Adventures in Billing & Coding: Evaluation & Management for Interventional Radiology

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Agenda

The IR Clinical Practice of Today & Tomorrow

Why Does E&M Coding Matter?

E&M Case Scenarios
IR believes that clinical practice is important...

American College of Radiology Practice Guideline for Interventional Clinical Practice: A Commitment to Patient Care

Timothy P. Murphy, MD

...however, referring physicians still have trouble understanding IR as a clinical specialty

"It's impossible to get in touch with the IR physicians"

"Those guys just do the procedure, and don't take care of the patient."

"I'll just send my patient directly to IR for a procedure, and see him in my own clinic afterwards."
Traditional IR mindshare is focused primarily on procedures

- **Our Mindshare**
  - Procedures
  - Clinic / Rounds

- **E&M Activities**
  - Inpatient Rounding
  - Inpatient Consults
  - Outpatient Clinic

- **Benefits**
  - Clinical care
  - Multi-touch interface with clinical teams
  - Feed case pipeline
  - Branding IR as true clinical consult service
  - Clinical care
  - Feed case pipeline
  - Enhance patient/referrer perception of IR as clinical specialty
However, there is an opportunity for improvement
However, there is an opportunity for improvement

Procedures

E&M
“Best practice” clinical IR can be complex

Inpatient Team
- Attending
- APC(s)
- Trainee
- New consults for IR expertise
- Pre- and post-procedural care on IR or med/surg inpatient service
- Inpatient floors (med/surg/ICU)
- Emergency room
- Observation units
- Consult for acute GI bleed, +/- angio, +/- follow up visits on ICU service
- s/p UAE for pain management on IR service

Outpatient Team
- Attending
- APC(s)
- Trainee
- New referrals, self-referrals to IR clinic
- Pre-procedural, follow-up, and longitudinal care for IR patients
- Stand-alone IR clinic, often near angio suites
- Co-located clinics (e.g. multidisciplinary HCC/onc)
- HCC patient seen with team of hepatology, med-onc, transplant surg, IR
- Chronic venous insufficiency patient seen in IR clinic
Inpatient rounding teams require significant commitment...
...and outpatient clinics may not show direct RVU generation
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The IR Clinical Practice of Today & Tomorrow

Why Does E&M Coding Matter?

E&M Case Scenarios
Benefits are clear across the spectrum

Increased visibility

- Stronger voice amongst hospital leadership
- Expanded clinical impact of the IR practice
- Documentation of work already being done

Growth

- Virtuous cycle of increasing referral base
- Increased complexity of case mix

Financial returns

- Return on investment can be modeled and proven
- Provide for resources to continue to develop clinical mission
Financial modeling can help assess the benefits

**Assumptions**

- **Volume**
  - Average Census
  
  - 8 existing patients per day
  - 4 new patients per day

- **Mix**
  - E&M Case Mix
    - New patients E&M mix (0% / 2% / 11% / 57% / 30%)
    - Existing patients E&M mix (0% / 3% / 9% / 50% / 38%)
  
  - Staffing Mix
  
  - APC solo visits and billing (0-5% of all visits)
    - APC billing as % of attending physician (85%)

- **Price**
  - Documentation
    - Compliance with billing documentation by providers (95%)
  
  - Charges and Collection Rate
    - Estimated charges for new patients: $150-$650
    - Estimated charges for existing patients: $75-$450
    - Estimated gross collection rate: 30%
We are leaving money on the table if we don't capture our inpatient rounding revenues

<table>
<thead>
<tr>
<th>Practice Type:</th>
<th>Small</th>
<th>Moderate</th>
<th>Large</th>
<th>Mega</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic Days/Week</td>
<td>0.5</td>
<td>2.0</td>
<td>4.0</td>
<td>5.0</td>
</tr>
<tr>
<td>Number MDs (FTE)</td>
<td>0.125</td>
<td>0.25</td>
<td>0.50</td>
<td>1.00</td>
</tr>
<tr>
<td>Number APCs (FTE)</td>
<td>0.25</td>
<td>0.50</td>
<td>1.00</td>
<td>1.50</td>
</tr>
<tr>
<td>New Consults/Day</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Existing Consults/Day</td>
<td>2</td>
<td>5</td>
<td>8</td>
<td>15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice Type:</th>
<th>Moderate</th>
<th>Large</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated annual charges</td>
<td>$284,298</td>
<td>$991,961</td>
</tr>
</tbody>
</table>

| Estimated annual collected revenues | $85,289 | $297,588 |
Our clinics need to be sustainable sources of revenue as well.

<table>
<thead>
<tr>
<th>Practice Type:</th>
<th>Small</th>
<th>Moderate</th>
<th>Large</th>
<th>Mega</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Billing Days/Week</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Number MDs (FTE)</td>
<td>Variable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number APCs (FTE)</td>
<td>0.5</td>
<td>1.0</td>
<td>2.0</td>
<td>4.0</td>
</tr>
<tr>
<td>New Consults/Day</td>
<td></td>
<td>0.2</td>
<td>0.5</td>
<td>2</td>
</tr>
<tr>
<td>Existing Consults/Day</td>
<td>5</td>
<td>10</td>
<td>35</td>
<td>50</td>
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<tr>
<td>Estimated annual charges</td>
<td></td>
<td>$643,761</td>
<td>$2,264,672</td>
<td></td>
</tr>
<tr>
<td>Estimated annual collected revenues</td>
<td></td>
<td>$110,574</td>
<td>$389,612</td>
<td></td>
</tr>
<tr>
<td>Estimated annual collected revenues</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Growth of both inpatient & outpatient volumes...
Year-over-year growth 124% (inpatient), 21% (outpatient)
...with commensurate growth in procedures...
…especially in interventional oncology

Total IO Case Volume Case Volume (2011-2015)

Indexed Volume (y1 = 1.0)

Outpatient E&M Volume

Procedural Volume

CAGR 19%

+41%
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The IR Clinical Practice of Today & Tomorrow

Why Does E&M Coding Matter?

E&M Case Scenarios
General E&M guidelines

• Understanding correct level of coding is a requirement to maximizing reimbursement

• Coding level must be supported by appropriate documentation

• E&M levels dependent on either component documentation or time
Time component can be a "shortcut," but has its own requirements.

Entire time is face to face with patient, and at least 50% of that time must be used for "counseling and coordination of care."

### Counseling & Coordination of Care

<table>
<thead>
<tr>
<th>Setting</th>
<th>Where</th>
<th>What</th>
</tr>
</thead>
</table>
| Outpt.  | Face to face time with MD and patient/family members | • Prognostic conversation  
• Discuss imaging results  
• Smoking cessation  
• Risks/benefits of treatment  
• Instructions for follow up  
• Family education |
| Inpt.   | Floor/Unit time                            |                                                        |
The History component itself has four different elements:

<table>
<thead>
<tr>
<th>HPI</th>
<th>ROS</th>
<th>Past, Family, Social History</th>
<th>Categorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief</td>
<td>N/A</td>
<td>N/A</td>
<td>Problem focused</td>
</tr>
<tr>
<td>Brief problem</td>
<td>Problem pertinent</td>
<td>N/A</td>
<td>Focused expanded problem</td>
</tr>
<tr>
<td>Extended</td>
<td>Extended</td>
<td>Pertinent</td>
<td>Detailed</td>
</tr>
<tr>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>
Medical decision making has four levels

<table>
<thead>
<tr>
<th># of diagnostic/management options</th>
<th>Amount of data to review</th>
<th>Risk of complications</th>
<th>Type of decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal/no one</td>
<td>Minimal</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td>Low complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Moderate complexity</td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td>High complexity</td>
</tr>
</tbody>
</table>
E&M office visit can fall into one of two categories

<table>
<thead>
<tr>
<th>New</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Level</td>
<td>Code</td>
<td>Time (min)</td>
<td>$$</td>
</tr>
<tr>
<td>Level I</td>
<td>99201</td>
<td>-</td>
<td>$20</td>
</tr>
<tr>
<td>Level II</td>
<td>99202</td>
<td>10</td>
<td>$75</td>
</tr>
<tr>
<td>Level III</td>
<td>99203</td>
<td>30</td>
<td>$108</td>
</tr>
<tr>
<td>Level IV</td>
<td>99204</td>
<td>45</td>
<td>$166</td>
</tr>
<tr>
<td>Level V</td>
<td>99205</td>
<td>60</td>
<td>$207</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Established</th>
<th></th>
<th></th>
<th></th>
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<tbody>
<tr>
<td>Level</td>
<td>Code</td>
<td>Time (min)</td>
<td>$$</td>
</tr>
<tr>
<td>Level I</td>
<td>99211</td>
<td>-</td>
<td>$20</td>
</tr>
<tr>
<td>Level II</td>
<td>99212</td>
<td>10</td>
<td>$44</td>
</tr>
<tr>
<td>Level III</td>
<td>99213</td>
<td>15</td>
<td>$73</td>
</tr>
<tr>
<td>Level IV</td>
<td>99214</td>
<td>25</td>
<td>$108</td>
</tr>
<tr>
<td>Level V</td>
<td>99215</td>
<td>40</td>
<td>$144</td>
</tr>
</tbody>
</table>

3/3 component documentation

2/3 component documentation
E&M inpatient care also falls into one of two categories

<table>
<thead>
<tr>
<th>Initial Hospital Care</th>
<th>Subsequent Hospital Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level</strong></td>
<td><strong>Code</strong></td>
</tr>
<tr>
<td>Level I</td>
<td>99221</td>
</tr>
<tr>
<td>Level II</td>
<td>99222</td>
</tr>
<tr>
<td>Level III</td>
<td>99223</td>
</tr>
</tbody>
</table>

3/3 component documentation

2/3 component documentation
Case 1: New consult for GI bleed

• 3/3 of detailed history, detailed exam, straightforward/low complexity medical decision making
  • Or 30 minutes of face to face time

• ICD-10: K92.2
  • Bleeding in any segment of the GI tract from esophagus to rectum

• E&M Initial Hospital Care, Level I, 99231
Case 2: Inpatient followup after PCN placement

- 2/3 of either expanded problem focused history, expanded problem focused exam, moderate complexity medical decision making
  - Or 25 minutes of face to face time
- ICD-10: N 13.2
  - Hydronephrosis with renal and ureteral calculous obstruction
- E&M: Level II, 99232

<table>
<thead>
<tr>
<th>Level</th>
<th>E&amp;M</th>
<th>History</th>
<th>PE</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>99231</td>
<td>Problem focused</td>
<td>Problem focused</td>
<td>Straightforward/Low</td>
<td>15</td>
</tr>
<tr>
<td>2</td>
<td>99232</td>
<td>EPF</td>
<td>EPF</td>
<td>Moderate</td>
<td>25</td>
</tr>
<tr>
<td>3</td>
<td>99233</td>
<td>Detailed</td>
<td>Detailed</td>
<td>High</td>
<td>35</td>
</tr>
</tbody>
</table>
Case 3: New visit for varicose veins

• 3/3 of detailed history, detailed exam, and straightforward/low complexity medical decision making
  • Or 30 minutes of face to face time

• ICD-10: K 92.2
  • Bleeding in any segment of the GI tract from the esophagus to the rectum

• E&M: New office visit, level I: 99203
Adventist Health System to Pay $118.7 Million to Settle False Claims Charge

By Editor Filed in News September 21st, 2015 @ 4:39 pm

Adventist Health System will pay a total of $118.7 million to the federal government and four states to settle a whistleblower lawsuit filed in December 2012 by three former employees.
Summary

• The rewards of a strong clinical practice are great but require real time and effort

• A clear financial benefit can be seen with a robust clinical practice

• The devil is in the details of E&M coding and require compliant documentation
Thank you

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