Podcast Transcript

Title: Common Miscoding of LARC Services Impacting Revenue Updated for October 1, 2016 Changes
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NCTCFP: Welcome to this podcast sponsored by the National Clinical Training Center for Family Planning. The National Clinical Training Center for Family Planning is one of the training centers funded through the Office of Population Affairs to provide training to enhance the knowledge of family planning staff. Our guest speaker today is Ann Finn from Ann Finn Consulting LLC. Ann will be talking about the common miscoding of LARC services impacting revenue. Ann is a healthcare reimbursement consultant and a national trainer with many reproductive health care organizations. Welcome, Ann!

Ann Finn: Thank you very much for the introduction and thanks for joining us. Today's podcast will focus on commonly miscoded LARC or long acting reversible contraceptive services, which include IUDs and implants.

Improper coding of services may lead to a reduction in reimbursement or an unintended over-payment of services which may open a provider to payer audits and payment take-backs when billing for services. Both are detrimental to a practice's fiscal health.

When coding and billing for LARC services, we need to first properly and fully document the services provided during the clinical visit.

- Did the patient present seeking contraception but was not sure what birth control method is a best fit?
- Did she present wanting an IUD or an implant based on her prior knowledge, her research or counseling received in another setting such as her primary care visit?
- Or, did she present for a scheduled LARC insertion procedure after receiving contraceptive counseling on a prior date?

Each of these services frequently takes place in a busy family planning clinic and each scenario would be coded and typically reimbursed differently.

So, let's start with the first scenario. Maggie is a 19 year old female patient who recently became sexually active. She has had unprotected sex since her last menstrual period and is worried about an unintended pregnancy. Maggie is not sure what method of contraception she would like so she and her clinical provider discuss the variety of methods available, their effectiveness, and potential side effects.

During her visit, Maggie has her vitals taken but a further exam is deferred. The majority of time during the clinical visit is spent counseling. After discussing these options, Maggie decides she would like an IUD. Maggie is given a urine pregnancy test, which is

negative. The provider is able then to successfully insert the IUD. So, what codes would we need to bill this visit and where do we see miscoding?

First we need to capture the contraceptive counseling service and tell the payer it is separate and distinct from the actual LARC insertion procedure. Depending on the extent of services provided, and the codes the payer accepts, the clinician may code a preventive evaluation and management or E/M code, a problem-oriented E/M code or a preventive counseling code for the contraceptive options counseling.

E/M visit codes are dependent on whether a patient is new to your practice or established, and new patient visits are typically reimbursed at a higher rate than an established patient. So what defines new to your practice?

According to the Current Procedural Terminology or CPT ® instructions, a new patient is one who has NOT received any professional services from the physician or qualified health care professional or another physician or qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice within the past three years. This includes prior face-to-face services such as counseling, medical visit, or surgical procedure.

Improper coding of new vs. established patients impacts payment so it is important to ensure accuracy here.

How does a clinician in your practice know if the patient is new or established when coding a visit? Some systems pull this information into the top of the chart note which is really helpful to the provider for coding.

Preventive E/M codes are also based on the patient's age during the visit, which also must be documented. Problem oriented E/M codes are assigned based on either 1) the 3 key components of a visit including: the history taken, examination done and the medical decision making involved in the patient care, or 2) on the amount of time the clinician spends face-to-face with the patient when greater than 50% of this part of the visit is documented as counseling.

Remember, new patients require all 3 of the 3 key components be factored into picking the level of code for the visit, whereas an established patient or one who has been seen within the last 3 years, only requires 2 of the 3 key components.

Let's think about Maggie's visit as a new patient. Our clinician documents a detailed history and a moderate level of medical decision making, but the patient only had her vitals taken with no further exam documented. The IUD insertion is separate from the E/M. This low level problem-focused exam for a new patient does not qualify for a code higher than a level 1 outpatient visit or a 99201. But, our clinician spent a great deal of time counseling the patient. To use time for E/M assignment, the clinician needs to document both their total face-to-face time and that greater than 50% of the time was spent counseling the patient. Based on using time, the E/M level may qualify for a level 2 or 3 visit, leading to increased reimbursement since payers typically pay more for a higher level visit.

How do we tell the payer the services were separate and distinct from each other and both should be reimbursed?

Adding a 2 digit modifier code to the existing CPT code alerts the payer that there was a special circumstance when the service was provided. In Maggie's case, we bill four service different codes, each associated with an ICD-10 code to tell the payer why we performed these services. For Maggie, we bill the LARC insertion CPT code; the LARC device; the point-of-care pregnancy test and a separate E/M code, or counseling visit code, with a modifier 25 to signify to the payer that the counseling was separate and distinct from the insertion procedure that was billed. Remember, Maggie received counseling on several method types prior to deciding on the IUD.

Without the modifier 25 on an E/M billed with a procedure to alert the payer of these 2 distinct services, the payer often bundles the services together which leads to reduced reimbursement.

Let's recap where we potentially see miscoding for Maggie's visit:

- Missing codes – for Maggie's visit we would need an E/M code for the contraceptive counseling plus a LARC procedure code plus the LARC device plus any point of care tests done during the visit to ensure full reimbursement.
- Over or under coding of E/M services based on new versus established patient status.
- Over or under coding of E/M services based on the 3 key components versus counseling time.
- E/M assignment based on time without both the total face-to-face time and that 50% or more was spent counseling the patient both documented in the patient's chart.
- Missed modifiers to tell the payer special circumstances.
- Lab tests performed without documented medical necessity. Remember, in Maggie's case, the clinician had noted unprotected sex so the clinician did a UPT test, but not all patients may need to have this test done to start contraception.
- Missing ICD-10 codes to support the medical necessity of each service provided such as a Z30.09 for the contraceptive options counseling, a Z30.430 for the IUD insertion, and a Z32.02 for the negative pregnancy test result.

Let's look at our second scenario. What if Maggie presents wanting an IUD or an implant? Our clinician reviews the effectiveness of the method and potential side effects and inserts the LARC. Should the clinician report an E/M along with the LARC insertion?

- In this case, the answer is no. The E/M and contraceptive counseling was not significant, and separate and distinct from the IUD procedure. Billing an E/M here would be a case of over-reporting of services.

How about our 3rd scenario where Maggie presents for a scheduled LARC insertion? Would we report an E/M with the LARC procedure here?

- Again, the answer is no. The contraceptive options counseling took place at a prior visit and was already billed. Billing an E/M here would also create an over-reporting of services.

What if Maggie presents to have a new IUD reinserted?

IUD reinsertions require 2 CPT codes to be reported for proper reimbursement. We would report both CPT code 58301 for the IUD removal and then CPT code 58300 for the IUD reinsertion. What happens if we submit these codes without a modifier to tell the payer we are reporting multiple procedures?

- Without a modifier 51 or 59 for multiple or distinct procedures appended to the lower paying service, the second procedure typically bundles into that first procedure and does not pay separately resulting in an underpayment.
- With the correct modifier appended, a second procedure will typically pay 50% in addition to the full payment for the first procedure.
- Missed codes for removals also mean missed revenue. Ensure there is a CPT code reported for every service documented in the medical record.
- Include an ICD-10 code from the family of codes under Z30.43 that are used to describe IUD procedures. There are distinct codes for IUD insertions, routine checking, removals and reinsertions in this grouping.
- Billing staff should understand coding of services, including modifier usage and expected payment of services, to ensure all missed revenue is recognized and correctly resubmitted to a payer in a timely manner.

Okay, so what if Maggie is having a LARC inserted and the clinician needs to stop the procedure due to the patient having a problem such as severe pain or the device is unusable?

- In both these cases, we would still bill for the procedure, but again, we need a modifier to tell the payer, "Hey, we attempted the procedure, did a lot of the work, but we needed to stop."
- By appending a modifier 52 or 53 for a reduced service to the LARC procedure CPT code and coding ICD-10 code to explain any complications, a payer may often reimburse a significant portion of the expected payment for a failed insertion. If you bill for a full insertion and then the patient presents for a second attempted insertion at the following visit, a payer may reject that 2nd claim in full as a duplicate service.
- Not all payers will reimburse for multiple devices so check with the payer for their policies along with contacting the manufacturer for a replacement device.

Unlike IUDs, implants have a unique CPT code for the insertion, the removal, and the reinsertion. For dates of service after October 1, 2016:

- We would use CPT code 11981 for the implant insertion, along with the newly added ICD-10 code Z30.017 Encounter for initial prescription or insertion of the implant.
- For removals and reinsertions, we would code the CPT code 11982 or 11983 along with the newly added ICD-10 code Z30.46 Encounter for surveillance of the implant, which includes the routine checking, removals and reinsertions of the implant.
- These 2 new codes for implants were added to the ICD-10 code set as of October 1, 2016 so they're new. Make sure your systems, forms, and claims are all updated with these new codes.

What about the LARC device?

- There are currently 4 types of IUDs and 4 unique device HCPCS codes: J7300 describes the copper Paragard IUD, J7397 for the Liletta IUD, J7298 describes the Mirena IUD, and finally J7301 for the Skyla brand. Remember, the device code J7302, which was previously used for the Mirena and the Liletta IUD, was deleted as an active code as of January 1, 2016. If you bill J7302 now, you will most likely receive no reimbursement for that device. Make sure that code is not active in your billing systems.
- If the clinician is using a device from their stock and the device was not gotten specifically through a pharmacy benefit for the unique patient and already billed by a pharmacy to the payer, the device would be included on the visit claim.
- Under-reporting of a charge amount versus the anticipated contracted amount allowed for the device by a payer will also result in missed revenue.
- Devices are expensive and any missed payments or denials should be a top priority for billing resolution.
- Billing staff should audit LARC insertions for a 1:1 match. For every insertion there is a device accounted for.
- Call your payer representative for further guidance or clarification if you don't understand why a service or device is unpaid.

We hope these tips will help you avoid common coding missteps impacting your reimbursement of LARC services. Remember, document all services provided, accurately code the services on the claim, and submit to your payers in a timely manner to ensure proper and full reimbursement of LARC services.

Thanks for joining us today.

NCTCFP: Thank you, Ann, for this information. For more training information and resources on coding in family planning settings, please visit the National Training Centers' website at www.fpntc.org or call the National Clinical Training Center for Family Planning at 1-866-91-CTCFP, that's 1-866-912-8237. Thank you.