HCCA’s 2002 Annual Compliance Institute
Coding for Attorneys and Compliance Professionals

Presented By:
Georgette Gustin, CPC, CCS-P, CHC
Susan N. Postal, MBA, RHIA

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Objectives

- Provide an overview of common coding classifications used in the inpatient, ambulatory, and physician settings
- Describe commonly used nomenclature and terminology
- Describe the components of a successful coding/Health Information Management (HIM) compliance program
Physician Professional Services
Understanding Physician Professional Services

✓ Part B Carrier processes
✓ Coding Classifications
  – CPT 4
  – ICD-9-CM
  – HCPCS Level II
✓ HCFA 1500 Form
✓ Place of Service
✓ Type of Service
**Part B Carrier Processes**

- **The Medicare Program** is divided into two parts: Part A or Hospital/Inpatient and Part B or Physician or Outpatient Services
- Part B covers physician services, DME, outpatient hospital services, x-rays, lab tests, home health, ambulance, etc.
- Medicare Part B covers individuals 65 years of age and older (also covers patients with certain disabilities) and is voluntary for those individuals willing to pay a small premium
- Develop Local Medical Review Policies (LMRP)
CPT-4: Overview

- **CPT-4** is the American Medical Association’s Current Procedural Terminology, Fourth Edition (first level of HCPCS codes)
  - Published annually by the AMA - proprietary
  - Transforms medical services and procedures into 5 digit numeric codes
  - Communicates “what” service was provided
  - Divided into 6 major sections
  - Over 8,000 CPT codes
  - Contains 2-digit numeric modifiers
**ICD-9-CM: Overview**

- **ICD-9-CM** is the International Classification of Diseases, Ninth Revision, Clinical Modification
  - Updated annually in October by CMS and public domain
  - Contains 3, 4 and 5 digit codes
  - Contains diagnosis and procedure codes
  - Arranged by diseases, injuries, and causes of death according to established criteria
  - 3 Volumes
    - Volume 1 contains the Tabular List of Diseases and Injuries
    - Volume 2 contains the Alphabetic Index of Diseases and Injuries
    - Volume 3 includes the Tabular List and Alphabetic Index to Procedures - used for facility billing
  - Only Volumes 1 and 2 are used for physician professional services
  - Communicates “why” the service was provided
**HCPCS Level II: Overview**

- **HCPCS Level II** is the acronym for Healthcare Financing Administration Common Procedure Coding

  - National codes published annually CMS and public domain
  - Codes consist of an alphanumeric code – a letter from A through V followed by four digits
    - J1160, injection digoxin, up to 0.5 mg
  - Grouped by the type of supply or service they represent
    - Home Health, Rehabilitation
    - Injections-Chemotherapeutic Drugs
    - Orthotics/Prosthetics
    - Durable Medical Equipment
  - Used by Medicare and private payers
HCFA 1500 Form

- HCFA 1500 provides a uniform mechanism to report codes and bill for physicians and payers
  - Clean claims when completed correctly
  - Accepted by most payers
  - Used to report procedures and diagnoses
  - Mismatch between place of service (POS) and type of service
    - POS by facility vs. provider
    - POS differential
# HCFA 1500 Form

## Health Insurance Claim Form

### Patient Information
- **Name (Last Name, First Name, Middle Initial):**
- **DOB:**
- **Sex:** M/F
- **Relationship to Insured:**
- **Address:**
- **City:**
- **State:**
- **ZIP Code:**
- **Employer:**
- **Full-Time:**
- **Part-Time:**
- **Single:**
- **Married:**
- **Other:**

### Insured's Information
- **Insured's I.D. Number:**
- **Insured's Date of Birth:**
- **Sex:** M/F
- **Employer's Name or School Name:**
- **Address:**
- **City:**
- **State:**
- **ZIP Code:**
- **Telephone (Include Area Code):**

### Other Insured's Information
- **Name (Last Name, First Name, Middle Initial):**
- **DOB:**
- **Sex:** M/F
- **Relationship to Insured:**
- **Address:**
- **City:**
- **State:**
- **ZIP Code:**
- **Telephone (Include Area Code):**

### Insurer's Information
- **Insurer's Name:**
- **Address:**
- **City:**
- **State:**
- **ZIP Code:**
- **Telephone (Include Area Code):**

### Diagnosis or Nature of Illness or Injury
- **Diagnosis Code:**
- **Charges:**
- **Net:**
- **Reserved for Local Use:**

### Provider Information
- **Name:**
- **Address:**
- **Telephone:**

### Medicare Information
- **Medicare No.:**
- **SSN:**
- **Insured's I.D. Number:**
- **SSN:**

### Medicaid Information
- **Medicaid No.:**
- **SSN:**
- **Insured's I.D. Number:**
- **SSN:**

### CHAMPUS Information
- **CHAMPUS No.:**
- **SSN:**
- **Insured's I.D. Number:**
- **SSN:**

### CHAMPVA Information
- **CHAMPVA No.:**
- **SSN:**
- **Insured's I.D. Number:**
- **SSN:**

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**Please Print or Type**

**Price Waterhouse Coopers**

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**Approved by:**

**Price Waterhouse Coopers**

**Approval Date:**

**Price Waterhouse Coopers**
Common Nomenclature and Terminology
Physician Professional Services

- Common Nomenclature & Terminology
  - Relative Value Units
  - Professional, Technical and Global Services
  - Global Surgery Package
  - Correct Coding Initiative
  - Level of Service and E/M Codes
  - Unbundling
  - Upcoding
  - Medical Necessity
  - Linking/Sequencing Diagnosis Codes
  - Starred procedures
  - Modifiers
**Resource Based Relative Value System**

- **RBRVS** was developed by Harvard University’s Public Health Department and was developed to produce uniform, nationwide policies, a national fee schedule and new CPT codes (E/M)
  - Compares the time, effort, risk and related overhead costs of providing patient medical care and performing surgical procedures
  - There are three separate values: physician work, practice expense and malpractice insurance
  - The Medicare Fee Schedule is made up of the relative value units for each service, a geographic adjustment factor and a national conversion factor (enacted by Congress on a yearly basis)
**Relative Value Units (RVU)**

- Medicare Physician Fee Schedule
- Federal Register
- Relative Value Units
  - Work, Practice Expense, Malpractice
  - Conversion Factor $36.1992
  - GPCIs (Geographic Practice Cost Indices)
- Professional, Technical and Total Component
- Facility vs. Non-facility setting
- Status Indicators
Certain procedures have both a professional and technical component and many of these procedures have companion codes.

-26 (Professional Component) identifies only the physician’s work

-TC (Technical Component) contains everything except that portion that must be reported by the physician (ie., facility charges, equipment, supplies, technicians)

Global Service – both the professional and technical component
### Evaluation and Management Services with Place of Service Differential

#### Addendum B—Relative Value Units (RVUs) and Related Information—Continued

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## PC/TC and Global Values

### ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

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<th>CPT/ HCPCS</th>
<th>MOD</th>
<th>Status</th>
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<th>Physician work RVUs</th>
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Global Surgical Package

- Payment for surgical procedures includes a “package” of services.

- Medicare includes:
  - Evaluation or consultation after decision to perform surgery
  - One day preoperative period covered under global surgical period
  - All operative services that are considered to be usual and necessary
  - 90-day postoperative period for major surgical procedures
  - 10-day postoperative period for minor surgical procedures
  - Any treatment of the same diagnosis or surgical encounter by the surgeon not requiring a return to the OR is include
Correct Coding Initiative (CCI)

- The CCI provides correct coding methodology and controls improper coding that leads to increased payments
- Implemented in two phases
  - Phase I contained 87,000 coding edits
  - Phase II released an additional 16,000 edits
Unbundling

Unbundling/Fragmenting occurs when multiple procedure codes are billed for a procedure that is covered by a single code

- Two types: unintentional and intentional
- Fragmenting one service into component parts and billing each component
- Reporting separate codes for related services
- Breaking out bilateral procedures when one code is appropriate
- Downcoding a service so an additional code can be billed
Level of Service and E/M Codes

- Evaluation and Management (E/M) Codes
  - Referred to as visit codes
  - All begin with “99” and are 5 digits
  - Various categories and levels of service
  - Defines the level of “intensity” of care
  - Comprised of key components
    - History
    - Exam
    - Medical Decision Making
Upcoding

- Upcoding continues to be a problem
- Addressed in OIG Workplan for FY02
- OIG Final Report to HCFA FY00 (dated 2/5/01) states:
  “Incorrect coding is the third highest error category this year, representing $1.7 billion in improper payments (the net of upcoding and downcoding)”
- E/M upcoding
  - Level and/or category of service
- Procedure upcoding
ICD-9-CM: Medical Necessity

- Defined by Centers for Medicare and Medicaid Services (CMS) as a “service that is reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member”

- Demonstrated by relationship of procedure codes (CPT-4) and diagnosis codes (ICD-9-CM) to support each other

  ✓ Example: Biopsy for neoplasm of uncertain behavior
Linking/Sequencing Diagnosis Codes

- The primary diagnosis should indicate the reason the patient presented.
- Link a single diagnosis code with a procedure code.
  - Medicare does not have the capability to link more than one diagnosis code to a procedure.
- Diagnosis codes must be taken to the highest level of known specificity.
Starred (*) Procedures/Minor Surgical Procedures

- Medicare characterizes as:
  - Those procedures taking 5 minutes or less
  - Those involving relatively little medical decision-making once the need has been determined
  - Example: suturing of a small, simple laceration

- CPT characterizes as:
  - The service includes the surgical procedure only
  - Associated pre- and postoperative services are not included in the service
Modifiers

- Two character (numeric, alpha-numeric, or alpha) code appended to an E/M code or to a surgical procedure to provide specific information about that service (CPT Levels I, II, and III)

- Modifiers provide the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstances but not changed in its definition or code

- 30 numeric modifiers in CPT 2002
Components of Successful Coding/HIM Compliance Program
Components of Successful Coding Program

- Organizational Structure
- Identifying number of resources
- Developing specific job descriptions
- Establishing communication and reporting lines
- Setting expectations
- Identifying and developing policies and procedures to support accurate and ethical coding
Components of Successful Coding Program

- Standards need to be developed
- Methodologies established
- Working rejected/denied claims
- Productivity measures developed
- Performance indicators measured
- Monitoring and feedback need to occur on a regular basis
Inpatient Services
Inpatient Services

- Part A (Hospital Inpatient) of the Medicare Program
- ICD-9-CM Coding Classification System
- Volume 3 Used For Facility Procedure Coding
- UB-92 Claim Form
**Inpatient Services**

The Medicare Inpatient Coding Process

- Review the Medical Record for Reportable Diagnoses and Procedures

- Convert the Descriptions for the Diagnoses and Procedures into Numerical Representations Called “Codes”

- Group These Codes Into a DRG
Inpatient Services

What Are DRGs?

- Patient Classification System Used to Reimburse Hospitals for Medicare Patients
- Represents Patients with Similar Resource Intensity, Resource Utilization and Cost
- Assigned a National Relative Case Weight
Inpatient Services

Reimbursement
Relative case weight for DRG x hospital rate.

Example:
DRG 294 Diabetes Age>35 has a relative case weight of .7608

.7608 x $3400 hospital rate = $2586.72 reimbursement
**Inpatient Services**

**Case Mix Index**

The total DRG case weights divided by the total discharges.

**Example**

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Total Case Weights $\frac{145.7328}{130} = 1.1210$ Medicare Case Mix Index
Inpatient Services

Tools Available

- ICD-9-CM Code Books
- Encoder/Grouper Software
- AHA Coding Clinic for ICD-9-CM Coding
- DRG Definition Manual
- Medical Dictionary
- Anatomy and Physiology Book
- Drug Reference Tool
- Disease Process Book
Compliance Program Focus Areas

- OIG 2002 Workplan
- Medicare Payment Error Prevention Program (PEPP)
- DRG Ratios
- Documentation/Query Process
Ambulatory Services
Ambulatory Services

- Ambulatory Visits
  - Ambulatory Surgery (hospital ambulatory surgical center)
  - Ambulatory Surgery (free-standing ambulatory surgical center)
  - Emergency Department
  - Ancillary
  - Observation Services
  - Recurring

- Coding Classification Systems
  - ICD-9-CM
  - HCPCS
    - Level I/CPT, E/M
    - Level II/National Codes
    - Level III/Local Codes
Ambulatory Services

Ambulatory Surgical Center (ASC) Payment Groups

- Eight Standard Payment Groups
- Out-Of-Scope Procedures
- HCFA-1500 Form and UB-92 Claim Form
Ambulatory Services

Ambulatory Payment Classifications (APCs)

- Ambulatory/Outpatient Prospective Payment System
- APCs are:
  - Visit-Based, Encounter driven, Classification System
  - Grouped by Similar Clinical Characteristics, Resource Use and Cost
  - Covers Cost For Designated Outpatient Services in a Hospital Department or Provider-Based Entity
Ambulatory Services

Assigning APCs

- HIM Coding
  - Documentation Review
  - ICD-9-CM and AMA CPT-4 Code Books
  - *AMA CPT-4 Assistant*
  - Access to OCE/NCCI Edits

- Chargemaster (CDM)
  - CPT
  - HCPCS
  - UB-92 Revenue Code

- Batch Grouper
  - HIM and CDM
  - Access to OCE/NCCI Edits
  - Billing Alerts
Coding/HIM Compliance Program
Coding/HIM Compliance Program

Basic Program Structure

- Monitoring Performance
- Setting Standards
- Providing Organizational Support
- Creating Awareness
- Identifying Exceptions
Coding/HIM Compliance Program

Ensure our Colleagues

- are familiar with the laws, regulations, and policies that impact them;
- understand the organization’s commitment to follow these laws, regulations, and policies;
- are familiar with our basic organizational values and our commitment to our stakeholders; and
- are able to make decisions reflecting these values and our commitment.
Complete, Accurate, and Consistent Coding

Appropriate Reimbursement

Data Integrity for:
- Physician Profiles
- Outcomes Management
- Resource Management
- Developing Best Demonstrated Practices

Coding /HIM Compliance Program
Policies, Procedures and Standards

- Adopted Thirteen (13) Coding/HIM Policies and Procedures that Support the Company’s Commitment to Complete, Accurate and Consistent Coding
  - Coding and Documentation Policy for Inpatient Services
  - Query Documentation for Inpatient Services
  - Coding and Documentation Policy for Outpatient Services
  - Coding References and Tools
  - Coding HelpLine
  - Coding Orientation and Training
  - Coding Continuing Education Requirements
Policies, Procedures and Standards

- Adopted Thirteen (13) Coding/HIM Policies and Procedures that Support the Company’s Commitment to Complete, Accurate and Consistent Coding, continued.
  - Coding/HIM: Reimbursement of License/Credential Examination Fee
  - Coding: Additional Compensation Plans
  - Prohibition of Contingency-Based Coding Arrangements
  - Coding and Documentation Policy for Skilled Nursing Facilities/Units
  - Certified External Vendors for Coding Reviews and Related Education
  - Outpatient Services and Medicare Three Day Window
Training and Education

- Conduct Regional Inpatient, Hospital-Based Outpatient and Freestanding Ambulatory Surgery Center Coding Seminars
- Regional Query Training Sessions
- Deployed Outpatient PPS Education Program
- Provide DRG Coding Course on Intranet
- Observation Services Training and Education
**Standardized Tools and Resources**

- Inpatient and Outpatient Coding Reference Manuals
- Monthly Coding/HIM Newsletters
- Standardized References
- Implementation Guidelines
- Query Workbook
Standardized Tools and Resources

- Coding Helpline
- P&P Helpline
- Website on Intranet
- Policy and Procedure Questions and Answers
Identification and Monitoring

Statistical Analysis of Coding Indicators → Coding Monitoring Reviews → Results Reporting
Coding Monitoring Reviews

- Action Plans
- High-Risk Coding Monitoring Reviews
- Automated Solutions
- Follow-up Reviews
- Implementation Support
- Training and Education
- Results Reporting
- Statistical Sampling and Estimations
Organizational Structure

- Commitment From All Levels of the Organization
- Accountability and Responsibility for Outcomes
- Quality Control
- Program Soundness Reviews
- Support of Performance Improvement
- Program Enhancement
Questions and Answers