FREE Frank Cohen Webinar on RBRVS!

From our friend Frank Cohen:

“I have some great news concerning the upcoming Mastering RBRVS quickinar™ on Tuesday, March 19 at 2:00 ET. The presentation has been granted 1.5 AAPC CEU credits. According to AAPC: “This program meets AAPC guidelines for 1.5 CEUs. Can be split between Core and CPCO, CPMA, CPPM and CEMC for continuing education units.”

This webinar is a comprehensive and entertaining look at RBRVS and how it is used within the medical practice. This is designed for all levels as I will work from the basic to the more complex. You will learn about the different RVU components, how to make adjustments for your specific geographic area, techniques to calculate conversion factors, how to factor the data for modifiers and how to use that information to perform a cursory examination of your practice’s overall health.

There is no charge for the webinar; but seats are limited so please register soon. Sign up on the Training page at FrankCohenGroup.com.”

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Coding for the Rest of Us: Why Everyone in Your Practice Needs a Basic Knowledge of Coding

There is no one, and I do mean no one, in your medical practice who does not need to know the basics of coding. Here is why:

- Providing services to patients is the business of healthcare. Every person who relies on healthcare for their living should understand something about the business they are in. This should not outweigh the fact that we are privileged to care for patients, but as the saying goes “No money, no mission.”
- It takes a team to produce care. The silos of front desk, billing, nursing and scheduling must come together to share their knowledge and produce a high-quality, reimbursable patient visit. Here are the roles each member of the team plays:
    - The patient calls for an appointment and the scheduler matches the patient’s problem to an appropriate appointment type. The scheduler finds out if the patient is **new or established** and **what the patient’s appointment is for.**
    - The patient arrives for the appointment and the front desk assures that all **current demographic and insurance information is collected**.
    - The nurse rooms the patient, taking vitals, reviewing medications and **reviewing the reason for the visit** – the chief complaint.
    - The physician or mid-level provider cares for the patient, documenting the visit and choosing the

appropriate service and diagnosis codes.

- The patient completes the visit by paying any deductibles or co-insurance due and making any future appointments needed. The checkout staff **enters the payments and/or charges** if the service codes have not already been posted via the EMR.
- The biller "scrubs" the claim, checking for any errors and **electronically submits the claim to the payer**. The hope is that the claim is clean and will be accepted and paid immediately (within 30 days.)

When staff understands how important their contribution is to the financial viability of the practice and how all the pieces fit together, they are more incentivized to perform.

"Coding" means two things: s**ervice codes** and **diagnosis codes**. Service codes describe office visits, surgery, laboratory, radiology, pathology, anesthesia and medical procedures that are provided by physicians, nurse practitioners, and physician assistants. Diagnosis codes describe signs, symptoms, injuries, diseases, and conditions. **The critical relationship between a service code and a diagnosis code is that the diagnosis supports the medical necessity of the procedure.**

Service codes are called either CPT codes or HCPCS (pronounced "hick-picks) based on the payer/insurer who uses them. Most commercial insurers use CPT (Current Procedural Terminology) codes, but Medicare and Medicaid use HCPCS (Healthcare Common Procedure Coding System.) Codes are globally grouped into Level I and Level II:

- Level I codes include the 5-digit numeric CPT (Current Procedural Terminology) codes. These were developed by the American Medical Association (AMA) in 1966 and remain proprietary to the AMA. The codes are updated in October and become effective as of the next calendar year. They are available as a printed manual or as an

electronic file.
- Level II codes are national codes developed by the Centers for Medicare and Medicaid Services (CMS) to describe medical services and supplies not covered in the CPT. They consist of alphabetic characters (A through V) and four digits.

There are two ways that patient services are coded so they can be billed to insurance companies. The first is through the use of a preprinted coding sheet, which goes by many different names: superbill, encounter form, routing sheet, patient ticket, or billing form. The physician or mid-level provider indicates which services were provided and maps specific diagnosis codes to the services.

The second is abstraction from the medical record. A coder reads the documentation provided by the physician or mid-level provider, and matches codes to the services described in the record. Computerized coding abstraction via an electronic medical record (EMR) is also an option

Here are some basic coding rules that apply to every type of practice:

- Always have the latest edition of CPT and HCPCS. Service codes change annually and it is important to use the correct code for the calendar year. Check new, revised and deleted codes annually and change your encounter form and codes in your billing system to match.
- Attend webinars or seminars annually to stay up-to-date on large-scale coding changes for your specialty or for all specialties. For instance, tobacco cessation counseling is reportable to and payable by Medicare for the first time in 2011 – see a **handy guide here** and every specialty can bill it. You may also want to subscribe to coding newsletters for your specialty or check your physician's specialty society to see what they offer.

- Utilize the National Correct Coding Initiative (NCCI) to make sure which codes are to be submitted individually versus being bundled. Many practices do not know about or use the NCCI information for the simple reason that it is complex and confusing and changes regularly. Someone in the field who offers great (free) information on the NCCI edits is Frank Cohen **here.**
- Have an in-house crosswalk for provider abbreviations to make sure that they have signed off on what their abbreviations mean. The best of all worlds is requiring the physician or mid-level provider to supply a code as opposed to a description.
- Use scrubbing software tools to check service and diagnosis code mismatches, Local Coverage Determinations (LCDs) for Medicare, any services without appropriate diagnosis codes and any diagnoses without standard accompanying services.
- Audit your documentation regularly to ensure it matches your level of service ("if you didn't document it, you didn't do it") especially if you are not documenting electronically with decision support tools. Audit yourself or hire a firm to audit for you and document lessons learned and any corrective action taken. This should be part of your practice compliance plan. Note that physician regulatory insurance is now available (Google it) for around $1500 per physician per year.
- It is always the physician or mid-level provider's ultimate responsibility to choose the codes that best correlate with what s/he did. When in doubt, always defer to the provider of the service.

Other articles of interest:

How Many Staff Do You Need?

A Perfect Day in Your Medical Practice

The Cohen Report: Analysis and “Quickinar” of the NCCI 17.1 Changes Effective April 1, 2011

There are 11,831 new edit pairs, which pushes the total for effective edits to 709,527. There were 346 terminations for a net gain of 11,485. In this release, we find that there are around 350 edit pairs that have termination and/or effective dates retroactive to an earlier period with some going as far back as October, 2001. In fact, all but 10 of the terminated edit pairs are retroactive, adding to the complexity of billing and possible targets for RAC auditors.

If you would like to get a copy of his summary report along with a couple of worksheets that detail these changes, go to www.frankcohengroup.com and click on the Download tab. There is no charge for the analysis or the worksheets.

Free Quikinar on NCCI

Frank will also be conducting a brief (free) Quickinar„¢ to go over the NCCI policies and changes for this release on March 24, 2011 from 11:00 to 11:30. To register, go to his website at www.frankcohengroup.com and click on the Quickinar tab.

If you have any questions, please feel free to contact Frank Cohen.

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The Cohen Report: Free Webinar on Auditing the RAC Auditors

ï»¿NOTE: If you need the basics on RACs, **click here for my article.**

Image by doug88888 via Flickr

From our friend Frank Cohen:

Over the past year or so, I have been involved in conducting post RAC (and other) audit analyses to determine whether the RAC (or other auditing agency) was using appropriate statistics and calculations to create their overpayment estimates.

As you can probably imagine, in nearly every case, I have found this not to be true. In fact, as it turns out, the errors I find nearly always are in favor of the auditor, not the healthcare provider.

RAC is able to take advantage of the practice in three areas

The first area has to do with pulling samples for review. If these samples are not random or worse yet, if they are intentionally biased, they can create a misrepresentation of overpayment that unfairly penalizes the provider and because RACs are paid a commission, benefits them.

The second area has to do with the way in which the overpayment point estimate is calculated. This is where they come up with something like the average overpayment per audited unit (i.e., claim, claim line, member event, etc.).

The third has to do with the methodology used to extrapolate the point estimate for the sample to the universe of units for the healthcare provider. An error in any one of these areas can result in a gross exaggeration of the final overpayment demand.

Understanding how to defend yourself from the results of an audit

I have developed a series of three short, free webinars to teach you how to catch potential errors in each of three areas.

Part 1 will be on validating random samples and is scheduled for Monday, December 13 from 1:00 to 2:00 EST.

Part 2 is on how to calculate the overpayment point estimate and is scheduled for Tuesday, December 14 from 1:00 to 2:00 EST.

Part 3 is on verifying extrapolation results and is scheduled for Wednesday, December 15 from 1:00 to 2:00 EST.

Each webinar will probably last around 30 minutes with an

additional 30 minutes for questions. I plan to record these and post them later so if you can't make it, don't worry. Each session will be available for review after the last one is completed.

For more info or to register, go to www.frankcohen.com and click on the Webinar tab. Also, feel free to forward this on to co-workers or to post wherever you think folks may benefit.

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The Cohen Report: What is the National Average Charge for 10,500 HCPCS Codes?

Frank writes:

I have finally completed my analysis of the 2009/2010 P/SPS (Physician/Supplier Procedure Summary) Master File. This file contains 100% of all claims submitted to Medicare during a given calendar year, along with a mid-year 5% update. For this analysis, I used around 2.5 billion claim lines that represent nearly every physician in every specialty in the US. For this run, I analyzed the charges submitted to the database and created a file that reports the national average charge for over 10,500 procedure codes. Each procedure code (and modifier, when applicable), report the weighted average

charge, the variation (standard deviation) and the sample error. The latter two will allow you to determine the value of the point estimate.

From the Report:

Level 1	Office/outpatient visit, est	38.11
Level 2	Office/outpatient visit, est	65.04
Level 3	Office/outpatient visit, est	92.54
Level 4	Office/outpatient visit, est	140.74
Level 5	Office/outpatient visit, est	198.77

Remember, even though the data come from the Medicare database, our studies show that nearly 95% of all providers submit their retail (or usual) charge so that this is an excellent source for a fee schedule analysis.

To get this file (at no charge),

go to www.frankcohengroup.com and click on the Download tab. When you get to the download page, it will be the second link down.

Also, I am going to be the keynote speaker

(as well as conducting some break-out sessions) for the 2011 Physicians RAC Summit to be held in Orlando, FL the second week of January. I am going to be talking about two major issues; how to assess your risk for an audit and then how to determine whether the post-audit overpayment estimates are calculated properly. So far, in nearly every analysis I have conducted, the overpayment estimate was wrong and, not surprisingly, biased towards the RAC, not the provider. To get more information, go to my website at www.frankcohengroup.com

and click on the RAC Summit link.

Please let me know if you have any questions or if I can be of assistance in any way.
Frank Cohen, MPA, MBB

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The Cohen Report: NCCI 16.3 Analysis for Edits Effective October 1, 2010

From MMP's friend Frank Cohen:
I have completed my analysis of NCCI version 16.3, including an analysis of the changes from the last quarter release (version 16.2) to the current release. Here are my summary findings:

- Currently, for version 16.3, there are 688,013 active edit pairs, meaning that, if the procedure codes listed in column 1 and column 2 were to be billed together by the same physician on the same patient on the same day, it is likely that payment would either be denied or the payment amount would be reduced.
- In addition, there are 221,954 terminated edit pairs, which are pairs of codes that at one time were active but under the current version, no longer indicate a restriction of their use as a code pair. For version 6.3, 19,667 new edit pairs have been added to the

database while 35 have been terminated, for a net gain of 19,932 new edit pairs. For this version, all have an effective and/or termination date of October 1, 2010 or September 30, 2010.

- There were changes to the modifier indicator for 83 edit pairs with 8 going from an indicator of 0 (no modifier allowed) to 1 (modifier allowed) and the remaining 75 going from a modifier indicator of 1 to a modifier indicator of 0.
- There are now 1,396 duplicate pairs present in the database, a gain of 20 from version 16.2. Duplicate pairs are edit pairs that were, at one time active, then were terminated and then made active again.
- There are also 5,360 swapped edit pairs, which are those that were introduced in one particular order (i.e., column 1 code was 99333 and column 2 code was 92014), terminated and then reintroduced in the opposite order (i.e., column 1 code is now 92014 and column 2 code is now 99333).

I have created a set of worksheets that contain the data associated to this analysis and it is available for immediate download (no charge) at www.frankcohen.com. Click on the Download tab and it should be the second or third link on the page. If you have any questions, feel free to email me at frank@frankcohen.com. Frank Cohen, MPA, MBB at The Frank Cohen Group, LLC.

NOTE: In the MLN Matters announcing the October edits was also this newsflash:

Get your NEW How to Use the National Correct Coding Initiative (NCCI) Tools booklet from the MLN and learn how to navigate the CMS NCCI website. This new MLN product explains how to look up Medicare code pair edits and Medically Unlikely Edits (MUEs). NCCI tools can help providers avoid coding and billing

errors and subsequent payment denials. If you want to become familiar with the “National Correct Coding Initiative Policy Manual for Medicare Services” and the tools on the NCCI website, this is your best resource! Click **here** to download a pdf of the booklet.

The Cohen Report: CMS Releases New RBRVS Data Set Effective June 1, 2010

Image by jen-the-librarian via Flickr

Report by Frank Cohen
Frank Cohen, MPA, MBB
The Frank Cohen Group, LLC

As many of you may already know, July 1, 2010 CMS released yet another RBRVS (Resource Based Relative Value Scale) data set that will be used to pay physicians under Medicare effective June 1, 2010. This data set includes the 2.2% increase in the CF. This puts the current conversion factor at **$36.8729.**

The link to the CMS file is **here.**

The good news is that the Conversion Factor (CF) increased by 2.2%.

The bad news is that for 2,226 procedure code/modifier groups within the database, the **RVU (Relative Value Unit) values decreased** by anywhere from 0.65% to 50% (or 0.01 to 2.04 RVUs). The median change was only 0.12 RVUs, which in and of itself doesn't seem like much, but if you add them up, you get a total reduction of 492.95 RVUs for just these procedure codes.

This doesn't consider frequency of use. For example, procedure code 75825 26 saw a reduction in RVUs of 1.16. In 2008, this procedure was reported to Medicare 60,864 times. That results in a net decrease in RVUs to those practices of 70,602 RVUs. At the current conversion factor, that is a payment reduction of $2.6 million.

In addition to the RVU changes, there were **180 non-RVU changes**, including changes to the PC/TC (Professional Component/Technical Component) policies, new records, modified status, etc.

Note: Frank ran a side-by-side analysis of the changes for these procedure codes. If you would like a copy of his worksheet, go to his **site** and click on the Download tab. Even if you don't want this file, he has lots of other goodies on his site for free. As always, thanks Frank!

email Frank

visit Frank's site

Frank Cohen Produces April 1, 2010 CCI Edit Analysis for Medicare Part B Claims

- **Here's a refresher from CMS on NCCI for those of us experiencing acronym-exhaustion:**

  The CMS (Centers for Medicare and Medicaid Services) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual). The Coding Policy Manual should be utilized by carriers and FIs as a general reference tool that explains the rationale for NCCI edits.

  Carriers implemented NCCI edits within their claim processing systems for dates of service on or after January 1, 1996. More information here.

If you've been reading my website for awhile, you know I'm a big Frank Cohen fan. He espouses the idea of giving away lots of good free stuff and his work is topnotch! If you've never taken one of his free webinars, do yourself a favor and tune in. I don't see any webinars on his website currently, but get on his mailing list and you'll be the first to know when he's offering them again.

As usual, he offers his analysis of the most recent CCI Edits. Franks states:

Version 16.1 of the CCI edit database is scheduled to be

effective on April 1, 2010. There are 2,054 new edit pairs effective for this release. 35 of these are effective retroactive to October 1, 2009. This means that if you billed for and were paid on one or more of these retroactive edits, you may be subject to repayment.

*

142 edit pairs are reported as terminated (no longer effective) for this release. Four are terminated retroactive to December 31, 2005; four are retroactive to December 31, 2006 and 76 are shown as terminated retroactive to December 31, 2007. I guess this means that if you were denied due to a CCI edit pair during these periods, you should be able to resubmit the claim and get paid.

*

You can expect 1,947 changes with respect to the modifier indicator with 1,892 going from an indicator of 0 (no modifier permitted) to an indicator of 1 (modifier permitted). 55 edit pairs report a change in the modifier indicator from a 1 to a 0.

*

In total, there are 1,337 duplicate edit pairs in the database. These are records that were made effective at one point, then terminated and then made effective again. There are also currently 5,309 swapped pairs. These are edit pairs that were introduced in one order (i.e., 99350 as column 1 and 96416 as column 2), terminated and then re-activated in the opposite order (i.e., 96416 as column 1 and 99350 as column 2).

For a worksheet that contains all of the changes, edits and updates, go to www.mitsi.org and click on the Download tab. It is the third link down the page. Frank invites all readers to email him with any questions or comments to fcohen@frankcohen.com.

Thanks, Frank!

Photo Credit: Mary Pat Whaley – taken at the Lone Star Barbeque and Mercantile in Santee, South Carolina (great food!)

October 2009 NCCI Edits Analysis Just Released by Frank Cohen

For those of you who have not tapped into the amazing wealth of information generously shared by Frank Cohen, go to **his site** now and see what he has that could help you.

Most recently Frank analyzed the October 2009 NCCI Edits Release 15.3 and organized the information into meaningful categories as well as providing an executive summary.

As a reminder, the **CMS website** tells us:

> *The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual). The Coding Policy Manual should be utilized by carriers and FIs as a general reference tool that explains the rationale for NCCI edits.*

Per Frank's assessment of the 2009 changes effective on October 1:

> *There are 706 terminated edit pairs but once again, around half have been terminated retrospectively. Two are terminated back to last quarter (7.1.09), 357 back to April, 2009 and 27*

> *all the way back to January, 2009.* ***This means that, if you were denied payment on edit pairs that are part of this last over the past few quarters, you should be able to resubmit and get paid.*** *The big hitters for terminated codes in both column 1 and column 2 fell within the surgical code category (520 and 513, respectively).*

For more information, go to **Frank's site here**, go to the Download tab and you will see the link at the top of the page.

Monday Special: Interview with Frank Cohen, Host of "Lean Six Sigma for the Medical Practice"

I was intrigued to interview the man behind the upcoming free webinar "Lean Six Sigma for the Medical Practice." Frank Cohen, former Physician Assistant, Hospital CEO, and Consultant of 20 years is the Senior Analyst of MIT Solutions, Inc., and the host for this and other webinars that I think many healthcare managers will be interested in.

Cohen specializes in data mining and statistical modeling for medical practices. His website **www.mitsi.org** describes their services this way:

> *MIT Solutions, Inc. has been leading the health care industry in the development of decision support and business intelligence tools for medical practices since 1992. Our sole*

> *purpose is to help the practice staff work faster, smarter, make more money and improve compliance. At MIT Solutions, we develop products and services that transform the way you do business.*

Cohen is a significant player in the healthcare improvement world for several reasons. He worked with the AMA in 2008 to introduce the first Payer Report Cards, which focused on how quickly and accurately payers reimburse physicians for medical services.

The report card compared Medicare and seven national commercial health insurers on the timeliness and accuracy of claims processing and was based on a random sample drawn from 3 million claims. According to the AMA report, UHC ranked lowest in contract compliance with a rate of 62% of claims correctly paid per contract. Aetna ranked higher with 71% correctly paid and 98% of Medicare claims were correctly paid. **You can review the payer report card here.** Knowing how hard it can be to ensure that claims are paid correctly in the typical medical practice makes the feat of collating and analyzing the data on this scale impressive.

Cohen also developed CMPA, or Comprehensive Medical Practice Analysis, which includes analyses of Procedure Code Compliance, Provider Productivity, Modifier Analysis, E & M Code Utilization Review, Correct Code Initiative (CCI) Compliance, Fee Analysis, EOB-Based Reimbursement Analysis, Procedural Cost-Accounting/Break-Even Analysis, Managed Care Contract Analysis, Relative Value Scale Studies, and Statistical Modeling by Location by Physician.

Cohen's website hosts an array of **valuable downloads** available for managers to use. Here are some examples:

- Comparison of GPCI values by Location – CY2009 vs. CY 2008
- Comparison of RVU values by procedure code – CY 2009 vs.

CY 2008

- Physician Compensation Model Using Work RVUs
- RBRVS Calculation Template – 4th Quarter, 2009

Like most of us, Cohen has an interest in how medical practices can continue to meet the burden of increasing costs and shrinking reimbursements. He looked to the dual programs of Six Sigma and Lean to reveal ways for practices to eliminate wasted time, energy and resources and promote efficiencies in the practice. Cohen writes:

> *…I obtained my Six Sigma Black Belt certification and more recently, certification as a **Lean Six Sigma** (LSS) instructor. Over the past few years, I have struggled with developing a process improvement model that is specific to medical practices only, vetting a host of different tools to eliminate those that have little or no application in our vertical market and customize others to work specifically within a physician's office. I started applying these to some projects in the past couple of years and am very excited about this model and encouraged that this is one of the best ways to optimize profitability for physicians.*

Cohen is providing an introduction to his Lean Six Sigma for medical practices through a **free webinar** on Tuesday, February 24, 2009 from 11:00 a.m. to 12:00 p.m. Eastern. Webinars are a wonderful way to spend a little time and no money to learn something. You need a phone for the audio and a computer for the video and chat functions. I've signed up and I hope to "see" you there.