column with the center circle and circle the code.</td>
<td></td>
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#### History
- D or C = Detailed or Comprehensive

#### Examination
- D or C = Detailed or Comprehensive

#### Complexity of medical decision
- SF/L = Straightforward or Low
- M = Moderate
- H = High

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<td>99231</td>
<td>99232</td>
<td>99233</td>
<td>99234</td>
<td>99235</td>
<td>99236</td>
</tr>
</tbody>
</table>

### FIGURE 7.4 Example of Evaluation and Management Code Assignment Audit Form (continued)

Services that are documented. The auditor then compares the code that should be selected with the code that has been reported. When the resulting codes are not the same, the auditor has uncovered a possible problem in interpreting the documentation guidelines.

Many practices use this type of audit tool to help them conduct audits in a standard way. These tools are distributed to physicians and staff members to develop internal audits, not to make initial code selections. An experienced medical insurance specialist may be responsible for using the audit tool to monitor completed claims and to audit selected claims before they are released.

**Auditing Example: Is It a Brief or Extended History of the Present Illness?**

**Selecting the Code**

As part of selecting the correct E/M code, the coder (the physician or medical coder) determines the extent of history. The overall history is problem-
focused, expanded problem-focused, detailed, or comprehensive. Part of determining this extent is based on the history of present illness (HPI). The HPI may include from none to eight factors in the patient's medical record:

- Location (where on the body the symptom is occurring)
- Quality (the character of the pain)
- Severity (the rank of the symptom or pain on a scale, such as 1 to 10)
- Duration (how long the symptom or pain has been present or how long it lasts when it occurs)
- Timing (when the symptom or pain occurs)
- Context (the situation that is associated with the pain or symptom, such as eating dairy products)
- Modifying factors (things done to make the pain or symptom change, such as using an ice pack for a headache)
- Associated signs and symptoms (other things that happen when this symptom or pain happens, such as “my chest pain makes me feel short of breath”)

Depending on the count, the HPI is either brief or extended. A brief HPI has one to three of the elements. An extended HPI has at least four of the eight elements. The coder should make this judgment on the evidence in the patient's medical record, not on recollecting or making assumptions about what was actually done. Remember, if it is not documented, it did not happen.

**Auditing the Code Selection**

After the coding is done, the auditor examines the patient's medical record and analyzes the documentation. The HPI section at the top of Figure 7.4, which matches the Documentation Guidelines counts for HPI, is as follows:

<table>
<thead>
<tr>
<th>HPI (history of present illness)</th>
<th>Brief</th>
<th>Extended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td></td>
<td>1–3 elements</td>
</tr>
<tr>
<td>Quality</td>
<td></td>
<td>4–8 elements</td>
</tr>
<tr>
<td>Severity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modifying factors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Associated signs and symptoms</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Using this tool, the auditor checks off the appropriate items for HPI:

*Patient's chief complaint:* Right shoulder pain

*History:* The patient noted a sharp pain in the right shoulder about three days ago. The pain is worse when he lies on the arm.

*Auditor's analysis:* The HPI is extended; four elements are documented, as follows:

- **Location:** Right shoulder
- **Quality:** Sharp pain
- **Duration:** Three days ago
- **Context:** Worse when lies on arm

The auditor follows the form through all its elements to verify the overall selection of the evaluation and management code.
Comparing Physician Fees and Payer Fees

Patients often have questions like “How much will my insurance pay?” “How much will I owe?” “Why are these fees different from my previous doctor’s fees?” Medical insurance specialists handle these questions based on their knowledge of the provider’s current fees and their estimates of what patients’ insurance plans will pay. Both to prepare compliant claims and to estimate what patients will owe, medical insurance specialists must be prepared to answer these key questions:

- What services are covered under the plan? Which services are not covered and therefore cannot be billed to the plan, but rather should be billed to the patient?
- What are the billing rules, fee schedules, and payment methods of the plan?
- In addition to noncovered services, what is the patient responsible for paying?

Sources for Physician Fee Schedules

Physicians establish a list of their usual fees for the procedures and services they frequently perform. Usual fees are defined as those that they charge to most of their patients most of the time under typical conditions. There are exceptions to the physician’s fee schedule. For example, workers’ compensation patients often must be charged according to a state-mandated fee schedule (see Chapter 13).

The typical ranges of physicians’ fees nationwide are published in commercial databases. For example, Figure 7.5 shows the fees for a group of CPT codes from the surgical section. The first and second columns list the CPT codes and brief descriptions of the services. The third, fourth, and fifth columns show the following amounts:

- **Column 3**: Half (50 percent) of the reported fees were higher than this fee, and the other half were lower. This is called the *midpoint* of the range.
- **Column 4**: One-quarter (25 percent) of the fees were higher than this fee, and three-quarters (75 percent) were lower.
- **Column 5**: Ten percent of the fees were higher than this fee, and 90 percent were lower.
### FIGURE 7.5 Sample Physician Fee Database

For example, in Figure 7.5, CPT 29085, Application of hand/wrist cast, columns 3, 4, and 5 show the values $86, $111, and $136. This means that half of the reporting providers charged less than $86 for this service, and half charged more. Three-quarters of the reporting providers charged less than $111 for this service, and 25 percent charged more. Ninety percent of the reporting providers charged less than $136, while only 10 percent charged more. (The sixth and seventh columns contain Medicare data, which is discussed in the RBRVS section below. That section also describes reasonable fees.)

### How Physician Fees Are Set and Managed

In every geographic area, there is a normal range of fees for commonly performed procedures. Different practices set their fees at some point along this range. They analyze the rates charged by other providers in the area, what government programs pay, and the payments of private carriers to develop their list of fees. Most try to set fees that are in line with patients' expectations so as to be competitive in attracting patients.

To keep track of whether the practice’s fees are correctly set, reports from the practice management program are studied. These reports indicate the most frequently performed services (say, the top twenty procedures) and the providers’ fees for them. This list is compared to the amounts that payers pay. If the providers’ fees are always paid in full, the fees may be set too low—below payers’ maximum allowable charges. If all fees are reduced by payers, the fees may be set too high. When the practice feels that fees are regularly too high or too low, the usual fee structure can be adjusted accordingly.

Medical insurance specialists update the practice’s fee schedules when new codes are released. When new or altered CPT codes are among those the practice reports, the fees related to them must be updated, too. For example, if the definition of a surgical package changes, a surgeon’s fees need to be altered to
tie exactly to the revised elements of the package. Or a new procedure may need to be included. Providers may refer to the national databases or, more likely, review those databases and the Medicare rate of pay to establish the needed new fees.

### Payer Fee Schedules

Payers, too, must establish the rates they pay providers. There are two main methods: charge-based and resource-based. **Charge-based fee structures** are based on the fees that providers of similar training and experience have charged for similar services. **Resource-based fee structures** are built by comparing three factors: (1) how difficult it is for the provider to do the procedure, (2) how much office overhead the procedure involves, and (3) the relative risk that the procedure presents to the patient and to the provider.

#### Usual, Customary, and Reasonable (UCR) Payment Structures

Payers that use a charge-based fee structure also analyze charges using one of the national databases. They create a schedule of UCR (**usual, customary, and reasonable**) fees by determining the percentage of the published fee ranges that they will pay. For example, a payer may decide to pay all surgical procedures reported in a specific geographical area at the midpoint of each range. These UCR fees, for the most part, accurately reflect prevailing charges. However, fees may not be available for new or rare procedures. Lacking better information, a payer may set too low a fee for such procedures.

#### Relative Value Scale (RVS)

Another payment structure is called a **relative value scale** (RVS). Historically, the idea behind an RVS was that fees should reflect the relative difficulty of procedures. If most providers agreed that procedure A took more skill, effort, or time than procedure B, procedure A could be expected to have a higher fee than procedure B.

Although it is no longer used, the California Medical Association's *California Relative Value Studies*, published from 1956 to 1974, was the foundation for the RVS approach. Providers were interviewed to determine the amounts they had charged for each procedure. They were also asked how difficult each procedure was and how much risk the procedure presented to the patient and the provider. The results of the interviews were organized into a relative value scale.

In an RVS, each procedure in a group of related procedures is assigned a **relative value** in relation to a **base unit**. For example, if the base unit is 1 and...
these numbers are assigned—limited visual field examination 0.66; intermediate visual field examination 0.91; and extended visual field examination 1.33—the first two procedures are less difficult than the unit to which they are compared. The third procedure is more difficult. The relative value that is assigned is called the relative value unit, or RVU.

To calculate the price of each service, the relative value is multiplied by a conversion factor, which is a dollar amount that is assigned to the base unit. The conversion factor is increased or decreased each year so that it reflects changes in the cost of living index.

**EXAMPLE**
The year’s conversion factor is $35.27.
The relative value of an extended visual field examination is 1.33.
This year’s price for the extended visual field examination is $35.27 \times 1.33 = $46.90.

The California Relative Value Studies eventually came under federal scrutiny and ceased to be published. It was accused of being a price-fixing book created by providers for providers. Despite the problems with this study, the relative value scale is a useful concept. Unlike providers, software companies and publishers are not restricted from gathering and publishing fee information, so the national fee databases they produce now list both UCR fees and a relative value for each procedure. Payers and providers may use the RVS factor in setting their fees.

**Resource-Based Relative Value Scale (RBRVS)**
The payment system used by Medicare is called the resource-based relative value scale (RBRVS). The RBRVS establishes relative value units for services. It replaces providers’ consensus on fees—the historical charges—with a relative value that is based on resources—what each service really costs to provide. There are three parts to an RBRVS fee:

1. **The nationally uniform RVU:** The relative value is based on three cost elements—the physician’s work, the practice cost (overhead), and the cost of malpractice insurance. Another way of stating this is that every $1.00 of charge is made up of x cents for the physician’s work, x cents for office expenses, and x cents for malpractice insurance. For example, the relative value for a simple office visit, such as to receive a flu shot, is much lower than the relative value for a complicated encounter such as the evaluation and management of uncontrolled diabetes in a patient. (Column 7 in Figure 7.5 lists the RVUs for procedures in column 1.)

2. **A geographic adjustment factor:** A geographic adjustment factor called the geographic practice cost index (GPCI) is a number that is used to multiply each relative value element so that it better reflects a geographical area’s relative costs. For example, the cost of the provider’s work is affected by average physician salaries in an area. The cost of the practice depends on things such as office rental prices and local taxes. Malpractice expense is also affected by where the work is done. The factor may either reduce or increase the relative values. For example, the GPCI lowers relative values in a rural area, where all costs of living are lower. A GPCI from a major city, where everything costs more, raises the relative values. In some states, a single GPCI applies; in others, different GPCIs are listed for large cities and for other areas.

3. **A nationally uniform conversion factor:** A uniform conversion factor is a dollar amount used to multiply the relative values to produce a payment
amount. It is used by Medicare to make adjustments according to changes in the cost of living index.

Note that when RBRVS fees are used, payments are considerably lower than when UCR fees are used. On average, according to a study done by the Medicare Payment Advisory Commission, a nonpartisan federal advisory panel, private health plans’ fees are about 15 percent higher than Medicare fees. (For example, compare columns 3, 4, and 5 with column 6 in Figure 7.5.)

**Medicare Physician Fee Schedule Updates**

Each part of the RBRVS—the relative values, the GPCI, and the conversion factor—is updated each year by CMS. The year’s Medicare Physician Fee Schedule (MPFS) is published by CMS in the Federal Register and is available on the CMS website.

Figure 7.6 shows the formula for calculating a Medicare payment. These steps are followed to apply the formula:

1. Determine the procedure code for the service.
2. Use the Medicare Fee Schedule to find the three RVUs—work, practice expense, and malpractice—for the procedure.
3. Use the Medicare GPCI list to find the three geographic practice cost indices (also for work, practice expense, and malpractice).
4. Multiply each RVU by its GPCI to calculate the adjusted value.
5. Add the three adjusted totals, and multiply the sum by the conversion factor to determine the payment.

---

**FIGURE 7.6** Medicare Physician Fee Schedule Formula

\[
\begin{align*}
\text{Work RVU} \times \text{Work GPCI} &= W \\
\text{Practice-Expense RVU} \times \text{Practice-Expense GPCI} &= PE \\
\text{Malpractice RVU} \times \text{Malpractice GPCI} &= M \\
\text{Conversion Factor} &= CF \\
(W + PE + M) \times CF &= \text{Payment}
\end{align*}
\]

**Example:**

- Work RVU = 6.39  
  Work GPCI = 0.998  
  \[6.39 \times 0.998 = W = 6.37\]
- Practice-Expense RVU = 5.87  
  Practice-Expense GPCI = 0.45  
  \[5.87 \times 0.45 = PE = 2.64\]
- Malpractice RVU = 1.20  
  Malpractice GPCI = 0.721  
  \[1.20 \times 0.721 = M = 0.86\]
- Conversion Factor = 34.54

\[
(6.37 + 2.64 + 0.86) \times 34.54 = \$340.90 \text{ Payment}
\]
Below are sample relative value units and geographic practice cost indices from a Medicare Fee Schedule. The conversion factor for this particular year is $34.7315.

### Sample RVUs

<table>
<thead>
<tr>
<th>CPT/HCPCS</th>
<th>Description</th>
<th>Work RVU</th>
<th>Practice Expense RVU</th>
<th>Malpractice Expense RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>33500</td>
<td>Repair heart vessel fistula</td>
<td>25.55</td>
<td>30.51</td>
<td>4.07</td>
</tr>
<tr>
<td>33502</td>
<td>Coronary artery correction</td>
<td>21.04</td>
<td>15.35</td>
<td>1.96</td>
</tr>
<tr>
<td>33503</td>
<td>Coronary artery graft</td>
<td>21.78</td>
<td>26</td>
<td>4.07</td>
</tr>
<tr>
<td>99203</td>
<td>OV new detailed</td>
<td>1.34</td>
<td>0.64</td>
<td>0.05</td>
</tr>
<tr>
<td>99204</td>
<td>OV new comprehensive</td>
<td>2.00</td>
<td>0.96</td>
<td>0.06</td>
</tr>
</tbody>
</table>

### Sample GPCIs

<table>
<thead>
<tr>
<th>Locality</th>
<th>Work GPCI</th>
<th>Practice Expense GPCI</th>
<th>Malpractice Expense GPCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Francisco, CA</td>
<td>1.067</td>
<td>1.299</td>
<td>0.667</td>
</tr>
<tr>
<td>Manhattan, NY</td>
<td>1.093</td>
<td>1.353</td>
<td>1.654</td>
</tr>
<tr>
<td>Columbus, OH</td>
<td>0.990</td>
<td>0.939</td>
<td>1.074</td>
</tr>
<tr>
<td>Galveston, TX</td>
<td>0.988</td>
<td>0.970</td>
<td>1.386</td>
</tr>
</tbody>
</table>

Calculate the expected payments for:

1. Office visit, new patient, detailed history/examination, low-complexity decision making, in Manhattan, NY ______
2. Coronary artery graft in San Francisco, CA ______
3. Repair heart vessel fistula in Columbus, OH ______
4. Coronary artery correction in Galveston, TX ______

### Payment Methods

In addition to setting various fee schedules, payers use one of three main methods to pay providers:

1. Allowed charges
2. Contracted fee schedule
3. Capitation

### Allowed Charges

Many payers set an **allowed charge** for each procedure or service. This amount is the most the payer will pay any provider for that CPT code. Whether a provider actually receives the allowed charge depends on three things:

1. *The provider's usual charge for the procedure or service:* The usual charge on the physician's fee schedule may be higher than, equal to, or lower than the allowed charge.
2. The provider’s status in the particular plan or program: The provider is either participating or nonparticipating (see Chapter 3). Participating (PAR) providers agree to accept allowed charges that are lower than their usual fees. In return, they are eligible for incentives, such as quicker payments of their claims and more patients.

3. The payer’s billing rules: These rules govern whether the provider can bill a patient for the part of the charge that the payer does not cover.

When a payer has an allowed charge method, it never pays more than the allowed charge to a provider. If a provider’s usual fee is higher, only the allowed charge is paid. If a provider’s usual fee is lower, the payer reimburses that lower amount. The payer’s payment is always the lower of the provider’s charge or the allowed charge.

EXAMPLE
The payer’s allowed charge for a new patient’s evaluation and management (E/M) service (CPT 99204) is $160.

\[ \text{Provider A Usual Charge} = \$180 \quad \text{Payment} = \$160 \]
\[ \text{Provider B Usual Charge} = \$140 \quad \text{Payment} = \$140 \]

Whether a participating provider can bill the patient for the difference between a higher physician fee and a lower allowed charge—called balance billing—depends on the terms of the contract with the payer. Payers’ rules may prohibit participating providers from balance billing the patient. Instead, the provider must write off the difference, meaning that the amount of the difference is subtracted from the patient’s bill as an adjustment and never collected.

For example, Medicare-participating providers may not receive an amount greater than the Medicare allowed charge from the Medicare Physician Fee Schedule. Medicare is responsible for paying 80 percent of this allowed charge (after patients have met their annual deductibles; see Chapter 10). Patients are responsible for the other 20 percent.

EXAMPLE
A Medicare PAR provider has a usual charge of $200 for a diagnostic flexible sigmoidoscopy (CPT 45330), and the Medicare allowed charge is $84. The provider must write off the difference between the two amounts. The patient is responsible for 20 percent of the allowed charge, not of the provider’s usual charge:

Provider’s usual fee: $200.00
Medicare allowed charge: $84.00
Medicare pays 80%: $67.20
Patient pays 20%: $16.80

The total the provider can collect is $84. The provider must make an adjustment to the patient’s account to write off the $116 difference between the usual fee and the allowed charge.

A provider who does not participate in a private plan can usually balance bill patients. In this situation, if the provider’s usual charge is higher than the allowed charge, the patient must pay the difference. However, Medicare and other government-sponsored programs have different rules for nonparticipating providers, as explained in Chapters 10 through 12.

EXAMPLE
Payer policy: There is an allowed charge for each procedure. The plan provides a benefit of 100 percent of the provider’s usual charges up to this maximum fee. Provider A is a participating provider; Provider B does not participate and can
balance bill. Both Provider A and Provider B perform abdominal hysterectomies (CPT 58150). The policy's allowed charge for this procedure is $2,880.

Provider A (PAR)
Provider's usual charge $3,100.00
Policy pays its allowed charge $2,880.00
Provider writes off the difference between the usual charge and the allowed charge: $ 220.00

Provider B (nonPAR)
Provider's usual charge $3,000.00
Policy pays its allowed charge $2,880.00
Provider bills patient for the difference between the usual charge and the allowed charge; there is no write-off: ($3,000.00 – $2,880.00)

Coinsurance provisions in many private plans provide for patient cost-sharing. Rather than paying the provider the full allowed charge, for example, a plan may require the patient to pay 25 percent, while the plan pays 75 percent. In this case, if a provider's usual charges are higher than the plan's allowed charge, the patient owes more for a service from a nonparticipating provider than from a participating provider. The calculations are explained below.

EXAMPLE
Payer policy: A policy provides a benefit of 75 percent of the provider's usual charges, and there is a maximum allowed charge for each procedure. The patient is responsible for 25 percent of the maximum allowed charge. Balance billing is not permitted for plan participants.

Provider A is a participating provider, and Provider B is a nonparticipant in the plan. Provider A and Provider B both perform total abdominal hysterectomies (CPT 58150). The policy's allowed charge for this procedure is $2,880.00.

Provider A (PAR)
Usual charge $3,100.00
Policy pays 75% of its allowed charge $2,160.00
(75% of $2,880.00)
Patient pays 25% of the allowed charge $ 720.00
(25% of $2,880.00)
Provider writes off the difference between the usual charge and the allowed charge: $ 220.00

Provider B (nonPAR)
Usual charge $3,000.00
Policy pays 75% of its allowed charge $2,160.00
(75% of $2,880.00)

Patient pays for:
(1) 25% of the allowed charge + $ 720.00
(25% of $2,880.00)
(2) the difference between the usual charge and the allowed charge: $ 120.00
($3,000.00 – $2,880.00)

Patient pays $840.00 ($720.00 + $120.00)
The provider has no write-off
Contracted Fee Schedule

Some payers, particularly those that contract directly with providers, establish fixed fee schedules with participating providers. They first decide what they will pay in particular geographical areas and then offer participation contracts with those fees to physician practices. If the practice chooses to join, it agrees by contract to accept the plan's fees for its member patients.

The plan's contract states the percentage of the charges, if any, its patients owe, and the percentage the payer covers. Participating providers can typically bill patients their usual charges for procedures and services that are not covered by the plan.

Capitation

The fixed prepayment for each plan member in a capitation contract (see Chapter 1), called the capitation rate or cap rate, is determined by the managed care organization that contracts with providers.

Setting the Cap Rate

To determine the cap rate, the plan first decides on the allowed charges for the contracted services and then analyzes the health-related characteristics of the plan's members. The plan calculates the number of times each age group and gender group of members is likely to use each of the covered services. For example, if the primary care provider (PCP) contract covers obstetrics and a large percentage of the group's members are young women who are likely to require services related to childbirth, the cap rate is higher than for a group of members containing a greater percentage of men or of women in their forties or fifties who are not as likely to require obstetrics services.

The plan's contract with the provider lists the services and procedures that are covered by the cap rate. For example, a typical contract with a primary care provider might include the following services:

- Preventive care: well-child care, adult physical exams, gynecological exams, eye exams, and hearing exams
- Counseling and telephone calls
- Office visits
- Medical care: medical care services such as therapeutic injections and immunizations, allergy immunotherapy, electrocardiograms, and pulmonary function tests
- Local treatment of first-degree burns, application of dressings, suture removal, excision of small skin lesions, removal of foreign bodies or cerumen from external ear
These services are covered in the per-member charge for each plan member who selects the PCP. This cap rate, usually a prepaid monthly payment (per member per month, or PMPM), may be a different rate for each category of plan member, as shown in Table 7.1, or an average rate. To set an average rate, the monthly capitation rate for each member profile is added, and the total is divided by the number of member profiles.

Noncovered services can be billed to patients using the provider’s usual rate. Plans often require the provider to notify the patient in advance that a service is not covered and to state the fee for which the patient will be responsible.

**Provider Withholds**

Some managed care plans may also require a provider withhold from their participating providers. Under this provision of their contract with the provider, the plan withholds a percentage, such as 20 percent, from every payment to the provider. The amount withheld is supposed to be set aside in a fund to cover unanticipated medical expenses of the plan. At the close of a specified period, such as a year, the amount withheld is returned to the provider if the plan’s financial goals have been achieved. Some plans pay back withholds depending on the overall goals of the plan, and some pay according to the individual provider’s performance against goals.

<table>
<thead>
<tr>
<th>Member Profile</th>
<th>Monthly Capitation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–2 Years, M/F</td>
<td>$30.10</td>
</tr>
<tr>
<td>2–4 Years, M/F</td>
<td>$8.15</td>
</tr>
<tr>
<td>5–19 Years, M/F</td>
<td>$7.56</td>
</tr>
<tr>
<td>20–44 Years, M</td>
<td>$8.60</td>
</tr>
<tr>
<td>20–44 Years, F</td>
<td>$16.66</td>
</tr>
<tr>
<td>45–64 Years, M</td>
<td>$17.34</td>
</tr>
<tr>
<td>45–64 Years, F</td>
<td>$24.76</td>
</tr>
<tr>
<td>Over 65 Years, M, Non-Medicare</td>
<td>$24.22</td>
</tr>
<tr>
<td>Over 65 Years, F, Non-Medicare</td>
<td>$27.32</td>
</tr>
<tr>
<td>Over 65, M, Medicare Primary</td>
<td>$10.20</td>
</tr>
<tr>
<td>Over 65, F, Medicare Primary</td>
<td>$12.05</td>
</tr>
</tbody>
</table>

**TABLE 7.1 Example of a Capitation Schedule**

Thinking it Through — 7.7

1. In Table 7.1, which category of plan member does the plan consider likely to use the most medical services in a given period? The fewest services?

2. If the capitation schedule in Table 7.1 is used to calculate an average payment per patient, what is the average cap rate?
Review

Steps to Success

❒ Read this chapter and review the Key Terms and the Chapter Summary.

❒ Answer the Review Questions and Applying Your Knowledge in the Chapter Review.

❒ Access the chapter’s websites and complete the Internet Activities to learn more about available professional resources.

❒ Complete the related chapter in the Medical Insurance Workbook to reinforce your understanding of visit charges and compliant billing.

Chapter Summary

1. Diagnoses and procedures must be correctly linked on health care claims because payers analyze this connection to determine the medical necessity of the charges. Correct claims also comply with all applicable regulations and requirements. Codes should be appropriate and documented as well as compliant with each payer’s rules.

2. The Medicare National Correct Coding Initiative (CCI) edits are computerized screenings designed to deny claims that do not comply with Medicare’s rules on claims for more than one procedure performed on the same patient (Medicare beneficiary), on the same date of service, by the same performing provider. The three types of edits are: (a) column 1/column 2 pair codes, in which the first column’s code includes any codes in the second column, which should not be billed separately; (b) mutually exclusive edits, which list code pairs that will not both be paid for the same date of service; and (c) modifier indicators, which note whether the appropriate use of a CPT modifier will allow the claim to bypass the edit.

3. Claims are rejected or downcoded because of (a) medical necessity errors, (b) coding errors, and (c) errors related to billing.

4. Major strategies to ensure compliant billing are to (a) carefully define bundled codes and know global periods, (b) benchmark the practice’s E/M codes with national averages, (c) keep up to date through ongoing coding and billing education, (d) be clear on professional courtesy and discounts to uninsured/low-income patients, (e) maintain compliant job reference aids and documentation templates, and (f) audit the billing process.

5. Payer audits are routine external audits that are conducted to ensure practice compliance with coding and billing regulations. Prospective internal audits help the practice reduce the possibility that coding compliance errors will cause claims to be rejected or downcoded. Retrospective internal audits are used to analyze feedback from payers, identify problems, and address problems with additional training and better communication. E/M codes, because they are so frequently used, are an ongoing audit focus. Practices should conduct internal audits of their E/M claims using audit tools based on the joint CMS/AMA Documentation Guidelines for Evaluation and Management Services. This audit process highlights possible problems with the practice’s interpretation of the guidelines or documentation approach.

6. Physicians set their fee schedules in relation to the fees that other providers charge for similar services.

7. Fee structures for providers’ services are either charge-based or resource-based. Charge-based structures, such as UCR (usual, customary, and reasonable), are based on the fees that many providers have charged for similar services. Relative value scales (RVS) account for the relative difficulty of procedures by comparing the skill involved in each of a group of procedures. An RVS is charge-based if the charges that are attached to the relative values are based on histor-
Medical fees. Resource-based relative value scales (RBRVS), such as the Medicare Physician Fee Schedule (MPFS), are built by comparing three cost factors: (a) how difficult it is for the provider to do the procedure, (b) how much office overhead the procedure involves, and (c) the relative risk that the procedure presents to the patient and the provider. Both charge-based and resource-based fee structures are affected by the geographical area in which the service is provided.

8. The following steps are used to calculate RBRVS payments under the MPFS: (a) determine the procedure code for the service; (b) use the MPFS to find the three RVUs—work, practice expense, and malpractice—for the procedure; (c) use the Medicare GPCI list to find the three geographic practice cost indices (also for work, practice expense, and malpractice); (d) multiply each RVU by its GPCI to calculate the adjusted value; (e) add the three adjusted totals, and multiply the sum by the annual conversion factor to determine the payment.

9. Most payers use one of three provider payment methods: allowed charges, contracted fee schedules, or capitation. When a maximum allowed charge is set by a payer for each service, a provider does not receive the difference from the payer if the provider's usual fee is greater. If the provider participates in the patient's plan, the difference is written off; if the provider does not participate, the plan's rules on balance billing determine whether the patient is responsible for the amount. Under a contracted fee schedule, the allowed charge for each service is all that the payer or the patient pays; no additional charges can be collected. Under capitation, the health care plan sets a capitation rate that pays for all contracted services to enrolled members for a given period.

10. Payments to participating providers are limited to the allowed charge. Some part of that amount is paid by the payer and some part by the patient according to the coinsurance provisions of the plan. Nonparticipating providers in most private plans (but not government-sponsored plans) can collect their usual fees, even when they are higher than the allowed charges, by receiving the specified part of an allowed charge from the payer and the rest of the allowed charge, plus the balance due resulting from a lower allowed charge and a higher usual charge, from the patient.

### Review Questions

Match the key terms with their definitions.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>edits</td>
</tr>
<tr>
<td>B.</td>
<td>downcoding</td>
</tr>
<tr>
<td>C.</td>
<td>capitation rate</td>
</tr>
<tr>
<td>D.</td>
<td>usual fee</td>
</tr>
<tr>
<td>E.</td>
<td>allowed charge</td>
</tr>
<tr>
<td>F.</td>
<td>prospective audit</td>
</tr>
<tr>
<td>G.</td>
<td>balance billing</td>
</tr>
<tr>
<td>H.</td>
<td>write-off</td>
</tr>
<tr>
<td>I.</td>
<td>conversion factor</td>
</tr>
<tr>
<td>J.</td>
<td>OIG Work Plan</td>
</tr>
<tr>
<td>1.</td>
<td>Fee for a service or procedure that is charged by a provider for most patients under typical circumstances</td>
</tr>
<tr>
<td>2.</td>
<td>The maximum charge allowed by a payer for a specific service or procedure</td>
</tr>
<tr>
<td>3.</td>
<td>If the provider's usual fee is higher than the payer's allowed charge, the provider collects the difference from the insured, rather than writing it off</td>
</tr>
<tr>
<td>4.</td>
<td>The amount that a participating provider must deduct from a patient's account because of a contractual agreement to accept a payer's allowed charge</td>
</tr>
<tr>
<td>5.</td>
<td>The contractually set periodic prepayment amount to a provider for specified services to each enrolled plan member</td>
</tr>
<tr>
<td>6.</td>
<td>An internal audit conducted before claims are reported to payers</td>
</tr>
<tr>
<td>7.</td>
<td>A payer's review and reduction of a procedure code to a lower value than reported by the provider</td>
</tr>
<tr>
<td>8.</td>
<td>The OIG's annual list of planned projects under the Medicare Fraud and Abuse Initiative</td>
</tr>
<tr>
<td>9.</td>
<td>A computerized system used to screen claims</td>
</tr>
<tr>
<td>10.</td>
<td>Dollar amount used to multiply a relative value unit to arrive at a charge</td>
</tr>
</tbody>
</table>
Decide whether each statement is true or false.

1. Resource-based fee structures are based on the procedure’s difficulty, the practice expense it involves, and the risk it entails. **True**

2. The Medicare Fee Schedule is based on the UCR method of setting charges. **False**

3. The geographic practice cost index (GPCI) is used to adjust each of the cost elements when a Medicare charge is calculated. **True**

4. The Medicare Fee Schedule’s conversion factor is set for a one-year period. **True**

5. If a provider’s usual fee is higher than a payer’s allowed charge, the higher of the two fees is paid. **True**

6. If a payer’s allowed charge is higher than a provider’s usual fee, the higher of the two fees is paid. **False**

7. If a payer does not permit a provider to balance bill a patient, the provider must write off the difference between the usual fee and the amount paid. **True**

8. Managed care capitation rates are based on the services that the group of members is likely to use. **True**

9. Under Medicare rules, no modifiers can be used with code combinations listed in the CCI. **False**

10. During an audit, all the claims from a particular period are usually examined. **False**

Select the letter that best completes the statement or answers the question.

1. The OIG Work Plan describes
   A. planned projects for investigating possible fraud in various billing areas **Correct**
   B. legislative initiatives under HIPAA
   C. the FBI’s investigations
   D. the current cases that are being prosecuted by the OIG’s attorneys

2. Under Medicare’s code edits, mutually exclusive codes
   A. can be billed together if they are component codes **Correct**
   B. can be billed together if they have a –1 modifier code attached
   C. cannot be billed together for the same patient on the same day
   D. cannot be billed more than once by a single provider on the same date of service

3. Based on the RVU table on page 225, the smallest cost element in most Medicare RBRVS fees is
   A. malpractice expense
   B. practice expense **Correct**
   C. work expense
   D. customary expense

4. In calculations of RBRVS fees, the three relative value units are multiplied by
   A. their respective geographic practice cost indices **Correct**
   B. the neutral budget factor
   C. the national conversion factor
   D. the UCR factor

5. Medicare typically pays for what percentage of the allowed charge?
   A. 50 percent **Correct**
   B. 60 percent
   C. 70 percent
   D. 80 percent
6. If a participating provider’s usual fee is $400 and the allowed amount is $350, what amount is written off?
   A. zero
   B. $25
   C. $50
   D. $75

7. If a nonparticipating provider’s usual fee is $400, the allowed amount is $350, and balance billing is permitted, what amount is written off?
   A. zero
   B. $25
   C. $50
   D. $75

8. If a nonparticipating provider’s usual fee is $400, the allowed amount is $350, and balance billing is not permitted, what amount is written off?
   A. zero
   B. $25
   C. $50
   D. $75

9. The usual fees for excluded services are
   A. written off
   B. collected at the time of service
   C. subtracted from the annual deductible
   D. subject to balance billing rules

10. An encounter form containing E/M codes should list
    A. the most frequently billed codes
    B. just blanks, so the correct E/M code can be entered
    C. complete ranges of codes for each type or place of service listed
    D. none of the above

Answer the following questions.

1. What is the formula for calculating a RBRVS charge using the Medicare Physician Fee Schedule?

2. Define the following abbreviations:
   A. CCI
   B. GPCI
   C. MPFS
   D. UCR
   E. RVS
   F. RBRVS
Applying Your Knowledge

Case 7.1 Auditing Linkage

A. Are the following procedure and diagnostic codes appropriately linked? If not, what is (are) the error(s)?

<table>
<thead>
<tr>
<th>CPT</th>
<th>ICD-9-CM</th>
<th>LINKED?</th>
</tr>
</thead>
<tbody>
<tr>
<td>76091</td>
<td>V76.12</td>
<td>LINKED?</td>
</tr>
<tr>
<td>99214</td>
<td>V54.8</td>
<td></td>
</tr>
<tr>
<td>57284</td>
<td>601.1, 041.1</td>
<td></td>
</tr>
<tr>
<td>96408</td>
<td>V58.1, 233.0</td>
<td></td>
</tr>
<tr>
<td>99203, 72040, 73600</td>
<td>824.2, 847.0, E888, E849.4</td>
<td></td>
</tr>
</tbody>
</table>

B. A forty-year-old established female patient is having an annual checkup. During the examination, her physician identifies a lump in her left breast. The physician considers this a significant finding and performs the key components of a problem-focused E/M service. These four codes and modifier should be reported. In what order should they be listed?

CPT codes: 99212, 99396
ICD codes: V70.0, 611.72
Modifier: –25

Case 7.2 Calculating Expected Charges

Using the sample relative value units and GPCIs shown on page 225 and a conversion factor of $34.7315, calculate the expected charge for each of the following services:

A. CPT 99204 in Galveston, TX

B. CPT 33502 in Manhattan, NY

C. CPT 99203 in Columbus, OH

Case 7.3 Calculating Insurance Math

Dr. Mary Mandlebaum is a PAR provider in Medicare and in Mountville Health Plan, which has allowed charges for services and does not permit balance billing of plan members. She is not a PAR provider in the Ringdale Medical Plan. Based on the following table of charges, calculate the charges that the payer and the patient will pay in each of the situations. Show your calculations.
### Service Charges and Compliant Billing

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT</th>
<th>Usual Charge</th>
<th>Mountville Health Plan Allowed Charge</th>
<th>Medicare Allowed Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office/Outpatient Visit, New, Min.</td>
<td>99201</td>
<td>$54</td>
<td>$48</td>
<td>$43</td>
</tr>
<tr>
<td>Office/Outpatient Visit, New, Low</td>
<td>99202</td>
<td>$73</td>
<td>$65</td>
<td>$58</td>
</tr>
<tr>
<td>Office/Outpatient Visit, New, Mod.</td>
<td>99203</td>
<td>$100</td>
<td>$89</td>
<td>$80</td>
</tr>
<tr>
<td>Office/Outpatient Visit, New, Mod.</td>
<td>99204</td>
<td>$147</td>
<td>$129</td>
<td>$116</td>
</tr>
<tr>
<td>Office/Outpatient Visit, New, High</td>
<td>99205</td>
<td>$190</td>
<td>$168</td>
<td>$151</td>
</tr>
<tr>
<td>Office/Outpatient Visit, Est., Min.</td>
<td>99211</td>
<td>$29</td>
<td>$26</td>
<td>$22</td>
</tr>
<tr>
<td>Office/Outpatient Visit, Est., Low</td>
<td>99212</td>
<td>$44</td>
<td>$39</td>
<td>$35</td>
</tr>
<tr>
<td>Office/Outpatient Visit, Est., Mod.</td>
<td>99213</td>
<td>$60</td>
<td>$54</td>
<td>$48</td>
</tr>
<tr>
<td>Office/Outpatient Visit, Est., Mod.</td>
<td>99214</td>
<td>$87</td>
<td>$78</td>
<td>$70</td>
</tr>
<tr>
<td>Office/Outpatient Visit, Est., High</td>
<td>99215</td>
<td>$134</td>
<td>$119</td>
<td>$107</td>
</tr>
<tr>
<td>Rhythm ECG with Report</td>
<td>93040</td>
<td>$30</td>
<td>$36</td>
<td>$30</td>
</tr>
<tr>
<td>Breathing Capacity Test</td>
<td>94010</td>
<td>$83</td>
<td>$69</td>
<td>$58</td>
</tr>
<tr>
<td>DTAP Immunization</td>
<td>90700</td>
<td>$102</td>
<td>$87</td>
<td>$74</td>
</tr>
</tbody>
</table>

**A.** Insurance Plan: Mountville Health Plan; patient has met annual deductible of $250; 80–20 coinsurance

Services: CPT 99203, 90700

Payer Reimbursement: _______ Patient Charge: _______

**B.** Insurance Plan: Mountville Health Plan; patient has paid $125 toward an annual deductible of $500; 80–20 coinsurance

Services: CPT 99215, 93040, 94010

Payer Reimbursement: _______ Patient Charge: _______

**C.** Insurance Plan: Ringdale Medical Plan A; no deductible or coinsurance; copayment of $5/PAR; $25/NonPAR

Services: CPT 99212

Payer Reimbursement: _______ Patient Charge: _______

**D.** Insurance Plan: Ringdale Medical Plan B; patient has met annual deductible of $300; 80–20 coinsurance

Services: CPT 99215

Payer Reimbursement: _______ Patient Charge: _______

**E.** Payer Reimbursement: _______ Patient Charge: _______
Internet Activities

   a. Click "What’s New." Select a recent audit, and prepare a report summarizing its major points.
   b. Using the search feature, locate a recent OIG Work Plan. Report on five points listed under “Medicare Physicians and Other Health Professionals.”

2. At the CMS website, http://www.cms.hhs.gov/PhysicianFeeSched/, read and accept the CPT copyright notice, and then click start on the Medicare Physician Payment Systems page.
   After selecting Single HCPC Code and RVU, accept Default on the next screen. When prompted, enter 63012. View and record the description and RVU for the CPT code.

3. Visit the CMS website and search for information on this year’s conversion factor for the Medicare Fee Schedule. Using this current factor, recalculate the math in the example that is shown in Figure 7.6 on page 224 to find the payment for this year.