



REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2748 WORTH ROAD
FORT SAM HOUSTON, TEXAS 7823443000

OTSG/MEDCOM Policy Memo 11-101

12 DEC 2011

MCHO-CL-P

Expires 12 December 2013

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, 2008.
http://library.ahima.org/xpedio/proups/public/documents/ahima/bok2_001166.hcsp?dDocName=bok2_001166.

b. AHIMA Coding Products and Services Team. "Managing and Improving Data Quality (Updated) (ANIMA Practice Brief)." *Journal of ANIMA* 74, no.7 (Jul/Aug 03):
http://library.ahima.org/xpedio/proups/public/documents/ahima/bok1_019255.hcsp?dDocName=bok1_019255.

c. Bowman, Sue, Health Information Management Compliance: Guidelines for Preventing Fraud and Abuse, Fourth Edition, ANIMA, 2007.

d. Office of Inspector General, Department of Health and Human Services, Compliance Program Guidance for Hospitals, 1998,
<http://oio.hhs.gov/authorities/docs/cpphosp.Pdf>, and OIG Supplemental Compliance Program Guidance for Hospitals, 2005,
<http://olp.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance>.

2. Purpose: To provide policy and procedures for ensuring uniform and compliant coding and billing practices, and provide procedures to address coding and billing compliance issues including management of claims denied due to coding.

3. Proponent: The proponents for this policy are the Patient Administration Systems and Biostatistics Activity, Assistant Chief of Staff, Program Analysis and Evaluation and the Patient Administration Division, Assistant Chief of Staff, Health Policy and Services.

4. Policy: Since our transition from all-inclusive billing to outpatient itemized billing, on 1 Oct 02, coding of outpatient services directly impacts billing. Since we use Diagnosis Related Groups for billing inpatient services, inpatient coding also directly impacts billing. Therefore, it is critical that our coding practices adhere to the Military Health

*This policy supersedes the OTSG/MEDCOM Policy Memo 09-088, 17Nov 09, subject: Coding and Billing Compliance Policy.

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System (MHS) coding guidelines and industry standard official guidelines for coding and reporting, including the International Classification of Diseases, 9th Revision, Clinical Modification and Current Procedural Terminology/Healthcare Common Procedure Coding System. The imperative is to ensure appropriate reimbursement while also complying with coding guidelines.

5. Responsibilities: Military treatment facility (MTF) Commanders will develop, implement, and maintain a coding compliance plan to be updated annually. The coding compliance plan will include procedures to address issues and corrective actions identified in this policy. The coding compliance plan will complement the 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.

6. Procedures: To assist 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).
- d. Sample Spreadsheet for Tracking Claims Forwarded for Coding Review (Enclosure 4).

FOR THE COMMANDER:
Encls ERBERT HOLEYV

as Chief of Staff

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 require 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 ANIMA 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, obtain the payer policies 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 ANIMA 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 ANIMA Payer's Guide to Healthcare Diagnostic and Procedural Data Quality, 2001 edition, available at www.ahima.org, is a useful tool to support the MTF's position and the underlying rationale.
6. 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 HIPAA includes the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) and Current Procedural Terminology/Healthcare Common Procedure Coding System. Under 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.
7. 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. See enclosures 2 and 3 for additional guidance on managing claim denials and submitting appeals.

Enclosure 1

Guidance - How to Manage Claims Denied Due to Coding

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

2. Investigation:

a. Billing Supervisor: Will ensure the billing office personnel do not change diagnosis or procedure coding to accommodate the payer's requirements and that the following actions are performed:

(1) Pull claim data to identify the diagnosis and procedure codes used for billing.

(a) Contact insurance carrier to identify why the claim was denied and what diagnosis or procedure code they are looking for on the claim. If possible, obtain in writing, the reason for claim denial, and the specific diagnosis or procedure codes 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 unsuccessful, continue with step "b".

(b) If the diagnosis or procedure code used is for a service not covered by the plan, obtain proof, attach it to the claim file with the Explanation of Benefits (EOB), and close the claim with the appropriate transaction code.

(c) If the diagnosis or procedure code used is not recognized by the payer's system, request an explanation in writing and request an alternative diagnosis or procedure code that would be recognized and appropriate to the situation. Forward packet to coding for review:

(1) Attach the explanation and alternate codes suggestions to the claim file with the EOB.

(2) Establish a spreadsheet to track and trend claim review requests and outcome. A sample spreadsheet is provided at Enclosure 4.

(3) Attach to the claim file, a coding review request sheet or send electronically via encrypted email to coding auditor or coding supervisor for review.

(2) Document the name of the insurance carrier representative, not; his/her contact number, email address, if possible, date/time and a summary of the discussion.

(3) Obtain a mailing address and contact information of the appeals department, in the event an appeal must be filed. It may be necessary to supply this information to coding if coding professional intervention is required.

(4) Track and trend denials by payer for reasons associated with coding.

b. Coding Auditor or Coding Supervisor: Will ensure the claim is reviewed and compared to the medical documentation and coding and that the following actions are performed:

Enclosure 2

(1) If the coding is correct, and a change of coding as suggested by the insurance carrier is not justified, a written summary explanation should be provided to the billing office along with a copy of the applicable coding guidelines; in order that an appeal can be filed.

(2) If the coding is not correct, properly code encounter and coordinate with billing office to revise the claim to reflect the coding changes so that the claim can be resubmitted.

c. Billing Office Appeal: In the event that the coding department disputes the insurance carriers' decision, an appeal must be filed.

(1) Obtain written summary explanation from coding department.

(2) Complete appeal letter (Enclosure 3) and submit to insurance carrier along with a copy of applicable coding guidelines.

(3) Track appeal on Claims Denied Due to Coding spreadsheet. A sample spreadsheet is provided at Enclosure 4.

Sample Letter of Appeal

Current Date

MTF Name
Uniform Business Office
Tax ID Number
NPI Number
Mailing Address
City, State ZIP

Name of Insurance Carrier
Contact/Appeals Department
Mailing Address
City, State ZIP

Re: Patient Name, Policy Identification Number, Group Number (if applicable), Date of Service,
Claim #

To Whom It May Concern:

Payment for the above referenced claim was denied or reduced for the following reason:

(Insert denial reason provided by insurance carrier)

Upon investigation of this denial and the related medical documentation, we have identified the coding on this service [indicate code used] to be correct and, therefore, must dispute your original denial.

Enclosed with this appeal, is a copy of the coding guidelines which was used to support our determination.

(MTF Name) makes every effort to ensure that claims are submitted with accurate coding. We are requesting you to consider the enclosed information and reprocess this claim for payment. If you require additional documentation to support the services provided, please submit your request in writing to: MTF Name, ATTN: Uniform Business Office, Mailing Address, City, State ZIP.

Thank you in advance for your time and consideration of this request. Please contact the undersigned at (insert email address and telephone number) should you have any questions concerning this request.

Sincerely,

Signature
Name
Title

2 Ends

1. (Correct Coding *Evidence*)
2. (Explanation of Benefits)

Enclosure 3

Sample Spreadsheet for Tracking Claims Forwarded for Coding Review

DOS	MEPR	Acct i	Type	Code	Date to	Ins Co	Description of Code	Code	Reason for Dental	Ins Co	Coding	Coding	U BO Action	Date of	R
		Case#	of Bill	D	D						for	Review		Action	
											Review	Outcome			
3-Mar-07	BGAA	A21662	Lab/Rad	V78.9		051	Unspecified disorder of blood and blood-forming organs		Because these charges were for services that were not related to specific	MHBP	03-Apr-07	Dx Code Corrected	Resubmitted	03-May-07	P; C
3-Mar-07	BGAA	A21655	Clinic	W2.31		D27	Routine cervical papanicoleou smear that is part of a general gynecological exam		NC due to only pays for ono per year	BC BS	03-Apr-07	Dx Code Corrected	Resubmitted	03-May-07	P; INF
3-Mar-07	BBAA	A07-5355	Lab/Re d	V72.0		1442	Examination of eyes and vision		This charge is NC by the membas plan	UHC	03-Apr-07	Dx Code Corrected	Resubmitted	03-May-07	P;
3-Mar-07	BGAA	A21764	Clinic	99212		287	Office visit modifier -25 from 99396 to 99212		Not covered at same visit	Aetna	03-Apr-07	Moved	Resubmitted	03-May-137	Pa
3-Mar-07	BAPA	A22001	Clinic	70.09		9213	Oh Oryschfania submitted is invalid because it does not exist		The procedureDx code	APWU	03-Apr-07	Dx Code Corrected	Resubmitted	03-May-07	Pai PF
3-Mar-07	MAA	A07-5400	ER	882.6		078	Cellulitis of buttock		Non emergent ER Is NC	GEHA	03-Apr-07	Ox Code	Resubmitted	03-May-07	Pai OC
Mar-07	*AAA	A07-6428	Lab/Rad	780.99		1007	Other General Symptoms		Da code is too generic	Cigna	03-Apr-07	Dx Code Corrected	Resubmitted	03-May-07	Pai
3-Mar-07	OHH	A07-6214	Clinic	11200		28	Removal of Skin Tag medically necessary Procedure was medically necessary		Procedure was not	MHBP	03-Apr-07	Coding disputes.	Appeal filed	03-May-07	Per

* OON = OUT OF MINE.*
 ** NN = In NoWork

Enclosure 4