Hospital Outpatient Coding Compliance Audits

PRESENTED TO:
Health Care Compliance Association (HCCA)
Las Vegas, NV
April 2009

Catholic Healthcare West
CHW

Speaker

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  – Catholic Healthcare West (CHW)
    • San Francisco, CA

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Disclaimer

- Every reasonable effort has been taken to ensure that the educational information provided in today’s presentation is accurate and useful. Applying best practice solutions and achieving results will vary in each hospital/facility situation.

Goals/Objectives

- Review Coding Auditing and Monitoring program elements
- Discuss specific target CPT or Modifiers
- Look at aspects of auditing ED/ER and other outpatient hospital department under OPPS (Outpatient Prospective Payment System)
- Optional action and recommendations to develop
Healthcare Compliance - Auditing and Monitoring

- Key element to any compliance plan/program per the OIG
  - Review the OIG Hospital Guidance
- Within Health Information Management (HIM) this activity can be a major part of your coding compliance initiatives

Compliance…Auditing & Monitoring

- Develop goals
- Define your objectives & identify risks
- Oversight - identify
- Policies and procedures
- Education
- Communication
- Enforcement, Corrective Action/Problem Solving
**Auditing & Monitoring - GOAL**

- Assure compliance with federal, state and regulatory statutes relating to coding and documentation
- Identify potential problem or risk areas
- Identify patterns and trends
- Identify educational needs
- Make recommendations for corrective action

**GOAL - example (HIM)**

- Example:
  - Happy Hospital Coding/HIM Compliance Auditing and Monitoring will determine adherence to AHA’s Coding Clinic guidelines, approved CMS guidelines, and compliance with established Happy Hospital internal coding compliance policies and procedures for all ICD-9-CM code assignments. In addition, compliance with AMA’s CPT assistant coding guidelines for CPT coding will be determined.
Auditing & Monitoring Objectives

- Promote healthcare compliance adherence to federal and state statutes within health information management arena
- Monitor OIG, PEPPER, QIO, and RAC risk areas
- Utilize audit findings to provide education to all those involvement
- Track audit findings to identify patterns and trends

OBJECTIVES

- Coding Compliance Auditing and Monitoring will assess and determine: The accuracy of all ICD-9-CM and CPT code assignments
- Determine the adequacy of physician documentation to support of the codes assigned
- Assess the timely processing and completion of the medical record in relation to the impact of coding accuracy
Auditing & Monitoring Oversight

- Define the responsible individual or individuals for HIM Auditing and Monitoring
- Compliance Manager, Coding Compliance Specialist, Director of Corporate Coding Compliance, etc.
- Provide a description of the necessary background and experience needed

OVERSIGHT

- Oversight Responsibility for Auditing and Monitoring: The “Corp Coding HIM Compliance Manager” (or Coding Compliance Reviewer/Auditor) will perform coding validation audits. The Corp Coding HIM Compliance Manager is directly responsible to the Corporate Coding HIM Compliance Director. It is the responsibility of the regional Coding HIM Compliance Manager to report all audit findings to the facility management, regional management, PFS and Corporate counsel, if applicable.
Levels of Coding Audit Review

- Concurrent documentation reviews
- Prebilling reviews
- Retrospective reviews
- Data Mining

Auditing & Monitoring Policies and Procedures

- Written protocols
- Define the scope of the HIM Coding Audits:
  - Limited to Medicare?
  - Both Medicare and Non-Medicare
  - All hospital settings: IP, OPS, ER, OP
  - Define reporting practices
Auditing & Monitoring Policies and Procedures

- Define Audit/Review sample size
  - Outpatient records, 10% average monthly Medicare visits/encounters (?)
    - No more than 100 for the audit
  - Select from a base of 1000 records, minimum and maximum base
    - Usually a 3 month period of time (ie., Jan-March)

Auditing & Monitoring - CHART SELECTION POLICY

- A combination of both random and target chart selection will be used.
- A **random** review selection will consist of 10% of the average monthly Medicare encounters, with a minimum of 65 charts. In addition, a random sample of non-Medicare encounters will be reviewed, consisting of 10% of the average monthly encounters, with a minimum of 40 charts selected and reviewed.
Auditing & Monitoring Policies and Procedures

- What should be reviewed?
- Random versus focused selection
- Facility top volume APCs (Medicare)
- CPT codes often unbundled
- CPT codes unlisted

Auditing Resources

- ICD-9-CM Coding Book
- AHA *Coding Clinic on ICD-9-CM*
- AHA *Coding Clinic on HCPCS*
- AMA CPT Book
- AMA *CPT Assistant*
- Coder’s Desk Reference - Ingenix
- OPPS Final Rule (CMS)
- OPPS Transmittal (usually release in January)
- OPPS Addendum B (CMS)
- OPPS Inpatient Only List
Auditing

- Rebilling Procedure following the audit
  - Create a log to list all identified DRG changes for inpatients
  - HIM initiate the rebilling
  - Coordinate with Business Office or PFS
  - Track and follow through, using the new RA to validate completion of the rebilling process
  - Maintain the rebilling log and new RA in files as a record of your activity

Monitoring

- **Defined as**: ongoing internal review of coding practices conducted on a regular basis
- Both proper code assignment and proper sequencing should encompass coding accuracy
- Daily coding compliance software can be used to achieve on-going monitoring
Monitoring

- Software designed to function after the encoder process is complete but prior to billing (prebill)
- Logic based editing systems that interface with the financial side to compare total charges to the national average for a particular APC or CPT
- Logic will look at combinations of codes compared to total charges

Education within the Auditing process

- Utilize audit findings to provide education
- Initial feedback to coding staff on findings
- Using AHA Coding Clinic for HCPCS
  - Hospital specific OPPS
- AMA CPT coding book
- AMA CPT Assistant
- A more formal educational inservice may be necessary
  - For example: Laceration Repair CPT codes
<table>
<thead>
<tr>
<th>Education</th>
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<tbody>
<tr>
<td>• Provide written objectives or goals for the educational in-service</td>
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<td>• Sign-in verification of who attended</td>
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<td>• Materials and handouts (retain for records)</td>
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<td>• Pre-Inservice quiz/test and Post in-service quiz/test (retain)</td>
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<td>• Question and Answer opportunity</td>
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<td>• Evaluation forms (retain)</td>
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<td>• Continuing education credit (CEU’s)</td>
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<table>
<thead>
<tr>
<th>Communication</th>
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<tr>
<td>• Audit Plan (written and verbal) - notification and time schedule/calendar</td>
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<tr>
<td>– Distribute to all necessary internal staff</td>
</tr>
<tr>
<td>– Legal counsel</td>
</tr>
<tr>
<td>• Date, Time and Plan</td>
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<tr>
<td>• Audit range, inpatient, etc.</td>
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<tr>
<td>• Coordination with HIM</td>
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<tr>
<td>– Report for chart selection</td>
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<tr>
<td>– List of selected cases</td>
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</table>
• **Audit Exit Conference:** usually held on the final day of the audit
  
  • **Participants:** CFO/COO, HIM Director, Coding Supervisor/Lead (sign-in). Summary of findings, recommendation and a proposed action plan should be made.
    
    – 30 mins to an hour
  
  • **Coding Exit Summation:** Review of each case with a coding/DRG change and other operational issues identified.
    
    (Sign-in) Findings, explanation of the how the coding guideline applies
    
    – Allow enough time to answer coding questions
  
  • Written Summary Report of Audit findings:
    
    – Summarize the findings
    
    – Total number of records reviewed, compared to identified variances
    
    – Any difference from prior review
    
    – Indicate any patterns or trends (ICD-9-CM, CPT, Documentation, Physician, etc.)
      
      • Prior to audit, determine what constitutes a pattern/trend
    
    – Identified operational issue effecting coding
    
    – Recommendations and Action Plan for correction and improvement
### Communication

- Distribution of written report:
- Legal counsel (label as confidential?)
- Administrative Staff
- HIM Director, Case Mgmt./UR Directors, Patient Financial Services (PFS)
- Regional or Corporate Staff (if appropriate)

### Enforcement

- Awareness of internal consequences and disciplinary action
- Awareness of potential outside consequences
- Look for noncompliant behavior
- All disciplinary action should be fair and equitable
- Various levels of disciplinary action (include Termination) should be established
- Accountability - all staff and Mgmt. are included
Enforcement and Corrective Action

- In order to meet enforcement compliance, always provide recommendations for adherence to established guidelines and rules
- Provide Steps and timeline for corrective action

Corrective Action & Problem Solving

- Demonstrate your steps
- Make them reasonable
- Always working towards compliance with policies, procedures and regulations
- Some problem solving will involve investigation using your auditing and monitoring tools
- Gather all the facts before proceeding
- From your audits, gather statistics about the results, this will assist you in identifying a problem
- For outpatient audit look at:
  - CPT selection problems
  - Multiple CPT codes
  - Omitted codes
  - Physician documentation as a problem
  - Modifiers
Corrective Action and Problem Solving

- Revising an internal policy or procedure may provide the corrective action needed
- Education as part of the corrective action
  - Coding Staff
  - Physicians
  - Other Ancillary staff
  - Charging staff
  - CDM
- Improving internal “operations”
  - HIM Dept.
  - Other

Using Outside Contractors

- Ask for verification of auditor (coding) staff qualifications (Bio/CV)
- Ask for a list of the last 12 -18 months of Continuing Education seminars, etc. (CEU’s)
  - Ask what education the coding staff attends
  - Ask the last date of education
- Ask about their own internal audits on their staff (What is their process for quality improvement??)
- Do they have a compliance plan and if so, you can see a copy of it.
- Ask for a list of references and make some calls
### Benefits of HIM Auditing and Monitoring

- Improve coding accuracy (ICD-9-CM & CPT)
- Identify problematic coding and documentation practices
- Establishment of effective internal controls to ensure compliance with federal regulations, payment policies and official coding guidelines
- Ability to initiate prompt responses and appropriate corrective action

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### Benefits of Auditing & Monitoring

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<thead>
<tr>
<th>Improvement in health record documentation</th>
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<td>Decrease denied admissions</td>
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<td>Decrease compliance risk areas</td>
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<td>Enhance physician awareness and understanding</td>
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<td>Increase internal communication and cooperation</td>
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<td>Opportunity for on-going education</td>
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<td>Reduce exposure in HIM area</td>
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<tr>
<td>Improvement in employee performance and morale</td>
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<tr>
<td>More efficient HIM operations</td>
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<tr>
<td>Increased interdepartmental collaboration</td>
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RAC Status Report  2006 Findings

CMS
RAC Status Document
FY 2006

Status on the Use of Recovery Audit Contractors (RACs) in the Medicare Program


RAC Status Report  2007 Findings

CMS
RAC Status Document
FY 2007

Status Report on the Use of Recovery Audit Contractors (RACs) in the Medicare Program

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February 2008
THE MEDICARE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM:
An Evaluation of the 3-Year Demonstration

June 2008

<table>
<thead>
<tr>
<th>NON INPATIENT HOSPITAL SERVICES</th>
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<tbody>
<tr>
<td>Injection, pegylated 6mg (J2505) — Nustasta</td>
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<tr>
<td>INCORRECT CODING: Provider billed one service per 1mg but...</td>
</tr>
<tr>
<td>definition of this code is one service per 1mg vital</td>
</tr>
<tr>
<td>EXAMPLE: A provider administered 6mg of Nustasta to the beneficiary but billed for 3 units of J2505. According to the definition of the code, six units of J2505 would be 36mg of Nustasta.</td>
</tr>
<tr>
<td>$ 3.05</td>
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</tbody>
</table>

| Speech/hearing therapy (92567) |
| INCORRECT CODING: Provider billed one service for each 10 minutes but... |
| definition of this code is one service per session |
| EXAMPLE: A therapist provided a 45 minute session of therapy to the beneficiary but billed for 2 units of J2695. According to the definition of the code, three units of J2697 would be for 3 separate sessions of therapy on the same day. |
| $ 3.04 |

| Blood transfusion service (36430) |
| INCORRECT CODING: Provider billed one service per pint of blood but... |
| definition of this code is one service per transfusion session |
| EXAMPLE: An emergency room provided one transfusion session during which 2 pints of blood were administered to the beneficiary. But the hospital billed for 2 units of 36430. According to the definition of the code, two units of 36430 would be for 2 separate transfusion sessions in the same day. |
| $ 2.40 |
RAC Findings

• Top Hospital Outpatient Services with RAC-Initiated Overpayments

<table>
<thead>
<tr>
<th>Outpatient Hospital</th>
<th>Amount Collected Less Cases Overturned on Appeal</th>
<th>Claims Found in Error Less Cases Overturned on Appeal</th>
<th>Location of Problem</th>
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</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>$2.0 m</td>
<td>5,134</td>
<td>NY</td>
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<tr>
<td>Speech Language Pathology Services</td>
<td>$1.4 m</td>
<td>3,295</td>
<td>CA</td>
</tr>
<tr>
<td>Infusion Services</td>
<td>$1.3 m</td>
<td>9,956</td>
<td>CA</td>
</tr>
</tbody>
</table>

Other RAC Targets

• LAB
• Pharmacy Drugs - units
• Physician Services –
  – E&M visits
  – Procedures with E&M
• Lack of MD orders
  – No MD order to admit to inpatient status
• Monitor and track these requests
• Are there other areas of risk and vulnerability?
National Expansion Schedule – was delayed & now moving forward

RAC Phase In Schedule

March 1, 2009 or later
March 1, 2009
August 1, 2009 or later

RAC Record Requests – Permanent Program

RAC Medical Record Request Limits

Summary of Medical Record Limits (for FY 2009)

- **Inpatient Hospital, IRF, SNF, Hospice**
  - 10% of avg monthly Medicare claims (max of 200) per 45 days

- **Other Part A Billers** (Outpatient Hospital, HH)
  - 1% of average monthly Medicare services (max of 200) per 45 days

- **Physicians**
  - Solo Practitioner: 10 medical records per 45 days
  - Partnership of 2-5 individuals: 20 medical records per 45 days
  - Group of 6-15 individuals: 30 medical records per 45 days
  - Large Group (16+ individuals): 50 medical records per 45 days

- **Other Part B Billers** (DME, Lab)
  - 1% of average monthly Medicare services per 45 days

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### RAC Record Request Limits

**Inpatient Hospital, IRF, SNF, Hospice by NPI**

- 10% of average monthly Medicare paid claims per 45 days
- Maximum of 200 medical records per 45 days

**Example 1: Local Community Hospital**
- 1,200 Medicare paid claims in 2007
- Divided by 12 = average 100 Medicare paid claims per month
- x 10% = 10
- **Limit = 10 medical records per 45 days**

**Example 2: Major Medical Center**
- 12,000 Medicare paid claims in 2007
- Divided by 12 = avg 1,000 Medicare paid claims per month
- x 10% = 100
- **Limit = 100 medical records per 45 days**

Other Part A Billers (Outpatient Hospital, Home Health, etc) by NPI

- 1% of average monthly Medicare paid services per 45 days
- Maximum of 200 medical records per 45 days

**Example 1:**
- 1,500 Medicare paid services in 2007

### RAC & CMS Information

- November audioconference calls – “Open Door Forum” for Part A and one for Part B

- **Two types of reviews**
  - Automated (data mining)
    - “Issue” will be submitted to MCS for review
    - CMS panel determines if it’s a valid issue
    - Then it will be posted on the RAC website for providers.
    - A wide scale review will then begin
  - Complex (medical record)
    - Limited # of medical record requests to begin
    - Providers will send the medical records
    - RAC will review them
    - RAC will send a new “issue” request to CMS
    - CMS will review and decide if valid
    - If approved it will be posted on the RAC website and begin wide scale review
RAC Automatic Review

- **What is automated review?**
  - Automated review will occur when a RAC makes a claim determination at the system level without human review of the medical record. RACs may use automated review when making coverage and coding determinations only when:
    - there is certainty that the service is not covered or is incorrectly coded; and
    - a written Medicare policy, article or sanctioned coding guideline exists.
  - However, if a RAC identifies a “clinically unbelievable” issue (i.e., where certainty of noncoverage or incorrect coding exists but no Medicare policy, articles or sanctioned coding guideline exists), a RAC may seek CMS approval for automated review. If there is certainty that an overpayment or underpayment exists, RACs may also use automated review for other determinations (e.g., duplicate claim determinations).

RAC Complex Review

- **What is complex review?**
  - Complex review will occur when a RAC makes a claim determination using human review of the medical record. RACs will use complex review when:
    - the requirements for automated review are not met;
    - there is a high probability (but not certainty) that a service is not covered; or
    - no Medicare policy, article or sanctioned coding guideline exists.

- **Will medical records be requested from providers for complex reviews?**
  - Yes. However, CMS is expected to impose medical record request limits. In fact, CMS may apply different limits for different provider types. For hospitals, the limit may be based on the size of the hospital (e.g., the number of beds). For example, CMS may limit a RAC medical records request to no more than 50 inpatient medical record requests for a hospital with 150-249 beds in a 45 day period. CMS may also impose a different limit for different claim types (e.g., outpatient hospital, physicians, suppliers, etc.). Further, RAC will not be permitted to “bunch” medical record requests. For instance, if the medical records request limit for a particular provider is 50 per month and a RAC does not request medical records in January and February, the RAC will not be able to request 150 records in March.
Audit ICD-9-CM on Outpatient Records/Accounts

- **ICD-9-CM**
  - International
  - Classification of Diseases
  - 9th Revision
  - Clinical Modification

- The Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics revise, adds and deletes bi-annually and are implemented on April 1st and October 1st of each year.

HIM Coding assigns the ICD-9-CM Diagnosis Codes
Outpatient, Emergency Room Visits & ICD-9-CM Codes

• CMS does not use ICD-9-CM codes to determine APC payment, but hospitals are still required to submit accurate diagnoses codes.

• CMS will continue to assess the value of using diagnoses codes in future APC revisions, and diagnoses codes are still required to validate medical necessity of performed services/procedures.

  – Hospital HIM Coding staff are responsible for this.

Understanding …. An Outpatient Hospital Encounter

• 42 CFR 210.2 Defines Hospital Outpatient. Outpatient means a person who has not been admitted as an inpatient but who is registered on the hospital or Critical Access Hospital (CAH) records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH. Medication therapy management patients are registered outpatients of the hospital.
Knowing … CMS Communications

- "Shall" denotes a mandatory requirement
- "Should" denotes an optional requirement
- Do you have a process in place for the dissemination of CMS Transmittal and memo’s?

Remember the above terms… may be contained within the Compliance and/or HIM departmental policies?

OPPS Key Components

- Under OPPS there are key components to calculate payment or to deny.
- Under OPPS Medicare pays the hospital a rate-per-service basis.
  - This varies depending on the CPT/HCPCS codes
  - The CPT/HCPCS group into an APC (Ambulatory Payment Classification)
  - Thus there can be multiple APCs on a given claim for a given outpatient encounter
**OPPS and/or APC Linked to Coding Systems**

- Audit the following:
  - ICD-9-CM Codes – diagnoses
    - Medical Necessity
  - CPT surgical range codes – payment
  - CPT Lab & Radiology - ?
  - HCPCS codes - payment
  - Revenue codes - payment

- Note: Existence of a code does not guarantee payment however

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**KNOW THE BASICS of HCPCS**

- HCPCS = Healthcare Common Procedural Coding System
  - Maintained by Medicare
    - Level II - (national codes) for physicians & non-physician services (alphanumeric)
    - Level III – no longer exist due to HIPAA standardize code sets

- Remember that CPT was developed by the American Medical Association (AMA) for physicians.
OPPS Status Indicators

- Payment status indicators and their descriptions that correlate to each CPT/HCPCSCs code

- These may be referenced annually in Addendum B of the Final Rule of the Outpatient Prospective Payment System (OPPS)

- Addendum B of the Final Rule of OPPS provides a detailed listing by HCPCS code and its assigned status indicator
**OPPS Addendum B**

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
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<tbody>
<tr>
<td>OPPS Addendum B - OPPS Payment by HCPCS Code for CY 2009</td>
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<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>CI</th>
<th>SI</th>
<th>APC</th>
<th>Relative Weight</th>
<th>Payment Rate</th>
<th>National Unadjusted Copayment</th>
<th>Minimum Unadjusted Copayment</th>
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<tbody>
<tr>
<td>F1312</td>
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<td>F133F</td>
<td>Biopsies, all sites</td>
<td>M</td>
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**OPPS Status Indicator & Descriptions - 2009**

A Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than ambulance services; clinical diagnostic laboratory; non-implantable prosthetic and orthotic devices; EPO for ESRD patients; physical, occupational and speech therapy; routine dialysis services for ESRD patient provided in a certified dialysis unit of a hospital; diagnostic mammography; screening mammography.

B Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x, 13x and 14x).

C Inpatient only procedures

D Discontinued codes

E Item, codes and services that: (a) are not covered by Medicare based on statutory exclusion, (b) that are not covered by Medicare for reasons other than statutory exclusion, (c) that are not recognized by Medicare, but for which an alternate code for the same item or service may be permitted, (c) for which separate payment is not provided by Medicare.

F Corneal tissue acquisition; Certain CRNA service; and Hepatitis B vaccines

G Pass-through drugs and biologicals
Status Indicator C

- **C** = Inpatient Only Procedure
- **Not paid under OPPS**
- This is an important status indicator to screen for during the scheduling or pre-admission process for elective ambulatory surgeries.
- Work with your Admitting or OR Scheduling Departments.

OPPS Status Indicator & Descriptions - 2009

- **H** Pass-through device categories; Brachytherapy sources; and Radiopharmaceuticals agents
- **K** Non-pass-through drugs, biologicals and radiopharmaceutical agents
- **L** Influenza vaccine; Pneumococcal Pneumonia vaccine
- **M** Items and services **non-billable** to the fiscal intermediary
- **N** Items and services packaged into APC rates
- **P** Partial hospitalization
- **Q** Packaged services subject to separate payment under the OPPS payment criteria (see next slide)
- **S** Significant service, separately payable
- **T** Significant service, multiple procedure reduction applies
- **V** Clinic or emergency department visit
- **X** Ancillary service
- **Y** Non-implantable durable medical equipment
New OPPS Status Indicator

- Q1 (“STVX” packaged codes)
- Q2 (“T” packaged)
- Q3 (codes that may be paid through a composite APC)
- R for blood and blood products
- U for brachytherapy source/seeds

Addendum E – Inpatient Only List

These procedure will not be paid under OPPS if performed as an outpatient. “C” status indicator
Services having a status indicator of “N” are considered packaged or bundled into other services. The costs of these services are allocated to the APC, but are not paid separately.

The relative weights for surgical, medical and other types of visits were developed to reflect packaged services in the APC-based fee.

Claim Header Information

The header information must relate to the entire claim (billing form or called a UB) and must include the following:

- From date;
- Through date;
- Condition code;
- List of ICD-9-CM diagnosis codes;
- Age;
- Sex;
- Type of bill; and
- Medicare provider number.
Line Item Detail on the Claim

- Each line item contains the following information:
  - HCPCS code with up to 4 modifiers;
  - Revenue code;
  - Service date;
  - Service units; and
  - Charge ($)

- The CPT/HCPCS codes and modifiers are used as the basis of assigning the APCs. Not all line items will contain a CPT/HCPCS code. The line item service dates are used to subdivide a claim that spans more than 1 day into individual visits. The service units indicate the number of times a CPT/HCPCS code was provided (e.g., a lab test with a service unit of 2 means the lab test was performed twice).
### Revenue Codes

| • Programmed into the CDM |
| • Required for proper claim process. |
| • Four digit number that identifies the main department service area. |
| – Each number begins with a zero |
| – Remaining three digits describe the location/area and specific service |
| • Providers have been instructed to provide detailed level coding for the revenue code series |

### What is an APC made of?

| • CPT code |
| • Status indicator |
| • CI – Comment Indicator |
| • Copayment |
| • National payment |
| – Each APC has a pre-established prospective payment amount associated with it. |

“DATA DRIVEN SYSTEM!!”
Patient Presents for Service and DOCUMENTATION IS IN THE MEDICAL RECORD

Are all charges being captured on the charge form/ticket?

Modifiers ?

CPT Codes Assigned by Provider (or HIM/Medical Records)

Order Entry/Charge Slip
Charge Master (IT/IS)

Modifiers ?

INCLUDE ALL Appropriate CPT CODES and ICD-9-CM Diagnosis Codes

Procedure APCs, Medical APCs, Ancillary APCs, Drug APCs, Blood APCs, Etc.

FI will process the claim
Payment or denial is made

Coding or Charging??

- CDM = Charge Description Master
- Service code = Departmental number linked to a departmental service &/or treatment
- Description = Narrative title or description of the service/treatment. Printed on the CDM, encounter or charge sheet
- Revenue Code = A 3-digit code on the UB claim. This is typically linked to CPT codes and is an indicator of the service provided
  - 360 = Surgery
  - 750 = GI
- Units = Quantity or volume (for surgical range codes, this most often is (1) as the modifier can indicate multiples)
  - Pharmacy will utilize units field and also in Observation
- CPT Code = A 5-digit numeric code or HCPCS code, which is alphanumeric that describe procedures or services as listed in the AMA CPT book
- Price $ = The dollar amount billed to the payor or the patient for the service/treatment

Check with the CDM staff if you have questions.
Develop CDM Standardization Policy

- Hospital CDM Responsibility - Hospitals will adopt standard CDM policies to clarify and facilitate maintenance of the Standard CDM.
- Departments working with System resources, will develop sufficient documentation for their standard CDM and will document their charging process.
- Standard CDM Structure - Emphasis will be to simplify charge structures, subject to prevailing payment rules and regulations.
- Miscellaneous codes will be minimized and limited.
- Abbreviations and order of description will be standardized, where applicable.
- Best practice & policy is to have HIM “final” code CPT of 10000-69999 in the surgical range, based on clinical documentation. CPT codes for this range will reside in the Corporate Standard for reference purposes only.
- Price Setting - Prices may not be standardized between affiliates as part of the CDM standardization process.

Audit/Review Worksheet - (hand written or computer/electronic based)

- Patient Name: MR #: Acct #:
- Date of Disch/encounter: Physician:
- Original Codes, Descript., Revised Codes
- Findings: (narrative)
- Recommendations: (narrative)
- References:
- Reviewer:
- Date of Review:
Outpatient Audit Worksheet

Medicare OPPS – E&M visits

- Each facility should be held accountable for following its own policies for assigning the different levels of HCPCS codes. Facilities are in compliance with these reporting requirements as long as:
  - The services furnished are documented and medically necessary;
  - The facility is following its own system; and
  - The facility’s system reasonably relates the intensity of hospital resources to the different levels of HCPCS codes.
• An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention.

• The facility must be available 24 hours per day.

• CPT codes within 99281-99285 are to be assigned for each patient encounter/visit to the emergency room.

• No distinction is made between new and established patients in the ED.

• Verify Type A and type B (Compliance oversight)

• Under OPPS, criteria for E&M leveling needs to be established by the facility to capture resources.
  – There are no national guidelines yet.
  – This is coming in the future though.
    • AHIMA/AHA has a draft proposal

• Many elements can be considered before finalizing the E&M level criteria.
  – i.e. Time, Diagnosis/complaint

• Utilizing a collaborative process developed ED/ER E&M visit/encounter leveling criteria.
Level of ED/ER Nursing Care via CPT Codes (E&M)

<table>
<thead>
<tr>
<th>Level I</th>
<th>99281</th>
<th>Level II</th>
<th>99282</th>
<th>Level III</th>
<th>99283</th>
<th>Level IV</th>
<th>99284</th>
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<th>99285</th>
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<td></td>
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<tr>
<td><strong>Comprehensive</strong></td>
<td></td>
<td><strong>Possibly unstable</strong></td>
<td></td>
<td><strong>Requires RN assessment &amp; possible reassessment of condition.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Example**

We cannot do justice to this problem in the time available, but we can mention a few points.

**Prepared Rx**

We recommend that nurses to a continue the daily monitoring of the ABCs (Airway, Blood pressure, and Circulation) and the daily assessment of the patient's condition, including the level of pain and discomfort.

**Comprehensive**

A thorough and comprehensive review of the patient's medical history and current condition is necessary to determine the level of care required. This includes assessing the patient's ability to walk, talk, and follow instructions, as well as evaluating their vital signs and oxygen saturation levels.

**Possibly unstable**

Patients who are experiencing symptoms that may indicate a medical emergency should be treated with high levels of care. This includes monitoring the patient's vital signs, administering medications, and providing ongoing support and monitoring.

**Requires RN assessment & possible reassessment of condition.**

Nurses should be prepared to provide emergency care and be able to assess the patient's condition frequently. This includes monitoring vital signs, administering medications, and providing ongoing support and monitoring.

**EXAMPLE OPPS Leveling Criteria**

- **Federal Register** Vol. 67, No. 217 on August 31, 2002/Policy and Regulations

The Department of Health and Human Services' Office of Inspector General, through its Nurse Practice Act Drug Enforcement Administration, has developed a set of guidelines for the proper management of nurses in the Emergency Department setting. These guidelines are designed to ensure that nurses provide safe and effective care to patients in the ED.

The guidelines provide a framework for nurses to use in determining the appropriate level of care for each patient. They include criteria for the development of a patient's level of care, as well as criteria for the assessment and management of patients with conditions that require emergency care.

The guidelines are intended to help nurses make informed decisions about the level of care that is appropriate for each patient. By following these guidelines, nurses can provide safe and effective care to patients in the ED and ensure that patients receive the appropriate level of care.

The guidelines are available on the Department of Health and Human Services' website, and are also available in printed format. They are designed to be used by nurses in the ED, as well as by other professionals who work in the field of emergency care.

The guidelines are regularly updated to reflect changes in the field of emergency care, as well as changes in the policies and regulations that govern the practice of medicine. Nurses and other professionals who work in the field of emergency care are encouraged to review these guidelines on a regular basis in order to ensure that they are up-to-date and are following the appropriate guidelines.
Emergency Room - Evaluation and Management Visits

- Obtain the facility E&M leveling criteria when auditing.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
<th>CI</th>
<th>SI</th>
<th>APC</th>
<th>Relative Weight</th>
<th>Payment Rate</th>
<th>National Unadjusted Copayment</th>
<th>Minimum Unadjusted Copayment</th>
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<td>S1</td>
<td>APC</td>
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<td></td>
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<td></td>
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</table>

Catholic Healthcare West
In determining E&M level code assignment, CMS states "we will hold each facility accountable for following its own system for assigning the different levels of HCPCS (visit) codes."

As long as the services furnished are documented and medically necessary and the facility is following its own system, which reasonably relates the intensity of hospital resources to the different levels of HCPCS codes, we will assume that it is in compliance with these reporting requirements as they relate to the clinic/emergency department visit codes reported on the bill.
CMS continues to hold facilities accountable for developing and consistently using their own E/M criteria.

It also states that the criteria must be valid, reasonable, and reliable. If it hasn’t done so already, your facility must develop its own specific criteria that incorporate objectivity, measurability, and documentation requirements.

Don’t incorporate procedures for which CMS pays separately in the E&M leveling criteria. Advise the ED to perform a spot check on claims to ensure that clinic documentation supports the visit level billed.

* Perform Charge reconciliation
Overview of E&M CPT codes

- Utilize the leveling criteria.
- Based upon single or multiple presenting and established diagnosis, sign or symptoms
- One E&M CPT per visit.
- Select the E&M with “+ Procedure” on the charge form, for modifier 25 to be assigned, when visit includes the performance of a procedure.
- Documentation in the medical record must support the level.
- Charge entry is timely and accurate.

Procedures in the ED/ER

- Laceration Repair APCs – Addendum B

<table>
<thead>
<tr>
<th>Code</th>
<th>Short Description</th>
<th>APC</th>
<th>Relative Weight</th>
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<th>Minimum Unadjusted</th>
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</tbody>
</table>
Laceration Repair description

- **CPT codes: 12001-12007** (12001, 12002, 12004, 12005, 12006, 12007)
  
  **12001 12001** Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

- The physician sutures superficial lacerations of the scalp, neck, axillae, external genitalia, trunk, or extremities. A local anesthetic is injected around the laceration and the wound is thoroughly cleansed, explored, and often irrigated with a saline solution. The physician performs a simple, one-layer repair of the epidermis, dermis, or subcutaneous tissues with sutures. With multiple wounds of the same complexity and in the same anatomical area, the length of all wounds sutured is summed and reported as one total length.

- Report 12001 for a total length of 2.5 cm or less, 12002 for 2.6 cm to 7.5 cm, 12004 for 7.6 cm to 12.5 cm, 12005 for 12.6 cm to 20 cm, 12006 for 20.1 cm to 30 cm, and 12007 if the total length is greater than 30 cm.

Procedures in the ED/ER

- **Fracture Care or Treatment**
Included in resources

- When a nurse provides care in a hospital outpatient department, the hospital bills for the care services as a facility charge and is reimbursed under APCs. The facility charge does not strictly represent the care/services per se; instead, it constitutes the resources the facility expends in providing the service. These resources could include the following:
  - Use of the facility equipment/room
  - Supplies & Dressing
  - Medications
  - Nursing staff
  - Discharge Instructions
  - Education
  - Any other resources used in providing care

Components of the Facility E&M Leveling Criteria

- There are several components that should be assessed to determine which E&M level should be charged for hospital ED/ER.
  - Presenting diagnosis
  - Level of nursing care via resources used (not separately billable)
  - Conditions that are both acute and chronic
  - Patients with multiple symptoms
- Procedures that are separately reimbursed are not included in the criteria matrix ie EKG, X-rays, Lab, surgical procedures, etc.
### E&M When a Procedure is Performed – Modifier 25

- In order for a payor to recognize that the procedure was performed on the same date as the evaluation and management service and that it was separate and distinct, it is necessary to append modifier 25 to the E&M CPT code in order to be considered for separate payment.
- The ED/ER CDM should have separate line item charges to charge the E&M code with a modifier 25.
- It is important that you consistently apply this modifier.
- Medicare has stated that modifier 25 is required when a procedure with a status indicator of ‘S’ or ‘T’ has been coded and reported with an E&M CPT code.
  - Check OPPS Addendum B for a list of CPT codes and their status indicator.

### Examples of Assigned Modifier 25 in the ED/ER

- **Example #1:** 3-year-old patient seen in the ED/ER for a finger laceration due to a knife. The patient is examined and evaluated by the ED/ER physician. The decision is made to suture the 3 cm laceration on the index finger (simple closure).
  - This would be CPT code 12002 along with E&M 99283 with 25 (according to hospital E&M criteria).
- **Example #2:** 67-year-old patient fell and hit their head, comes into the ED/ER complaining of dizziness and a headache. After examination and evaluation, a CT of the brain (CPT code 70450) is ordered and performed.
  - The E&M CPT would be 99284 according to hospital’s E&M leveling criteria. You would add the modifier 25 to the 99284.
ED/ER E&M with Procedure

- The ED/ER CDM Standard has separate line item charges to charge the E&M code with a modifier 25.
- It is important to consistently apply this modifier.
- Medicare has stated that modifier 25 is required when a procedure with a status indicator of ‘S’ or ‘T’ (check Addendum B) has been coded and reported with an E&M CPT code.

Know the Different CPTs - Represented Within the Procedure Details

- CPT 23520 Closed treatment of sternoclavicular dislocation; without manipulation
  - The physician treats a dislocation of the joint between the sternum and the clavicle (sternoclavicular) without making incisions and without any manipulation in 23520. The physician applies a splint or brace to hold the joint in place until it has healed. In 23525, manipulation is required. Anesthesia may be necessary. The physician pushes, pulls, or moves the arm and chest to restore the joint to correct position and alignment. After manipulation, the patient is placed in a brace or splint.

- CPT 23530 Open treatment of sternoclavicular dislocation, acute or chronic;
  - The physician treats a chronic or acute dislocation of the sternoclavicular joint. The physician makes an incision overlying the joint between the clavicle and sternum where the dislocation has occurred. The tissues are dissected down to the joint and the dislocation is visualized. The physician may debride the area before realigning the joint back to proper position. In 23532, the physician harvests a fascial graft from the patient through a separate incision. The physician repairs the surgically created graft donor site. The fascial graft is attached to the bones in the sternoclavicular joint, preventing recurrent dislocation. Fixation may be applied. The joint is irrigated and the incision is closed in layers. A splint or brace may be applied to the outside of the body.

Specific and detailed physician documentation is critical
Clinical Documentation of the procedure

- Documentation of any procedure performed in the ED/ER must be present in the medical record
  - Written or dictated report
  - Timely
  - Legible – if it can’t be read it may not get coded
- Critical for the correct CPT code assignment and payment

Charge/Encounter Form for the ED/ER
## Other Services to Charge/code for . . .

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Finger Sticks</strong> – Need to report all finger sticks with CPT 82962 ($pd lab fee). Need MD order and documentation of the results in the medical record. Verify if your facility has a CLIA certificate. If yes, must use –QW modifier.</td>
<td></td>
</tr>
<tr>
<td>2. <strong>Urine Dip</strong> – Use CPT 81000 ($pd lab fee) to report urine dip, non-automated with microscopy. Use CPT 81002 to report urine dip, non-automated without microscopy. Need MD order and documentation of the results in the medical record. Verify if your facility has a CLIA certificate. If yes, must use –QW modifier.</td>
<td></td>
</tr>
<tr>
<td>3. <strong>Blood Draws</strong> – Use CPT 36415 venipuncture ($pd) when performed by Nursing in the ED</td>
<td></td>
</tr>
<tr>
<td>4. <strong>Pulse Oximetry</strong> – Assign CPT 94760 for pulse oximetry. It is a packaged service under OPPS, but should still be charged</td>
<td></td>
</tr>
</tbody>
</table>

*Documentation must be present in the medical record*

## Auditing Other Services . . .

- **Simple vs. intermediate skin closures:** be sure the closure is into the deeper layer, check documentation closely.

- **Noncovered, Self-Administered Drugs (SAD):** PO meds and Self-Admin drugs, Check the UB, this should appear on the “noncovered charges” column. Insulin only when the patient is “comatose”.

Catholic Healthcare West

CHW
Other Services Audit . . .

- **Irrigation & Foley Catheter Insertion, other than for a urine sample:**
  - **Foley Catheter:** There are 3 CPT codes (51701, 51702, & 51703) available and should be assigned accordingly. *Effective 1/1/06, Medicare will reimburse for these procedures.*
    - MD Order and documentation in the medical record

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Time</th>
<th>Rate</th>
<th>Amount</th>
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<td>98</td>
<td>$4.71</td>
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<td>Insert bladder catheter</td>
<td>0.05</td>
<td>98</td>
<td>$4.71</td>
</tr>
<tr>
<td>51702</td>
<td>Insert temp bladder cath</td>
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<td>51703</td>
<td>Insert bladder cath, complex</td>
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<td>98</td>
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</table>

P Code - Change

- **Urinary Catheterization:** **P9612 Catheterize for urine specimen.... has a status indicator A meaning paid on Lab fee schedule ($3.00).**
  - P9615 Urine specimen collect mult.... Paid on lab fee schedule ($3.00)
  - Do not assign 51701, 51702, & 51703 for a catheterization for the purpose of a urine specimen or for just a urine specimen collection

- **CDM driven**
  - Update your charge form, educate your staff

- **Important for OPPS**
ER Auditing

Injections/Infusion in the ED/ER

- This service was covered in detail in a prior session.

  **Injections** – Injection Administration should be charged based on the number of syringes used ($pd); not the number of drugs administered. Review Nursing documentation.

  - Review for an MD order. Charge in addition for the actual drug/medication J/C codes (Pharmacy)

  **Infusions** – Non-Chemo Infusion charges MUST be based upon the documented start and stop time of each substance infused.

  - Rules change… so auditors, staff and coding contract vendors must keep up to date!
Injection/Infusion is complex – audit this area!!

Infusion / Hydration (single)

Piggyback (IVPB) (Concurrent if two in the same line, same time)

Push Injection
Audit Infusions Services in the ED/ER, in Chemotherapy or in Infusion Unit/Dept.

Is there documentation that the service was provided?

Start and stop times for infusion (check with FI requirements)

<table>
<thead>
<tr>
<th>CDM and Charge #</th>
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<tbody>
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<td>60002771 INFUS IV HYDRATION 1ST HR</td>
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<td>60002789 INFUS HYDRAT EA ADDL HR</td>
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</table>
CPT Basics for Hydration and Infusion

- Per AHA Coding Clinic for HCPCS communication to CHW, **we may not charge/bill** for hydration or infusion if there is **no “start AND stop” time documented** in the medical record.

- What does this mean for ER clinical staff?
- What does this mean for the ER charging staff?
- What does this mean for the hospital coding staff?
- Clinicians MUST document the time each hydration or infusion started and stopped dripping/running.
- Clinicians MUST use standardized abbreviations that we all can interpret, e.g, IVP, IM, IV Infusion/Drip, IVPB, etc.

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**Infusion, Injection and Hydration Charge Hierarchy**

- **Chemotherapy Infusions**
- **Chemotherapy Push**
- **Non-chemo Infusions**
- **Non-chemo Push Injections**
- **Hydration services**
When these codes are reported by the facility, the following instructions apply. The initial code should be selected using a hierarchy whereby chemotherapy services are primary to therapeutic, prophylactic, and diagnostic services which are primary to hydration services. Infusions are primary to pushes, which are primary to injections.

**Terms and Definitions**

- **Initial:** The “initial” code in the facility setting is based on the hierarchy of services:
  - An initial service code is irrespective of the order in which the infusions or injections occurred.
  - The type of service within the hierarchy is the key, not which service was given “first.”
  - Only one “initial” code may be assigned per encounter per venous access site.
  - If multiple IV sites are required during the same encounter, report the initial and additional services provided at each site separately; append/charge/code modifier -59 to the codes for services at the additional site.
### Terms and Definitions

**Sequential:** Sequential codes are add-on codes. They are used to report the infusion of a second or subsequent different drug before or after the initial drug.

- It must be a drug given during the same encounter, before or after the “initial” drug.
- Report the sequential code *once per drug*.
- A simultaneous infusion of two or more drugs into one IV line (one arm) is reported using the “concurrent” code, not sequential.

---

**Concurrent:** The concurrent infusion code is an add-on code. It is used when multiple medications are provided simultaneously through the same IV line, with each drug in a separate IV bag.

- Multiple substances mixed in a single bag are considered **one** infusion, not a concurrent infusion charge code.
  
  - *It should be assigned when 2 different therapeutic drug(s) are infusing simultaneously into the same line.*

- There are no concurrent charge codes for hydration.
- There are no concurrent charge codes for push injections.
CPT Basics for Hydration

• **Summary of the reporting rules:**
  – Medical Necessity must be met
  – Medically necessary infusions for **hydration** (saline etc.) have their own codes, separate from “infusion”.
  – Documentation must support all **time-based** charges.
    • Start and stop times are required
  – Hydration must be provided for at least **31 minutes** to allow or justify a charge/code
    • Time and documentation is key

Hydration Services

• Hydration must continue for 31 mins into the next hour in order to charge an additional hour of hydration services.
  – Secondary or subsequent
• Hydration lasting less than 31 mins is **not** charged/coded

Two specific CDM charges (via CPT codes) for hydration services:

96360 Intravenous infusion, hydration; initial, 31 minutes to 1 hour

96361 each additional hour (List separately in addition to code for primary procedure)
Clinical Example - Hydration

• An 83-year-old patient receives 79 minutes of IV normal saline for a diagnosis of dehydration. There was an MD order and nursing documented the start and stop times for administration of the fluid.

• Initial vs. Add-on?
• What CPT code(s) would you assign?

Therapeutic/Diagnostic Injection Rules

• Document the medication used
• Document the Site & Method used: subcutaneous or intramuscular
• If drugs are mixed in a single syringe injection, and later one of those same drugs is given alone, it does not count as a “same” medication/drug and should be charged as an injection.
• If the same drug is provided via IV push 31 minutes or more after the first, report/charge/code using CPT code 96376
• A subsequent IV push (IVP) of the same medication given 31 minutes after the first may be reported and charged
• Date, time and initial all documentation
### Rule For Two Injections Of Same Drug

- CMS instructs hospitals to report only one unit of an intravenous push, single or initial substance/drug, to bill all pushes for same substance or drug provided to the patient in one hospital encounter unless the reported administrations are more than 30 minutes apart.

- Additional IV push, should be reported for each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure), may be charged as long as all of the IV push injections contained a different drug.

### Document all Therapeutic/Diagnostic Injections

Injection Services must be documented:

- **96372** Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
- **96373** intra-arterial
- **96374** intravenous push, single or initial substance/drug
- **96375** each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)
- **96376** each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)
Case Example – Injection & hydration

- Patient in ER for pneumonia and not been eating, he receives an intravenous hydration lasting 63 minutes per start/stop times, followed by an IV push injection of Phenergan for nausea.

- What service(s) would you charge. What code(s) would be assigned? ______

Case Example - Injection

- An ER patient receives an IV push injection (IVP) of Demerol at 10:00am followed by a separate IV push injection of Phenergan at 10:10am.

- At 11am the patient receives an IVP of Lasix.

- At 1pm the patient receives an IVP of Demerol and Phenergan mixed in one syringe. Then again at 2 pm IVP of Demerol and Phenergan mixed into on syringe.

- What CPT code(s) would be charged?
Infusion Services: Guidelines for what is “Included” in Infusion

• If performed to facilitate the infusion (or injection), the following services are included and are not reported separately:
  – Use of local anesthesia
  – IV Start
  – Access to indwelling IV, subcutaneous catheter or port
  – Flush at conclusion of infusion
  – Standard tubing, syringes, and supplies
  – (For declotting a catheter or port, see 36593)

CPT Basics for Infusion Services

• Summary of the rules for charging infusion services:
  – An infusion must run at least 16 minutes to bill the first “hour,” otherwise it is coded as an IV push injection.
  – To charge a second hour of infusion, the drip must run at least 31 minutes into the next hour, and so on.
  – “TKO” (to keep open) and “KVO” (keep vein open) cannot be charged --- unless this was the only service provided, then charge for TKO service.
Some Tips about Infusion services

– Discrepancy between how ordered and how given, i.e., drug ordered ‘IV,” nursing documents given “IVP”
  • **Action:** The route of administration documented by the performing clinician will determine the charge. Complete documentation is required.

– Drug A with Drug B ‘bracketed’, ‘carrot’, ‘>’ -- unclear if two drugs in one syringe or two syringes (helps if timed one minute apart if separate syringes)

Billing For Infusions Started Prior To Arrival

• **Per CMS (Transmittal 785 1/1/2006):**
  • Hospitals may bill for the first hour of intravenous infusion that the patient receives while at the hospital, even if the hospital did not initiate the infusion, and codes for additional hours of infusion, if warranted.
  • Make sure your ER is charging for infusions that were started in the field by ambulance personnel (ie comes into ED/ER with infusion running).
Infusion Charges and Revenue Loss

- **Charges and Revenue Lost…**
  - No start or stop time documented = No charge
  
  = **Revenue loss**
  - $128.62 (1st Hr infusion, CPT 96365)
  - $24.89 (Ea add Hr infusion, CPT 96366)

---

<table>
<thead>
<tr>
<th>E.D. NURSING / PROCEDURE NOTES</th>
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<tbody>
<tr>
<td><strong>DATE</strong></td>
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<tr>
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<tr>
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</tr>
<tr>
<td>12/31/03</td>
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</table>

Example of Infusion Start & Stop Time …Best Practice
Document all Therapeutic/Diagnostic Infusion

Charging infusion services generates CPT codes:

96365 Intravenous infusion for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour

96366 each additional hour (List separately in addition to code for primary procedure)

96367 additional sequential infusion, up to 1 hour (List separately in addition to code for primary procedure)

96368 concurrent infusion (List separately in addition to code for primary procedure)

Example of Charging for Infusion Services

- Dx: Gastritis and skin staph infection. Tx: IVPB Vancomycin and IVPB Reglan
- Nursing documentation:
  
  Start: @ 1300 IV NS right arm
  @ 1310 IVPB Vancomycin
  @ 1310 IVPB Reglan
  
  All Stop: @ 1530 IV complete (IVPB total 2 hr 20 min)

Charge:  IV TX/Dx/Pro initial 1st HR - 1 unit  (CPT code 96365)
          IV TX/Dx concurrent – 1 unit  (CPT code 96368)
          IV TX/Dx/Pro Ea Add Hr - 1 unit  (CPT code 96366)
Example of Charging for Infusion Services

Dx: Cirrhosis, Sepsis, bleeding Ulcer.

Tx: IV Vitamin K infusion, Lt arm; IV Rocephin infusion Rt arm

Start: @ 1720 NS, Stop: @ 18:10
  @ 1720 Vitamin K, Stop: @ 1750
  @ 1725 Rocephin, Stop: @ 1810

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<td>Infusion TX/Dx 1st HR, addtl site (mod -59)</td>
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<td>$63.00</td>
</tr>
</tbody>
</table>

Medicare Payment/Revenue Overview

- Payment: (Nat’l Avg.)
  - $73  Hydration 1st Hour
  - $24  Hydration each additional hour
  - $128 Infusion 1st Hour
  - $24  Infusion each additional hour
  - $36  Subsequent Infusion
  - $24  Subcutaneous/Intramuscular Injection
  - $36  IV push injection (Initial and additional subsequent)
  - $0   Each additional sequential IV push injection

- Documentation, etc.: Need an MD order, a medically necessary diagnosis/condition (sign/symptom), and start/stop times.
Chemotherapy APCs

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Describer</th>
<th>Cl</th>
<th>SI</th>
<th>APC</th>
<th>Relative Weight</th>
<th>Payment Rate</th>
<th>National Unadjusted Copayment</th>
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<td>043</td>
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<td>$197.98</td>
<td>$27.50</td>
<td></td>
</tr>
</tbody>
</table>

Infusion Key Questions to Ask When Auditing ...

- Why is the patient here?
- What did the patient receive?
- How was it given?
- How long did it take?
Audit Other Services Charged/coded...

- **Tetanus (Td) Injection** – Requires two CPT code 90471 & 90718. Caution the codes are “age” specific. Review for MD orders and nursing documentation. Caution that the toxoid isn’t charged via Pharmacy as a J code. Effective 1/1/06, Medicare will reimburse for CPT 90471.

  Don’t also charge/code the injection code 90772 for tetanus admin

---

Audit Drugs - Pharmacy

**Drugs** – Use J and C HCPCS codes when appropriate. Need to report all codes with appropriate units, follow Medicare guidelines regarding waste. Need to report even if packaged. Make certain administration codes have been charged.

Audit the “units” – dosage versus what was charged and given

Review CMS guidance regarding “waste”
Other Services to Charge/code for . . .

- **Blood Transfusion** – CPT 36430
  must be assigned for the transfusion
  and the blood bank should charge
  for the blood product with
  appropriate P code (PRBC = P9021).
  – Units for the blood product
  – Administration – once per
    encounter 36430

Audit - Charging for Blood and Blood Products

- Always use the “P” code for blood and blood products
  – The revenue code, units, and charge alone are not
    sufficient for payment

- When you have a blood or blood product
code, you should also report the blood
administration CPT code 36430

- Also report a blood draw code and
  associated labs

- **Audit** your internal practices by running a
  report
Review the Encounter/Charge Form

- Ask to see the Charge form
- The outpatient department must/should have a encounter/charge form as a mechanism to capture all related charges for each encounter/visit for each patient. (ED/ER, Chemo, Wound Care, etc.)
- The encounter/charge form should accurately reflect current and appropriate CDM charge codes for services/tests or treatment/procedures provided.
- The encounter/charge form should be reviewed & revised annually.

Encounter/Charge Form (con’t)

- The encounter/charge form has been changed to uniformly capture ED/ER facility levels and associate procedures performed.
- It is the responsibility of the nursing staff to document (TIMELY and ACCURATELY) all ED/ER facility services provided for each patient encounter/visit.
- It is also the physicians’ responsibility to document timely, thoroughly and accurately.
### Example Encounter/Charge Form

<table>
<thead>
<tr>
<th>QTY</th>
<th>CPT</th>
<th>CDM DESCRIPTION</th>
<th>CDM #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ER E/M LEVELS, CRIT CARE**
- **LEVEL 1**: 99281
  - Application of Cast
- **LEVEL 2**: 99282
  - Application of Splint
- **LEVEL 3**: 99283
  - Strapping
- **LEVEL 4**: 99284
  - Windowing/Wedging of Cast
- **LEVEL 5**: 99285
  - Laceration Repair Simple

**ER LEVEL 1 W/PROCEDURE 99281 25**
- Removable Cast Arm/Leg

**ER LEVEL 2 W/PROCEDURE 99282 25**
- Laceration Repair Intermediate

**ER LEVEL 3 W/PROCEDURE 99283 25**
- Laceration Repair Complex

**ER LEVEL 4 W/PROCEDURE 99284 25**
- Windowing/Wedging of Cast Add-on

**ER LEVEL 5 W/PROCEDURE 99285 25**
- Laceration Repair Complex Add-on

**ER CRITICAL CARE NO TRAN 99291 25**
- Remove Foreign Body Simple

**ER CRITICAL CARE W/PROCEDURE 99291 25**
- Remove Foreign Body Complex

**ER PROCEDURES**
- **REPR HAND/FINGER EXTENSION**
- **INJ CT DX INTRAVENOUS**
- **INJ CT DX SURGIM**
- **IV INFLUENZA VACCINE**
- **ADMIN INFLUENZA VACCINE**
- **ADMIN HEP B VACCINE**
- **ADMIN PNEUMO VACCINE**

**MD Order - required**

- Medicare requires an order for therapeutic or diagnostic services performed in the ED. The Medicare Benefit Policy Manual, Chapter 6, section 20.5.1, states:
  - Therapeutic services and supplies which hospitals provide on an outpatient basis are those services and supplies (including the use of hospital facilities) which are incident to the services of physicians in the treatment of patients. Such services include clinic services and emergency department services.

- The services must be furnished in the hospital or in a hospital department that has provider-based status in relation to the hospital under 42 Code of Federal Regulations 413.65.
Audit Hospital-Based Clinics

- If being based under OPPS
- ICD-9-CM diagnosis codes
- MD Orders
- Documentation
- CPT procedures
- CPT E&M
- Modifiers

Hospital Based Clinic – Visits (E&M)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Modifier</th>
<th>Code</th>
<th>Volume</th>
<th>Price</th>
<th>DRG Price</th>
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<tbody>
<tr>
<td>99012</td>
<td>0015</td>
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<td>G3</td>
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<td>$86.95</td>
<td>$57.10</td>
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</tbody>
</table>

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CHW
Audit Wound Care

- OIG area of interest
  - 2 published reports in 2007
- Documentation of surgical debridements
- Medical Necessity of surgical debridements
- Surgical debridements in addition to E&M visit on the same day

OPPS – Wound Care

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Type</th>
<th>Unit</th>
<th>Value</th>
<th>Rate</th>
<th>Amount</th>
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<tbody>
<tr>
<td>97607</td>
<td>Active wound care ≤ 20 cm</td>
<td>T</td>
<td>D015</td>
<td>1.5176</td>
<td>$100.21</td>
<td>$20.05</td>
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<td>97609</td>
<td>Active wound care &gt; 20 cm</td>
<td>T</td>
<td>D015</td>
<td>1.5176</td>
<td>$100.21</td>
<td>$20.05</td>
</tr>
<tr>
<td>97610</td>
<td>Wound(s) pars non-selective</td>
<td>CH</td>
<td>D013</td>
<td>0.9281</td>
<td>$954.70</td>
<td>$86.44</td>
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<tr>
<td>97615</td>
<td>Neg press wound ≤ 50 cm</td>
<td>T</td>
<td>D013</td>
<td>0.9281</td>
<td>$954.70</td>
<td>$86.44</td>
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<td>CH</td>
<td>D013</td>
<td>0.9281</td>
<td>$954.70</td>
<td>$86.44</td>
</tr>
</tbody>
</table>
### Audit HBO

- Review CMS coverage guidance
- MD order
- Frequency of HBO treatments
- C code versus CPT code
- Documentation of services by staff
- Documentation of improvement and benefits of HBO treatment

### Audit Cardiac Cath and CVIR CPT Coding

- ICD-9-CM diagnosis coding
- CPT for “diagnostic” procedures
- CPT for therapeutic procedures
- CDM dependent
- Documentation review and CPT code finalization in place?
- Weaknesses and risk?
Audit IVR (Interventional Radiology) CPT Coding

- CDM dependent
- Need for review of clinical documentation
- CPT coding validation
- Education

Audit Outpatient Surgery (OPS) CPT Coding

- **Surgical Range CPT Code (10000-69999):** Must be assigned/coded or validated by HIM for final billing per CHW corporate policy and supporting physician documentation.
  - * Look for mapping issues, check the UB and make sure the CPT codes are appearing. Look for duplicate CPT codes posting on the UB. HIM assigned codes with $-0-.$
  - * Check the “units” for the surgical range CPT code
Audit Outpatient Surgery (OPS) CPT Coding

- **Surgical Pain Management**: Payment for an outpatient procedure includes post procedure recovery services and associated pain management treatments.

- If a problem not related to the surgery anesthesia or pain management occurs, you may bill for the administration of IVs and injections separately. You could do so under revenue code 761 as long as documentation supports a separate charge for this service.

Audit Outpatient Surgery (OPS) CPT Coding

- **Cancelled Surgery**: Is there a Reason for the cancellation (V code)? After patient is prepped and taken to the operating room reimbursement is paid at: Prior to the administration of anesthesia - 50% of planned procedure. After the administration of anesthesia - 100% of planned procedure (Medicare). Modifier 73 - prior to the administration of anesthesia, under extenuating circumstances or those that threaten the well being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient’s surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed); Modifier 74 after the administration of anesthesia (local, regional block, or general) [Medicare includes moderate (conscious) sedation]

- **Modifier 52**: is used to indicate discontinuation of procedures that do not require anesthesia, or the anesthesia was only topical or drops, etc.
Audit Outpatient Surgery (OPS) CPT Coding

- **EKG Preop:** Charge CPT 93005 for EKG, often done as preop testing prior to the outpatient surgery. Look for the V code assigned, this will help justify medical necessity. This is chargeable services. Should not appear on the “noncovered charges” column of the UB, check the UB.

- **PreOp X-ray:** Look for the V code assigned, this will help justify medical necessity. This is a chargeable services. Should not appear on the “noncovered charges” column of the UB, check the UB.

OPS Auditing

<table>
<thead>
<tr>
<th>Category</th>
<th>OPS Medicare</th>
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<tr>
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<table>
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<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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CHW
The Role of HIM/Coding

- Health Information Management/Coding staff will review the medical record documentation and assign the specific ICD-9-CM diagnosis code or codes.

- HIM/Coding will review the medical record documentation and assign the surgical range CPT code(s).
  - This will link to the “charge/fee $ code” and crosswalk to the bill/claim. Check the UB as there may be crosswalk issues (IT).
  - DON’T be CDM dependent...= risk
Physician Order

• A MD order is required for all services administered/provided to the patient.
• The MD order should contain a diagnosis to support medical necessity.
  – Verify that the medical record has an MD order(s)
• It should also contain details regarding method of administration, drug, dosage and frequency.
• Every MD order should be signed and dated.

Work Flow? . . . Walk through the departmental process

• Review the work flow
  – Paper process and trail
• Triage in ED/ER
• Admitting/Registration
• Patient is received at the department
• Nursing takes a history and vitals (triage)
• Clinician takes history and documents information.
  – Review MD orders
• Treatment/services are given to the patient.
  – Documentation in the medical record
• Patient is discharged.
• Charge for service on the encounter/charge form.
Case Example #1

- 3 year old male child comes to the ED/ER with parents complaining of ear pain. Triaged (vitals taken) and Registration completed.
- Taken to Room by nursing.
- History taken from the parents and family members and the Physician examines the patient. HEENT examined.
- Diagnosed with Otitis Media and Upper Respiratory Infection
  - Instructed to p/u medication at Pharmacy
  - Drink fluids and see pediatrician in 2 days
- What level E&M CPT code does this represent? _______

Case Example #2

- 65 year old male was involved in a fall from a ladder at his daughter’s home while putting up Christmas lights. Patient fell 10 feet landing on his left arm and left hip. An ambulance was called and the patient was transported to the trauma unit.
- In the ED/ER, the patient was examined. The patient has a history of a CVA in the past without any residual. Patient is taking levaquin for a recent bronchitis. Examination including extremities, cardiac, neuro, and respiratory systems was performed. An x-ray of the left arm, hip and chest were performed as well as an EKG. He was placed on a cardiac monitor and noted to have some Atrial Fib.
- X-ray confirmed a Colles’ fracture of the left wrist and an intertrochanteric fracture of the hip. Admission was advised but since the patient was now stable he wanted to be hospitalized at a hospital near his home, so transfer was arranged via ambulance.
- What level E&M CPT code would be assigned? _________
Again, Let’s Talk About Documentation

- The documentation, in your office record **MUST BE**:
  - TIMELY
  - THOROUGH & CONCISE
  - LEGIBLE
  - DETAILED & SPECIFIC

Every entry should be **SIGNED, DATED and TIMED**.

Summary - ED/ER APC Specific Documentation Risks

- Lack of Documentation to Support the procedures charged, lack of orders

- Lack of Documentation to Support E/M Assignment

- Lack of Documentation to Support Modifier Use
Summary – Auditing

• Reimbursement covers overhead, such as costs for electricity, square footage, supplies, packaged drugs, and equipment.
• Claim Line item detail via codes for payment
• Outpatient department directors/managers need to be attentive to charging processes
• Up to date CDM – outpatient directors/mgrs must know its contents

Summary – Auditing

• Complete and accurate Charge/encounter form
• Auditors determine if coders should have the ability and tools to add charges to the accounts so that the coding and charges are appropriate based on clinical documentation
Summary and Auditing Next Steps

- Is there a written policy to support the E&M leveling criteria?
- Written policy to support the charge/encounter form process and usage?
- Daily charge reconciliation is imperative for proper OPPS payment
- Clinical Documentation it a must!
- Self-audit off and on
- Are the key departments working as a “team”?
- Review the RAC reports and take on top of the RAC activities
- Compliance is your role…

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Questions

- Are there any questions?

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Resources/References

- OPPS Final Rule 2000
- OPPS Final Rule 2008 and 2009
- Coder’s Desk Reference 2009
- AHA Outpatient Services CPT 2007 and 2008
- AHA CPT Book 2008 and 2009
- Addendum B 2008 and 2009

References/Resources

- *CPT Assistant*® November 2005, 2006
- OPPS Final Rule 2009 (Federal Register)
- *CPT® 2008 Changes: An Insider’s View*, ©2009 American Medical Association
- Hydration, Infusions, Chemotherapy; Martinelli, Penley. 2005 AMA CPT Symposium Presentation
- Medicare Claims Processing Manual, Part B Hospital, Chapter 4, Section 230.2.
- NCCI Manual, Chapter 11
Thank you

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