Specialty Audit Billing Clarification

March 31, 2023

Since November, the Colorado Hospital Association (CHA), the Colorado Medical Society (CMS), and HCPF have been discussing a component of an audit specifically related to billing practices for initial codes. The most recent Department response continues omit any justification from HCPF's provider billing manual or sound guidance from the American Medical Association (AMA) current procedural terminology (CPT) that contradicts the basic billing principle that admitting providers and consultants are able to and encouraged to code the first time they saw the patient under the initial visit (99221, 99222, 99223) for any given hospital stay. CHA and CMS continue to strongly believe Medicaid payment reviews and audits have value to ensure the state's resources are safeguarded from fraud, but also that these reviews and audits should be consistent with clear, transparency billing standards and warranted, effective, and efficient.

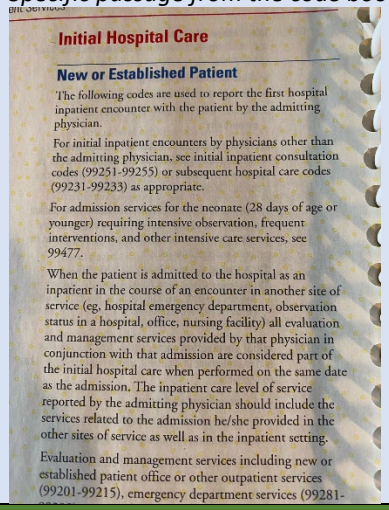
CHA and CMS prepared the following questions to seek to clarify the appropriate initial visit billing procedures in Colorado to ensure providers are aware of and following the correct billing procedures to further the integrity of the Medicaid program. Providers are currently billing claims consistent with AMA guidance without contradictory HealthFirst guidance; however, they appear to be inappropriately audited. **As there remains significant differences between HCPF's recounting of AMA and HCPF billing procedures and the existing documentation, CHA and CMS request that this audit remain paused pending a determination by the Court of Appeals concerning any active appeal on this matter or an outside review by a third-party billing expert.**

Core, Outstanding HCPF Payment Policy Question
Where is the policy that HCPF is interpreting (either through Health First provider billing or AMA guidance) that consultants cannot bill initial codes? Furthermore, in the absence of a stated policy, why is HCPF through HMS clawing back money for claims that comports with established billing guidelines?
Procedural Payment Policy Question
If HCPF does not recognize the AI modifier, then how are providers fairly compensated in line with AMA guidance?
Relevancy Question
For the citations concerning HIPAA and NCCI, CHA and CMS do not see a relevant connection to any payment policy or principles – what position are these citations intended to affirm?

In the Appendix, CHA and CMS provide a graphic of standard billing practice for ease of reference (Appendix A) and a timeline of communications for consistency (Appendix B).

Background on Specialty Payment Policies		
Core, Outstanding HCPF Payment Policy Question		
Question(s)	**HCPF 2.2.23 Policy Position**	**CHA/ CMS Response**
The core outstanding question continues to be: **<u>Where is the policy that HCPF is interpreting (either through Health First provider billing or AMA guidance) that consultants cannot bill initial codes?</u>** **Furthermore, in the absence of a stated policy, why is HCPF through HMS clawing back money for claims that comports with established billing guidelines?**	The Department does not publish each AMA CPT/HCPCS code, but if a deviation from the AMA coding guidelines occurs, the Department is required to publish the guidance that is specific to Health First Colorado as a payor. The documentation sent to the Department by Colorado Hospital Association and Colorado Medical Society was related to claims processing specific to Medicare and it states "*Policy: Effective January 1, 2010, the consultation codes are no longer recognized for Medicare Part B payment. Link: (<u>Principal Physician of Record</u>; MAC Transmittal)*	The Department recognizes an obligation "to publish the guidance that is specific to Health First Colorado" when it "deviates from AMA coding guidelines", however **despite several requests, we have still not been provided a copy of this guidance.** The specific point of clarification relates to the process for billing the initial visit code. AMA guidance governs the process for Medicare (and subsequent Medicaid unless specifically outlined) coding practices. As a reminder on the Medicare billing practice, according to the CMS.gov memo titled "Revision to Consultation Services Payment Policy" effective Jan. 1, 2010 and available here (page 3, section B), the following rules are to be applied: *Multiple billings of initial hospital and nursing home visit codes could occur even in a single day.* *Modifier "-AI," defined as "Principal Physician of Record," shall be used by the admitting or attending physician who oversees the patient's care, as distinct from other physicians who may be furnishing specialty care.* In addition, see the section on page 16 title "30.6.10 Consultation Services (Codes 99241-99255)" which states: *In the inpatient hospital setting and the nursing facility setting all physicians (and qualified nonphysician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221 – 99223).*

		The principal physician of record shall append modifier "-AI", Principal Physician of Record, in addition to the E/M code.
	With regard to consultations, The Health First Colorado Medical/Surgical Provider Billing Manual states that Providers must comply with coding standards. This is also part of the Provider Agreement. It states: *"Effective April 1, 2010, CPT consultation codes (ranges 99241-99245 for office/outpatient consultations and 99251-99255 for inpatient consultations) will no longer be recognized for payment. This change was implemented to be consistent with Medicare policy.* *Please submit claims for consultation services using another Evaluation and Management (E/M) code that most appropriately represents where the visit occurred and that identifies the complexity of the visit performed."* Link: (Medical-Surgical Billing Manual | Colorado Department of Health Care Policy & Financing)	We strongly agree that Medicare/ Medicaid disallows the use of consultation codes. The end of consultation codes led to the change where admitting and consulting providers can and should bill for the initial visit code the first time they see the patient. To the best of our knowledge, there is no published guidance from the Department that differs from CMS guidance in this regard as no guidance has been provided at this time.
	For AMA and CPT codes, initial and subsequent hospital care codes are not "new" or "established" patient codes. These codes pertain to the patient's encounter and define the progression of services throughout the inpatient stay. Subsequent care is any care (as applicable to the code set) that happens after the Client is admitted. This is clearly defined in AMA CPT rules.	Subsequent care is any care provided by a physician after that physician's (or practice partner/covering) INITIAL visit. The previously cited document clearly states that more than multiple initial billing codes can occur even in a single day.
	All providers beyond the admitting providers may bill the evaluation and management codes that best identify the services provided. All other treatments, interventions, or applicable and billable services are still payable to the consultant physician, but the initial code is a code that should not be duplicative. AMA rules for all years in our	This quote from the AMA CPT Book appears only in the AMA code book and applies only to commercial payors as this coding scheme remains relevant for them. As referenced previously in our correspondence and affirmed by HCPF, providers have been directed not to use consult codes for government payors since 2010.

	audit define the appropriate code to use and it states: *"The following codes (99221-99223) are used to report the first hospital inpatient encounter with the patient by the admitting physician. For initial inpatient encounters by physicians other than admitting physicians, see initial inpatient consultation codes (99251-99255) or subsequent hospital care codes (99231-99233) as appropriate."*	*Specific passage from the code book denoted below:*  **Initial Hospital Care** **New or Established Patient** The following codes are used to report the first hospital inpatient encounter with the patient by the admitting physician. For initial inpatient encounters by physicians other than the admitting physician, see initial inpatient consultation codes (99251-99255) or subsequent hospital care codes (99231-99233) as appropriate. For admission services for the neonate (28 days of age or younger) requiring intensive observation, frequent interventions, and other intensive care services, see 99477. When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service (eg, hospital emergency department, observation status in a hospital, office, nursing facility) all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The inpatient care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the inpatient setting. Evaluation and management services including new or established patient office or other outpatient services (99201-99215), emergency department services (99281-
Procedural Payment Policy Question		
If HCPF does not recognize the AI modifier, then how are providers fairly compensated in line with AMA guidance?	The Audit did not consider the -AI modifier because this rule does not apply to Health First Colorado (Medicaid) policies. CMS.gov has the right to make their own rules as a payor, as does Health First Colorado. We make rules that are most beneficial to the population of Clients we serve in Colorado. For Providers billing for Medicare Part B, I would encourage them to follow the rules of that payor. Any CMS.gov guidance that is from the Code of Federal Regulations (CFR), under subsections specific to State Programs, is what we are required to follow as Medicaid. All payers and providers do have to follow HIPAA and Federal regulations mandated by CMS.gov for coding standards, including following AMA Specific Coding Rules. Link: (eCFR :: 45 CFR 162.1002 -- Medical data code sets.).	This is an incomplete answer that fails to understand that the standard billing practice for these sets of codes recognizes that admitting and consulting providers can and should bill the initial visit code when seeing a patient for the first time. **Standard practice is that the AI modifier is used to identify the sequence of patient visits during the course of billing multiple initial visit codes as appropriate.** We were not able to find any documentation in HCPF's HealthFirst billing manual that contradicts the use of the AI modifier or provides an alternative process to comply with the AMA coding rules HCPF is purporting to follow.
Relevancy Question		

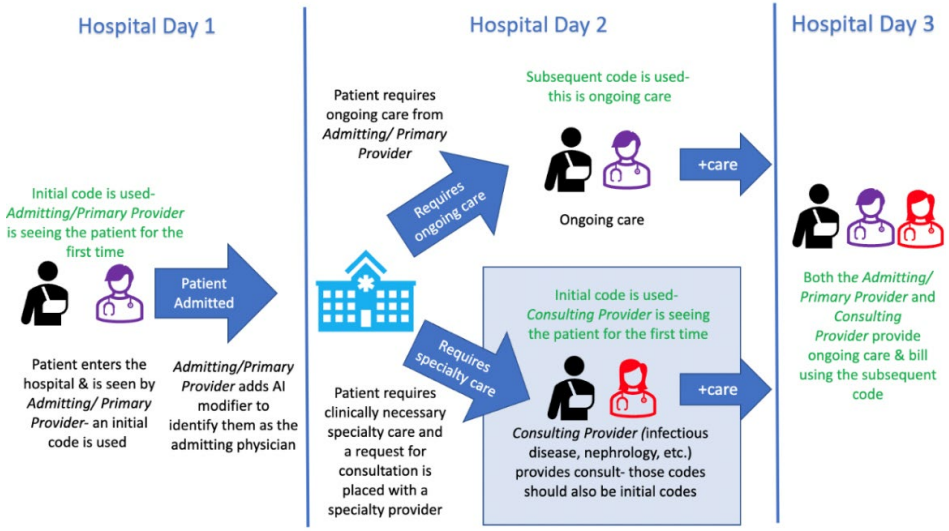
For these citations, CHA and CMS do not see a relevant connection to any payment policy or principles – what position are these citations intended to affirm?	For more information here is a Link to 20 years of HIPAA, including the Administrative Simplification Act and Code sets. https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/Downloads/Timeline-of-Key-Statutes-and-Regulations-20181116.pdf	There is no substantive link between this background and the policy being disputed.
	Another set of rules we are required to follow is National Correct Coding Initiative (NCCI) Rules published by CMS.gov. Please note there is a difference between Medicare NCCI rules and Medicaid NCCI rules as our population of Clients is different. To help explain the background of the published manuals, NCCI States: *The NCCI Policy Manual for Medicaid Services and the edits were developed for the purpose of encouraging consistent and correct coding and reducing inappropriate payments. The edits and policies do not include all possible combinations of correct coding edits or types of unbundling that exist. Providers are obligated to code correctly even if edits do not exist to prevent use of an inappropriate code combination. If a provider determines that they have been coding incorrectly, the provider should contact his/her state Medicaid agency or fiscal agent about potential payment adjustments.The NCCI Policy Manual for Medicaid Services and edits were initially based on evaluation of procedures referenced in the 2010 CPT Manual and HCPCS Level II codes. An ongoing refinement program has been developed to address annual changes in CPT codes and instructions including additions, deletions, or modifications of existing codes or instructions. Additionally, ongoing changes occur based on changes in technology, standard medical practice, and input from the AMA, specialty societies, other national health care organizations, Medicaid*	The link above points to a generic page which does not list the paragraph mentioned. The manual, Chapter U specifically, does not mention any of the language noted above. Chapter U describes the principles and entirely comports with the standards of billing as providers as we have presented them.

	*contractor medical directors and staff, providers, consultants, etc.*Additionally, Evaluation & Management codes are covered throughout the NCCI manuals to address when to use certain codes for specific services. It states throughout the chapters "Since initial inpatient consultation services with a patient present are reported using per diem CPT codes 99231-99233…". This again, clearly states that Providers should be using the subsequent care codes. Link: https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicaid	

Appendix:

Appendix A: Below is a graphic that documents the billing process and specifically identifies what visits are being inappropriately denied. As illustrated below (*when the Consulting Provider in red provides care for the first time*), the Consulting Provider's claim using the initial code is being incorrectly denied.

Process Step-By-Step:



Appendix B: Below is a brief timeline of events to ensure consistency across conversations:

- Formal conversations began in November between CHA, the Colorado Medical Society and HCPF- HCPF was not able to clarify the origination of the billing rules. Dec. 14 HCPF Memo
- On Jan. 5, 2023, CHA and the Colorado Medical Society submitted a memo providing clear documentation from the federal billing rules that contradicts the basis of HCPF's audit.
- On Jan. 23, 2023: CHA and the Colorado Medical Society met with HCPF and were informed that there was no contradictory HCPF billing rule and that HCPF's billing in this manner complies with federal billing standards.
- CHA and the Colorado Medical Society immediately connected with the federal Centers for Medicare and Medicaid Services who noted that while states have their own processing guidelines, CHA and the Colorado Medical Society's confirmed that the federal billing guidance documents that affirmed the CHA/ Colorado Medical Society position were accurate and the most recent federal billing guidance – a call between HCPF federal CMS and the stakeholders was requested.
    - On Feb. 21, the Centers for Medicare and Medicaid Services indicated they would not be able to get involved in a state billing dispute as they are not experts on those practices.
- CHA clarified that they were asking about federal billing rules as that is what HCPF indicated the state is using on the Jan. 23 call.
    - On Feb. 22, HCPF changed course and indicated that they do not utilize the same billing modifiers as the federal government but remains unable to provide documentation for how that operates.