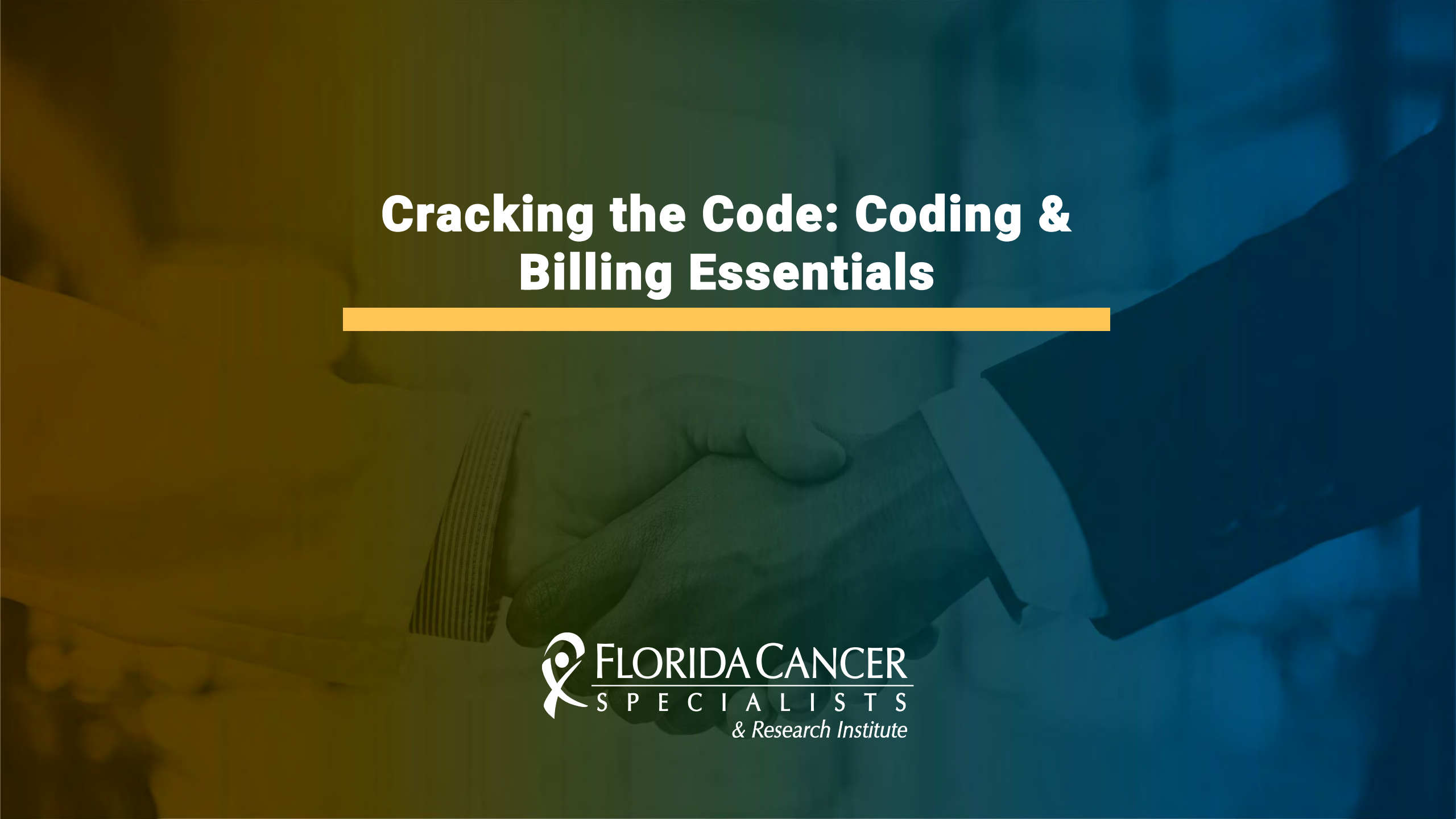
Cracking the Code: Coding & Billing Essentials



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Overview:

- ✓ Brief Overview
- ✓ Introduction to Coding & Billing
- ✓ Overview of the Revenue Cycle Management Process
- ✓ Key Principles
- ✓ Common Pitfalls
- ✓ Provider Must-Knows
- ✓ Q&A

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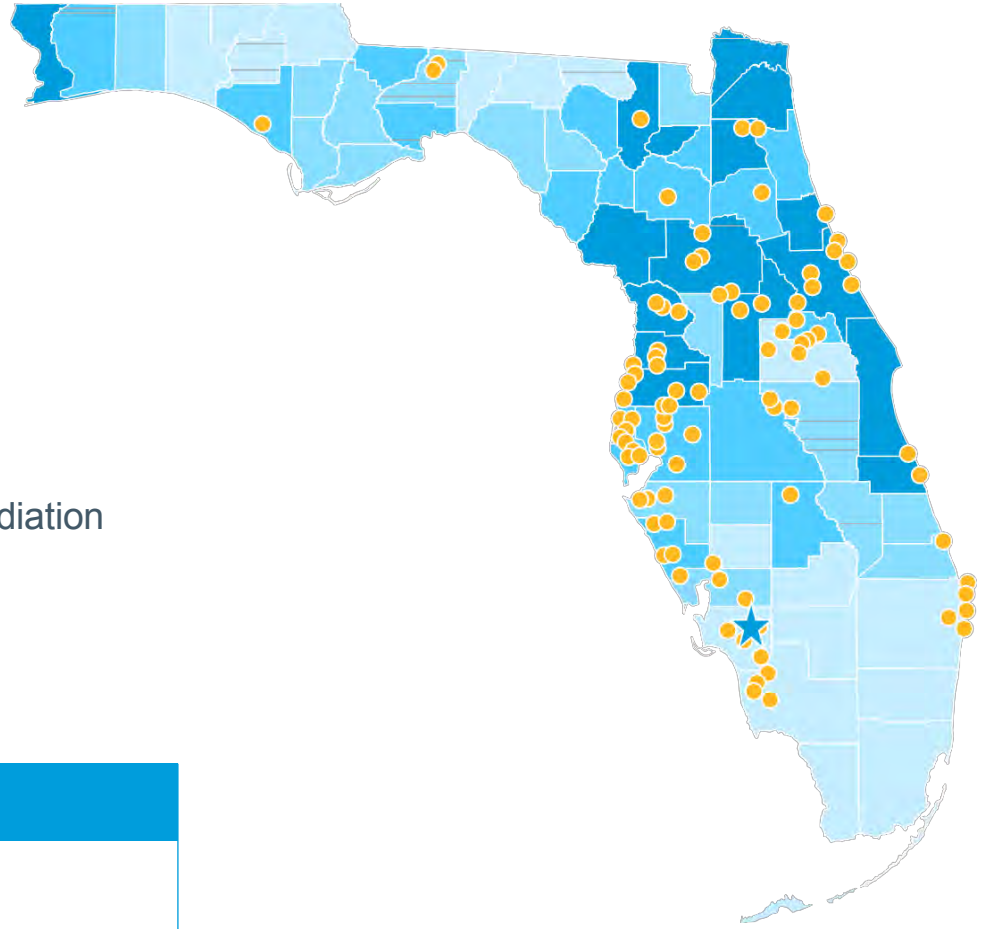
Florida Cancer Specialists

- **Leading, independent physician-owned community oncology care provider**
  - Providing world-class care to communities in Florida
  - Partnership model solidifies alignment with physicians
- **One of the largest oncology care platforms in the US**
  - Headquartered in Fort Myers, Florida with over 93 clinical sites and 267 physicians
- **Unparalleled care delivery through wholistic care capabilities**
  - Enabled by breadth and depth of ancillary offerings, including specialty pharmacy, radiation oncology, imaging, pathology lab, and research
  - Leverage proprietary technology for optimized drug selection, care costs and patient outcomes



Key Stats

60% Floridians within 20 Miles of FCS Clinic	**280+** NP / PAs	**124** Active Clinical Trials
$200mm+ Savings Generated in OCM	**88%** Patient Net Promoter Score	**$410mm+** Savings Commercial VBC

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You have finally made it! After years of medical school, residency, and fellowship, you're ready to practice. You see patients, provide top-notch care, and everything seems great. Until you realize something is missing – your revenue.

Why You Should Care:

Understanding billing and coding directly impacts your ability to deliver care and sustain your practice.

1. Ensures proper reimbursement for services
2. Impacts revenue cycle & financial health
3. Reduces denials and administrative burden

Goal: Equip you with the knowledge to navigate billing & coding successfully

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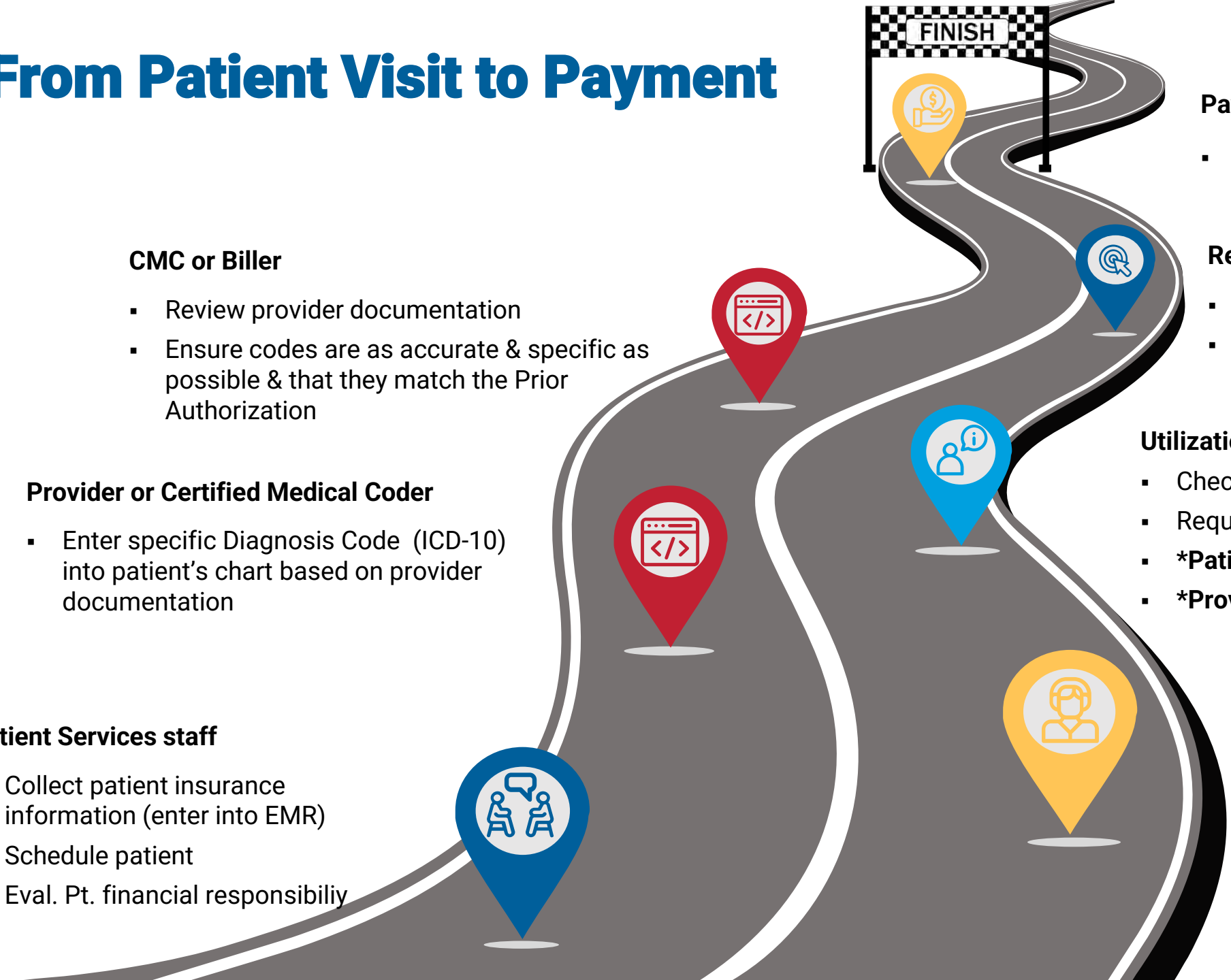
From Patient Visit to Payment



Payer

- Pay Claim

CMC or Biller

- Review provider documentation
- Ensure codes are as accurate & specific as possible & that they match the Prior Authorization

Revenue Cycle Mgmt team

- Finalize bill
- Submit to payer for reimbursement

Provider or Certified Medical Coder

- Enter specific Diagnosis Code (ICD-10) into patient's chart based on provider documentation

Utilization Management staff

- Check insurance portal for eligibility
- Request Prior Authorization
- ***Patient** receives service/test/drug
- ***Provider** signs off on documentation

Patient Services staff

- Collect patient insurance information (enter into EMR)
- Schedule patient
- Eval. Pt. financial responsibiliy

Provider

- Evaluate patient and order diagnostic tests & services using CPT codes
- Document prior medical history & all pertinent medical information into patient's chart

Patient Access & Pre-Visit

Define: Pre-registration is the process of collecting and recording essential information about a patient, such as demographics, insurance details, basic medical history and current concerns. This can be done prior to the patient ever arriving at a provider facility.

Patient Registration & Insurance Verification

1. Ensures proper reimbursement for services
2. Impacts revenue cycle & financial health
3. Reduces denials and administrative burden

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Prior Authorization

Define: (also called pre-authorization or precertification) is a cost-control measure used by health insurance plans. A provider submits a request to the patient's insurance company to perform a specific service, test, medication, or treatment for a patient.

Verify Payer Requirements before services

1. Ensures proper reimbursement for services
2. Impacts revenue cycle & financial health
3. Reduces denials and administrative burden

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During the Visit:

Provider is Key Stakeholder:

1. Evaluation of patient & order tests & services
2. Documentation
3. Coding
4. Charge Entry

We will be diving into Provider Documentation & Coding later on in the presentation

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Revenue Cycle Management (Billing)

Define: the comprehensive set of processes and activities involved in ensuring healthcare providers receive timely and accurate payments for the services they provide. It encompasses all aspects of the financial cycle, from patient registration and insurance verification to claim submission and payment collection.

Key Objectives of Revenue Cycle Management

1. Maximize revenue
2. Minimize denials & double work
3. Streamline the administrative processes to reduce costs
4. Ensure compliance with regulations & billing guidelines
5. Submit accurate & timely claims
6. Monitor and report payment trends to identify & address areas of improvement

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Claims Payment Process

Define: the process by which an insurance company reviews a claim for accuracy and coverage, and if approved, pays the provider based on the negotiated reimbursement method…ideally.

Additional details

1. Portion of claim may be patient responsibility
2. Payer reviews claim. If claim is clean, paid on contracted amount
3. If a claim is denied or underpaid = resubmissions & appeals

Claim Lifecycle:

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Most Common Claim Denials

1. Prior Authorization
2. Doctor Not Covered
3. Coding
4. Timely Filing
5. Patient Information is wrong (demographic)
6. Claim information mismatched
7. Drug or service not covered

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Resolving Denials

Type of denial determines strategy to resolve.

RCM may:

1. Provide Additional Documentation
2. Correct & Resubmit the claim
3. File an appeal

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Measuring Success in RCM

- **Net Collection Rate** (Payments Received / Payer Allowed)

- **Denial Rate** (% of claims denied)

- **Days in Accounts Receivable** (AR – How long it takes to get paid)

- **Clean Claim Rate** (% of claims paid on first submission)

- **Net Cost Recovery** (Drug Reimbursement vs. Cost)

- **E/M Utilization** (are providers coding appropriately?)

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Provider Key Take-Aways:

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Provider Documentation

Define: refers to the process of healthcare professionals recording and maintaining accurate, comprehensive, and timely records of patient encounters, treatments, and outcomes, which are essential for effective communication, continuity of care, and legal compliance.

Ensure your documentation is accurate, relevant, complete, & signed timely

1. Enhances continuity of care
2. Improves communication between providers
3. Improves patient safety
4. Compliance with regulations
5. Impacts revenue cycle & financial health
6. Reduces denials and administrative burden

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Documentation Overview:

Providers play a key role in reimbursement

1. Provider documentation drives everything

2. Errors in documentation can lead to revenue loss, audits, & compliance risks.

3. Strong documentation = better patient care + appropriate reimbursement

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Provider Documentation Tips

To improve reimbursement, physicians should focus on detailed, accurate, and complete documentation, including specific details about procedures, diagnoses, and treatment plans, ensuring legibility and clarity for coding purposes.

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Coding 101 – E/M Coding:

Evaluation & Management Coding – Utilized for office visits, hospital visits, consultations, etc.

Key Components of E/M Coding

- History
- Exam
- Based on MDM or Time

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Coding 101 – Diagnosis Coding:

ICD-10 = Diagnosis Codes

- Indicate **why** a service was provided
- Must justify medical necessity for procedures/tests
- Always code to highest level of specificity

Linking the Diagnosis & Procedure Code

- ICD-10 must support CPT code

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Mapping Dx Codes to Zero Payments/Denials:

Top 25 Oncology Dx Codes that led to claim denials:

Diffuse large B-cell lymphoma, unspecified site
Follicular lymphoma, unspecified, unspecified site
Malignant (primary) neoplasm, unspecified
Malignant melanoma of skin, unspecified
Malignant neoplasm of bladder, unspecified
Malignant neoplasm of cervix uteri, unspecified
Malignant neoplasm of colon, unspecified
Malignant neoplasm of corpus uteri, unspecified
Malignant neoplasm of esophagus, unspecified
Malignant neoplasm of larynx, unspecified
Malignant neoplasm of oropharynx, unspecified
Malignant neoplasm of pancreas, unspecified
Malignant neoplasm of stomach, unspecified
Malignant neoplasm of tonsil, unspecified
Malignant neoplasm of unsp site of unspecified female breast
Malignant neoplasm of unspecified fallopian tube
Malignant neoplasm of unspecified main bronchus
Malignant neoplasm of unspecified ovary
Malignant neoplasm of unspecified site of left female breast
Malignant neoplasm of uterus, part unspecified
Myeloid leukemia, unspecified, not having achieved remission
Non-Hodgkin lymphoma, unspecified, unspecified site
Secondary malignant neoplasm of unspecified lung
Squamous cell carcinoma of skin, unspecified
Unspecified B-cell lymphoma, unspecified site

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Coding 201: Risk Adjustment

The primary driver of a RAF score is the patient's HCC codes, which represent specific medical conditions.

HCC's and the patient's demographic and program enrollment information to determine their total RAF score or estimated cost to a healthcare organization.

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Hierarchical Condition Category (HCC) Goal

As Healthcare moves toward value-based care programs, HCC Coding will impact:

- Benchmark rates
- Quality-of-care programs
- Quality Bonus Programs

Documentation/Diagnoses become the basis for funding and reimbursement.
The patient's care is accurately and completely funded based on actual need

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ICD-10 Codes Mapping to HCCs

- Not all diagnoses carry an HCC weight and contribute to a patient's risk adjustment.
- Always document to the highest specificity to accurately describe the patient's condition.

ICD-10	Has CMS-HCC Value	ICD-10	No CMS-HCC Value
I48.91	Atrial Fibrillation	I49.9	Arrhythmia
N18.4	CKD 4	N28.9	Renal Insufficiency
E10/E11	Type 1/Type 2 Diabetes Mellitus	R73.9	Hyperglycemia
D61.9	Aplastic Anemia	D64.9	Anemia
F32.0	Major Depression, single, mild	F32.9	Depressed

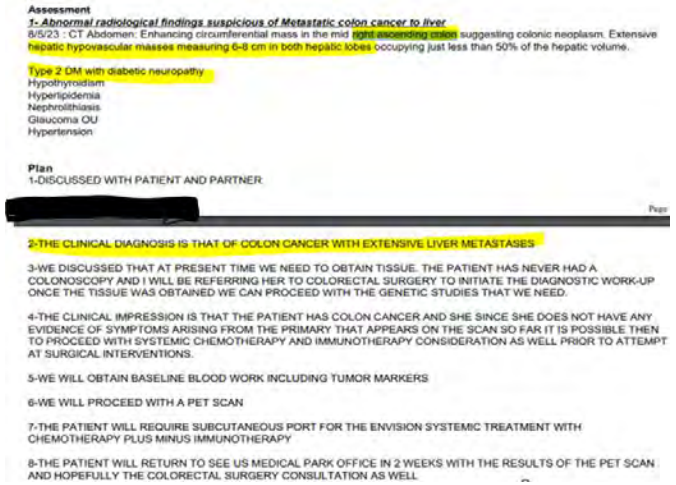
Risk Adjustment – Case Study

Primary Insurance Carrier: Medicare

Scenario 1 - Physician Linked Dx Code: Unspecified Colon, C18.2

Scenario 2 - Coder Adjusted: C78.7

Scenario 3 – (Missed HCC due to lack of documentation): DM 2 W/ Neuropathy, E13.40



Assessment

1- Abnormal radiological findings suspicious of Metastatic colon cancer to liver

8/5/23 : CT Abdomen: Enhancing circumferential mass in the mid right ascending colon suggesting colonic neoplasm. Extensive hepatic hypovascular masses measuring 6-8 cm in both hepatic lobes occupying just less than 50% of the hepatic volume.

Type 2 DM with diabetic neuropathy
Hypothyroidism
Hyperlipidemia
Nephrolithiasis
Glaucoma OU
Hypertension

Plan

1-DISCUSSED WITH PATIENT AND PARTNER

[redacted]

2-THE CLINICAL DIAGNOSIS IS THAT OF COLON CANCER WITH EXTENSIVE LIVER METASTASES

3-WE DISCUSSED THAT AT PRESENT TIME WE NEED TO OBTAIN TISSUE. THE PATIENT HAS NEVER HAD A COLONOSCOPY AND I WILL BE REFERRING HER TO COLORECTAL SURGERY TO INITIATE THE DIAGNOSTIC WORK-UP ONCE THE TISSUE WAS OBTAINED WE CAN PROCEED WITH THE GENETIC STUDIES THAT WE NEED.

4-THE CLINICAL IMPRESSION IS THAT THE PATIENT HAS COLON CANCER AND SHE SINCE SHE DOES NOT HAVE ANY EVIDENCE OF SYMPTOMS ARISING FROM THE PRIMARY THAT APPEARS ON THE SCAN SO FAR IT IS POSSIBLE THEN TO PROCEED WITH SYSTEMIC CHEMOTHERAPY AND IMMUNOTHERAPY CONSIDERATION AS WELL PRIOR TO ATTEMPT AT SURGICAL INTERVENTIONS.

5-WE WILL OBTAIN BASELINE BLOOD WORK INCLUDING TUMOR MARKERS

6-WE WILL PROCEED WITH A PET SCAN

7-THE PATIENT WILL REQUIRE SUBCUTANEOUS PORT FOR THE ENVISION SYSTEMIC TREATMENT WITH CHEMOTHERAPY PLUS MINUS IMMUNOTHERAPY

8-THE PATIENT WILL RETURN TO SEE US MEDICAL PARK OFFICE IN 2 WEEKS WITH THE RESULTS OF THE PET SCAN AND HOPEFULLY THE COLORECTAL SURGERY CONSULTATION AS WELL

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M.E.A.T documentation Standards

Monitoring

- How is the individual doing?
- Are there new signs or symptoms?
- Conceptually represents ongoing surveillance of the condition(s).

Evaluation

- What is the current state of the condition?
- What is the provider's judgement of the condition currently?
- Review of results or the treatment outcomes

Assessment

- How will the condition(s) be evaluated or estimated?
- May be documentation of prior records review, counseling, or ordering further studies.

Treatment

- What care is being offered or what is being done to help the patient with the condition(s).
- May be medication, diagnostic study, or therapeutic service.

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M.E.A.T documentation Standards

To have an HCC Code successfully captured for a patient, the chronic condition must have supported documentation that includes elements of M.E.A.T **

Monitored
Disease progression/regression
Ordering labs/x-rays
Diagnostic tests (echo, EKG)
Review of Logs (blood sugar, B/P)

Evaluated
Reviewing lab/test results
Review of diagnostic tests
Relevant physician examination
Medication/treatment effectiveness

M.E.A.T

Assessed
Stable, improving, worsening, etc.
Exacerbation of condition
Discussion/Counseling
Relevant record review

Treated
Referral to specialists
Adjusting, refilling, prescribing medication
Surgical procedures

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Common Documentation Errors

Missed Opportunities for HCC Capture

- No documentation to support diagnosis billed
- Chronic conditions not assessed
- Not enough specificity of disease
  - *Renal insufficiency vs CKD stage 3*
  - *Hyperglycemia vs Type 1/Type 2 Diabetes without Complications*
- Cause and Effect documentation not present
  - *"due to", "manifested by", "associated with", "secondary to"*
- Use of "history of" when current condition exists
  - *History of RA vs Rheumatoid Arthritis*
- BMI Status and level of obesity missing
  - *Obese/Very Obese vs Morbid Obesity with BMI >40*
- Active health status missing
  - *Amputation, transplant, congenital diseases*
- Diagnosis listed in Problem List, but not documented in the visit note A/P
- Long term use of medication for chronic diseases missing
  - *Coumadin, ASA, Insulin, etc.*

Optimizing documentation practices and verbiage on patients' active, chronic and co-existing conditions will support in accurately and optimally capturing HCC codes.

Documentation Requirements

- Chronic condition(s)/Diagnosis(es) must be:
  - Reported at least once each year.
    - Jan 1st a patient's RAF score is "wiped clean".
    - From a risk adjustment perspective: Treatment (within the current year) is evidence of diagnosis
  - Captured in a face-to-face setting
    - Telehealth via video qualifies
    - Telehealth via audio only does not qualify
  - Documented in the health record with appropriate identification, date, and provider signature

Risk-Adjustment Factor (RAF)

RAF Calculations Affecting Payments

Example 1

HCC Financial Differences in Coding Specificity

No Conditions Coded (Demographics Only)		Some Conditions Coded (Claims Data Only)		All Conditions Coded (Chart Review by Certified Coder)	
76 year-old female	.468	76 year-old female	.468	76 year-old female	.468
Medicaid Eligible	.177	Medicaid Eligible	.177	Medicaid Eligible	.177
DM Not Coded		DM (no manifestations)	.118	DM with Vascular Manifestations	.368
Vascular Disease not coded		Vascular Disease without complication	.299	Vascular Disease with complication	.41
CHF not coded		CHF not coded		CHF coded	.368
No interaction		No interaction		+ Disease Interaction bonus RAF (DM + CHF)	.182
Patient Total RAF	.645	Patient Total RAF	1.062	Patient Total RAF	1.973
PMPM Payment for Care	$452	PMPM Payment for Care	$743	PMPM Payment for Care	$1,381
Yearly Reserve for Care	$ 5,418	Yearly Reserve for Care	$8,921	Yearly Reserve for Care	$16,573

Q&A

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THANK YOU

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Risk-Adjustment Factor (RAF)

RAF Calculations Affecting Payments

Example 2

If the patient has diabetes with complications that is not documented/coded, the payment impact is pronounced:

Scenario 1			Scenario 2			Scenario 3		
	HCC	Risk Adjustment Factor		HCC	Risk Adjustment Factor		HCC	Risk Adjustment Factor
72-Year-Old Female		0.386	72-Year-Old Female		0.386	72-Year-Old Female		0.386
Diabetes not coded		--	E11.9 Type 2 diabetes mellitus w/o complications	HCC19 Diabetes w/o Complication	0.105	E11.41 Type 2 diabetes mellitus w/diabetic mononeuropathy	HCC18 Diabetes w/Chronic Complications	0.302
Total RAF		0.386	Total RAF		0.491	Total RAF		0.688
Payment per month		$ 347.40	Payment per month		$ 441.90	Payment per month		$ 619.20
Payment per year		$ 4,168.80	Payment per year		$ 5,302.80	Payment per year		$ 7,430.40

to be continued…

Risk-Adjustment Factor (RAF)

RAF Calculations Affecting Payments

Example 2

That same patient may have multiple conditions that contribute to the HCC score.
Missing documentation carries a cost.

Scenario 4			Scenario 5			Scenario 6		
	HCC	Risk Adjustment Factor		HCC	Risk Adjustment Factor		HCC	Risk Adjustment Factor
72-Year-Old Female		0.386	72-Year-Old Female		0.386	72-Year-Old Female		0.386
E11.41 Type 2 diabetes mellitus w/diabetic mononeuropathy	HCC18 Diabetes w/Chronic Complications	0.302	E11.41 Type 2 diabetes mellitus w/diabetic mononeuropathy	HCC18 Diabetes w/Chronic Complications	0.302	E11.41 Type 2 diabetes mellitus w/diabetic mononeuropathy	HCC18 Diabetes w/Chronic Complications	0.302
K50.00 Crohn's disease of small intestine w/o complications	HCC35 Inflammatory Bowel Disease	0.308	K50.00 Crohn's disease of small intestine w/o complications	HCC35 Inflammatory Bowel Disease	0.308	K50.00 Crohn's disease of small intestine w/o complications	HCC35 Inflammatory Bowel Disease	0.308
			M05.60 Rheumatoid arthritis of unspec site w/involvement of other organs/systems	HCC40 Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.421	M05.60 Rheumatoid arthritis of unspec site w/involvement of other organs/systems	HCC40 Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.421
						F33.1 Major Depressive Disorder, Recurrent	HCC59 Major Depressive, Bipolar, and Paranoid Disorders	0.309
						Bonus for 4 Chronic Conditions		0.006
Total RAF		0.996	Total RAF		1.417	Total RAF		1.732
Payment per month		$ 896.40	Payment per month		$ 1,275.30	Payment per month		$ 1,558.80
Payment per year		$ 10,756.80	Payment per year		$ 15,303.60	Payment per year		$ 18,705.60

The Impact of Coding Comorbidities

Example 3

Table Hypothetical Patient with Pancreatic Cancer: Impact of Coding or Not Coding of Comorbidities on Costs

I. Patient with chronic conditions not coded (demographics only)	**RAF score**	**II. Patient with some chronic conditions coded** (claims data only)	**RAF score**	**III. Patient with all chronic conditions coded** (chart note reviewed)	**RAF score**
76-year-old female	.448	76-year-old female	.448	76-year-old female	.448
Medicaid eligible	.177	Medicaid eligible	.177	Medicaid eligible	.177
Malignant neoplasm of pancreas unspecified (C25.9)	.955	Malignant neoplasm of pancreas unspecified (C25.9)[a]	.955	Malignant neoplasm of pancreatic duct (C25.3)[a]	.955
Metastatic disease not coded	—	Secondary malignant neoplasm of liver and intrahepatic bile duct (C78.7)[a]	2.442	Secondary malignant neoplasm of liver and intrahepatic bile duct (C78.7)[a]	2.442
Diabetes not coded	—	Diabetes type 2 unspecified (E11.9)[a]	.098	Diabetes type 2 with diabetic kidney disease (E11.22)[a]	.354
Chronic kidney disease not coded	—	Chronic kidney disease unspecified (N18.9)[a]	No RAF value	End-stage renal disease on dialysis (N18.6)[a] + dialysis status (Z99.2)[a]	.184 + .435
Depression not coded	—	Major depression unspecified (F32.9)[a]	No RAF value	Major, mild recurrent depression (F33.0)[a]	.413
Weight loss documented, not coded	—	Severe protein malnutrition noted in chart, but not coded	—	Protein malnutrition of moderate degree (E44.0)[a]	.562
Patient total score	1.58	Patient total score	4.12	Patient total score	5.97
Payment	**Cost**	**Payment**	**Cost**	**Payment**	**Cost**
PMPM payment for care	$1291	PMPM payment for care	$3366	PMPM payment for care	$4878
Annual expected cost of care	$15,494	Annual expected cost of care	$40,402	Annual expected cost of care	$58,544

[a]*International Classification of Diseases, Tenth Revision* code.
PMPM indicates per-member per-month; RAF, risk-adjustment factor.

Appendix – Hierarchical Condition Category (HCC)

- **Hierarchical Condition Category (HCC):** A risk-adjustment coding model that assigns weight to chronic comorbidities and is used to predict future health care costs of patients.
- HCC coding was designed by CMS in 2004 as a model for risk assessment or risk adjustment by assigning weight to chronic comorbidities that contribute to overall healthcare costs.
- HCCs are used to determine a risk-adjustment factor (RAF), calculated using demographics and comorbidities, which predict the overall cost and burden a patient will be to the healthcare system.
- The more chronic comorbidities a patient has appropriately documented in their medical history/reported on claims, the higher the patient's risk-adjustment factor (RAF).
- The HCC coding capture provides an accurate picture of how medically complex a patient's overall health status.
- Presumably, a patient with a high RAF score, will cost more to medically treat. Therefore, patients with a high RAF score will be assigned a higher target price.
- If actual costs of treatment for the patient are lower than the set target price, then the provider will have **positive** shared savings

Appendix – Risk-Adjustment Factor (RAF)

- **Risk-Adjustment Factor (RAF) score:** Risk score calculated using HCC codes/chronic comorbidities on patient claims and demographics. RAF scores predict the overall future cost and burden a patient will be to the healthcare system.

- The more chronic comorbidities a patient has appropriately documented in their medical history/reported on claims, the higher the patient's risk-adjustment factor (RAF).

- Presumably, a patient with a high RAF score, will cost more to medically treat. Therefore, patients with a high RAF score will be assigned a higher target price.

- If actual costs of treatment for the patient are lower than the set target price, then the provider will have **positive** shared savings

Appendix – Common Conditions/HCC Categories

- **Diabetes with and without complications – HCCs 18 & 19**
  - DM with renal manifestations
  - DM with neurological manifestations
  - DM with circulatory manifestations
- **Chronic Obstructive Pulmonary Disease (COPD) – HCC 111**
  - COPD
  - Asthma w/ chronic COPD (chronic obstructive asthma)
  - Chronic Bronchitis
  - Emphysema
- **Congestive Heart Failure (CHF) – HCC 85**
  - CHF
  - Primary Cardiomyopathy
  - Hypertensive Heart Disease w/ heart failure
- **Cancer – HCCs 8, 9, 10, 11, & 12**
  - All malignant neoplasm's including Melanoma, but not skin cancer
  - All Secondary malignant neoplasms
- **Vascular Disease – HCC 107 and 108**
  - Peripheral Vascular Disease (PVD)
  - PVD in other diseases (diabetes)
  - Acute DVT
  - Atherosclerosis of Aorta
  - Abdominal Aortic Aneurysm (AAA)
- **Chronic Kidney Disease (CKD)/ESRD – HCCs 134-138**
  - CKD stages 3-5
  - Dialysis status
- **Specified Heart Arrhythmia – HCC 96**
  - Complete AV block
  - Atrial Fibrillation
  - Sick Sinus Syndrome (SSS)
- **Angina – HCC 88**
  - CAD with Chronic Angina Pectoris

List not exhaustive

Appendix – Common Conditions/HCC Categories

- **Major Depression – HCC 59**
- **Rheumatoid Arthritis/Inflammatory Connective Tissue Disease – HCC 40**
  - Rheumatoid Arthritis (RA)
  - SLE
  - Polymyalgia Rheumatica (PMR)
  - Sacroiliitis
- **Protein Calorie Malnutrition – HCC 21**
- **Artificial Openings – HCC 188**
  - Gastrostomy
  - Colostomy
  - Tracheostomy
  - Ileostomy
- **Amputations**
  - BKA/AKA
  - Foot/Toe
- **Morbid Obesity – HCC 22**
- **Inflammatory Bowel Disease – HCC 35**
  - Crohn's disease
  - Ulcerative colitis
- **Hematological/Immunity Disorders – HCCs 46, 47, 48**
  - MDS
  - Neutropenia
  - Thrombocytopenia
  - Thrombophilia
  - Sickle-Cell trait
  - HIV
- **Dementia – HCC 51, 52**
- **Myasthenia Gravis, Polyneuropathy – HCC 75**
- **Seizures – HCC 79**
  - Epilepsy
- **Parkinson's and Huntington's Disease – HCC 78**
- **Multiple Sclerosis – HCC 77**

List not exhaustive