



REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH VA 22041-3258



DASG-ZH

09 APR 2003

MEMORANDUM FOR Commanders, MEDCOM Regional Medical Commands

SUBJECT: Coding and Billing Compliance Policy

1. References.

a. American Health Information Management Association (AHIMA) Standards of Ethical Coding, 1999.

b. AHIMA Coding Policy and Strategy Committee, "Practice Brief: Data Quality," Journal of AHIMA 67, no. 2 (1996).

c. Prophet, Sue, Health Information Management Compliance, AHIMA, 2002.

2. This memorandum provides policy and procedures military treatment facility (MTFs) must adhere to in ensuring uniform and compliant coding and billing practices. It provides the background on coding and billing compliance issues and procedures to address these issues, including management of claims denied due to coding.

3. As we transition to outpatient itemized billing, effective 1 October 2002, coding of outpatient services directly impacts billing. Since we use Diagnosis Related Groups for billing inpatient services, inpatient coding also directly impacts billing. It is, therefore, critical that our coding practices adhere to the official guidelines for coding and reporting; including the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), and Current Procedural Terminology/HCFA Common Procedure Coding System. Third party payers do not uniformly adhere to these coding guidelines, requiring MTFs to stress to payers the importance of adhering to them. The imperative is to ensure appropriate reimbursement while also complying with coding guidelines.

4. Medical treatment facility commanders will develop and implement a coding compliance plan that includes procedures to address issues and corrective actions identified herein. The coding compliance plan will complement the established MTF Uniform Business Office (UBO) compliance plan. Additionally, the procedures and corrective actions identified in this policy, as they apply to billing, will be incorporated into the MTF UBO Compliance Plan. All coding and billing personnel must be familiar with these issues and procedures for taking corrective action.

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5. To assist you in meeting these requirements, the following guidance documents are enclosed:

- a. Background - Coding and Billing Compliance Issues (enclosure 1).
- b. Guidance - How to Manage Claims Denied Due to Coding (enclosure 2).
- c. Sample Letter of Appeal for Claims Denied Due to Coding (enclosure 3).

6. Our points of contact for coding is MAJ Joan Ulsher, Directorate of Patient Administration Systems and Biostatistics Activity, DSN 421-8936 or Commercial (210) 295-8936; and for billing is Mr. Doug Ashby, Patient Administration Division, Office of the Assistant Chief of Staff for Health Policy and Services, DSN 471-7840 or Commercial (210) 221-7840.

FOR THE SURGEON GENERAL:

3 Encls


JAMES K. GILMAN
Colonel, MC
Acting Assistant Surgeon General
for Force Projection

Enclosure 1

Background – Coding and Billing Compliance Issues

1. The collection of accurate and complete coded data is critical to healthcare delivery, research and analysis, reimbursement, and policy-making. The integrity of coded data and the ability to convert it into functional information requires that all users consistently apply the same official coding rules, conventions, guidelines, and definitions (the basis of coding standards). Use of uniform coding standards reduces administrative costs, enhances data quality and integrity, and improves decision-making--all leading to quality healthcare delivery and information.

2. Today, many coding practices are driven by health plan or payer reimbursement contracts or policies requiring providers to add, modify, or omit selected medical codes to reflect the plan or policies, contrary to standards for proper use of the official code sets. Code sets are not revised on the same date, and often payers require the continued use of deleted or invalid codes. These variable requirements, which affect all the medical code sets currently required for claims submission to third party payers, undermine the integrity and comparability of healthcare data.

3. The American Health Information Management Association (AHIMA) Standards of Ethical Coding states that:

Coding professionals should not change codes or the narratives of codes on the billing abstract. When individual payer policies conflict with official coding rules and guidelines, these policies should be obtained in writing. Reasonable efforts should be made to educate the payer on proper coding practices in order to influence a change in the payer's policy.

4. The AHIMA clearly states that it is the medical facility's responsibility to confront payers when denials in claims are determined to be due to a conflict between a payer requirement and the official coding rules or guidelines. Coding and billing staff are responsible for contacting that payer and explaining the irregularity and indicating that the conflict could cause data inconsistency and comparability problems. The applicable coding guidelines should be referenced in discussions, and included with any documentation sent to the payer for resolving the conflict.

5. The AHIMA's Payer's Guide to Healthcare Diagnostic and Procedural Data Quality, available at www.ahima.org, is a useful tool to support the MTF's position and the underlying rationale.

6. When the payer involved is Medicare and no satisfactory resolution is achieved with the Fiscal Intermediary, the appropriate Center for Medicare and Medicaid Services (CMS) regional office should be contacted. If the payer still refuses to change its policy, an attempt should be made to obtain the policy in writing. If the payer refuses to provide the policy in writing, all conversations with the payer should be documented, including dates, names of individuals involved, and the substance of the discussion. Furthermore, confirmation of the payment policy should be obtained from the payer's management. The MTF should work with the Medicare Fiscal Intermediary or third party payer to resolve any issues where it appears that CMS policies or coding guidance is being interpreted incorrectly.

7. The Health Insurance Portability and Accountability Act (HIPAA) requires the adoption of standards for code sets for data elements that are part of all healthcare transactions. The regulation pertaining to electronic transactions and code sets promulgated under the HIPAA includes the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) and Current Procedural Terminology /HCFA Common Procedure Coding System. Under the HIPAA, both payers and providers are required to adhere to the official ICD-9-CM Guidelines for Coding and Reporting. The MTFs should stress the importance of adhering to these guidelines with their payers so that MTFs will receive the appropriate reimbursement for the item or service without being required to violate coding rules and guidelines.

8. Any discrepancies between payer policies and official guidelines should be investigated. All payment denials, full or partial, believed to be inappropriate, should be appealed. Claims denials should be monitored for patterns of errors and corrective action should be initiated when a pattern is identified.

Enclosure 2

Guidance – How to Manage Claims Denied Due to Coding

I. Scenario: Insurance carrier partially or fully denies payment on a claim, indicating that coding was invalid or does not meet their requirements.

II. Investigation:

A. Billing Supervisor: Will ensure that the billing office personnel do not change coding to accommodate the payer's requirements. Rather, the following actions will be taken.

1. Pull claim data to identify the codes used for billing.

a. Contact insurance carrier or visit them in person, if possible, to identify why the claim was denied and what CPT (or other) code they are looking for on the claim. If possible, obtain in writing, the reason for claim denial, and the specific (code(s)) they want on the claim in lieu of those used, and why. If successful in getting the insurance carrier to reconsider the claim, resubmit the claim. If you were unsuccessful, continue with step b.

b. If the code is for a service not covered by the plan, obtain proof, attach it to the claim file with the Explanation of Benefits (EOB), and have the claim closed.

c. If the code used is not recognized by the plan's system, request they explain in writing why, and they provide the code that is recognized in that particular situation. Attach this explanation to claim file with the EOB and provide to coding auditor or coding supervisor for review.

2. Document the name of the individual you spoke with, the telephone number you called, the date, time, and the content of your discussion with the insurance carrier representative.

3. Obtain the mailing address to send an appeal and a telephone number to contact related to appeals. If available, obtain the name of an individual to contact regarding appeals.

4. Take all information gained to the billing supervisor for coordination with the coding supervisor or coding auditor.

5. Billing supervisor coordinate with the coding auditor or supervisor, to discuss the claim denial and to ask them to review the coding to verify it is correct.

6. Track and trend denials by payer for reasons associated with coding.

B. Coding Auditor or Coding Supervisor.

1. Pull the medical documentation for the claim.

2. Review the coding on the claim.

a If the coding is correct:

(1) Make a copy of the applicable coding guidelines.

(2) Provide to billing supervisor a written summary of why the coding on the claim is correct, and cannot be changed to meet the insurance carrier's requirements, attaching the coding guidelines.

(3) Billing supervisor submits appeal to insurance carrier, attaching written justification of why coding is correct (see paragraph III).

b If the coding is not correct, coordinate with billing supervisor to revise the coding on the claim for resubmission by billing. Correct all coding documentation to correspond with the revised coding on the claim.

III. Appeal Letter – Billing prepare a letter of appeal (see sample letter, enclosure 3).

A. First Paragraph outlines the reason you are writing your letter.

B. Tell your story - why the claim should be reconsidered for payment and actions previously taken (indicating dates and with whom you spoke) with payer in an attempt to resolve.

C. State your request and ask if additional information is needed.

D. Indicate how the insurance carrier can contact you.

E. Close the letter.

Enclosure 3

Sample Letter of Appeal

UBO Rep & Phone #
Mailing Address
City, State Zip Code

Current Date

Name of Insurance Carrier
Contact
Mailing Address
City, State Zip Code

Re: Patient Name, Insurance Carrier Identification Number, Insurance Carrier Group Number (if necessary), Date of Service, Claim Number

Dear XXXXX (To Whom It May Concern),

You have apparently denied/reduced payment of the above referenced claim(s) because (MTF Name) submitted an invalid (ICD-9-CM/CPT/HCPCS) code, to which we disagree.

Upon investigation of this denial, we have identified that the coding on this service (indicate code used) is correct under the current coding guidelines, which are attached for your review.

(Name of the MTF) makes every effort to ensure that claims are submitted with the accurate coding. Request you consider the attached information and reprocess this claim for payment. If you require additional clinical documentation to support the services provided, please submit your request in writing to: Name MTF, Mailing address, City, State zip code.

Thank you in advance for your time and consideration of this request. If I can provide you with additional detail, feel free to contact me at the above noted telephone number.

Sincerely,

Signature
NAME
Title

- 2 Atchs
1. Coding Guidelines
2. Additional Information

Enclosure 3