Hospital Outpatient Coding Compliance Audits

PRESENTED TO:

Health Care Compliance Association (HCCA)
Las Vegas, NV
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Speaker

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    - 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

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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

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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*
- *ICD-9-CM Coding Handbook – Faye Brown* (AHA)
- AMA CPT coding book
- AMA CPT Assistant
- A more formal educational inservice may be necessary
  - For example: Laceration Repair CPT codes

Education

- Provide written objectives or goals for the educational in-service
- Sign-in verification of who attended
- Materials and handouts (retain for records)
- Pre-Inservice quiz/test and Post in-service quiz/test (retain)
- Question and Answer opportunity
- Evaluation forms (retain)
- Continuing education credit (CEU's)

Communication

- Audit Plan (written and verbal) - notification and time schedule/calendar
  - Distribute to all necessary internal staff
  - Legal counsel
- Date, Time and Plan
- Audit range, inpatient, etc.
- Coordination with HIM
  - Report for chart selection
  - List of selected cases

Communication

- 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
    - 45 mins to an hour

Communication

- 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

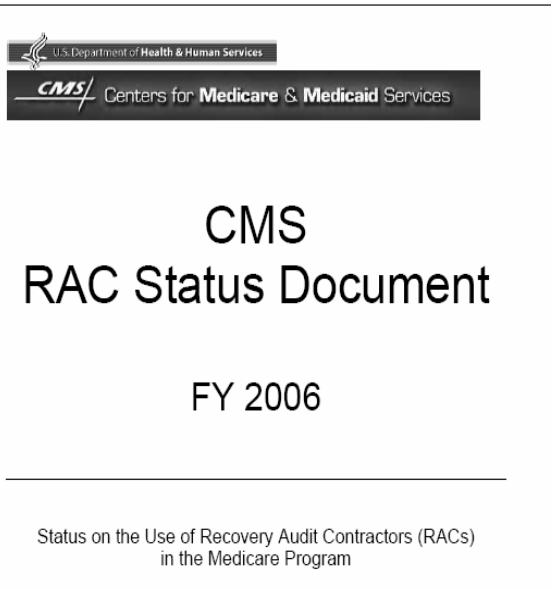
Benefits of HIM Auditing and Monitoring

- 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

Benefits of Auditing & Monitoring

- Decrease denied admissions
- Decrease compliance risk areas
- Enhance physician awareness and understanding
- Increase internal communication and cooperation
- Opportunity for on-going education
- Improvement in health record documentation
- Reduce exposure in HIM area
- Improvement in employee performance and morale
- More efficient HIM operations
- Increased interdepartmental collaboration

RAC Status Report 2006 Findings



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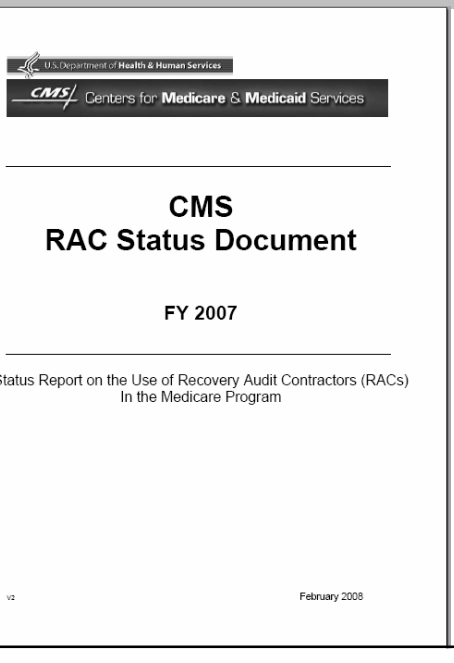
Source at http://www.cms.hhs.gov/RAC/Downloads/RACStatusDocument--FY2006.pdf

RAC Status Report 2007 Findings



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THE MEDICARE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM:

An Evaluation of the 3-Year Demonstration

June 2008

CMS - For Immediate Release: Friday, July 11, 2008

NON-INPATIENT HOSPITAL SERVICES	
Injection, pegfilgrastim 6mg (J2505) -- Neulasta INCORRECT CODING: Provider billed one service per 1mg but… definition of this code is one service per 6mg vial EXAMPLE: A provider administered 6mgs of Neulasta to the beneficiary but billed for 6 units of J2505. According to the definition of the code, six units of J2505 would be 36mg of Neulasta.	$ 0.5
Speech/hearing therapy (92507) INCORRECT CODING: Provider billed one service for each 15 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 3 units of J2505. According to the definition of the code, three units of 92507 would be for 3 separate sessions of therapy on the same day.	$ 0.4
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.	$ 2.4

RAC Findings

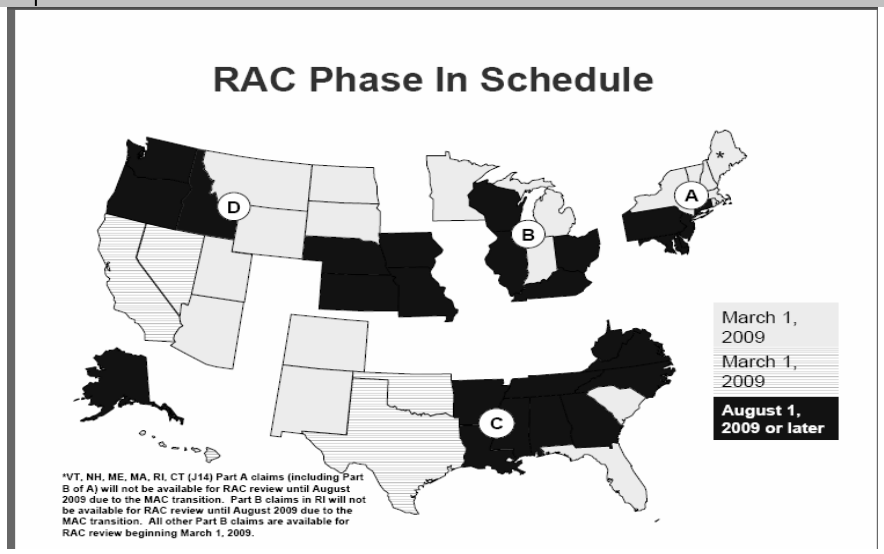
- **Top Hospital Outpatient Services with RAC-Initiated Overpayments**

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

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



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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 mthly 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 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

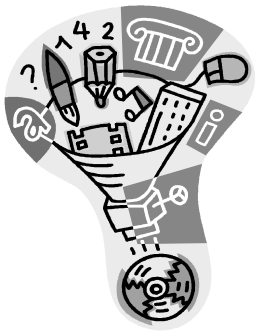
- **What is complex review?**
- Complex review will occur when a RAC makes a claim determination using human review of the medical record. RACs will use complex review when:

  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.

Hospital Outpatient Coding Audits



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Audit ICD-9-CM on Outpatient Records/Accounts

- ICD-9-CM
  - **I**nternational
  - **C**lassification of
  - **D**iseases
  - **9**th Revision
  - **C**linical **M**odification

- 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.

CMS

HIM Coding assigns the ICD-9-CM Diagnosis Codes

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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

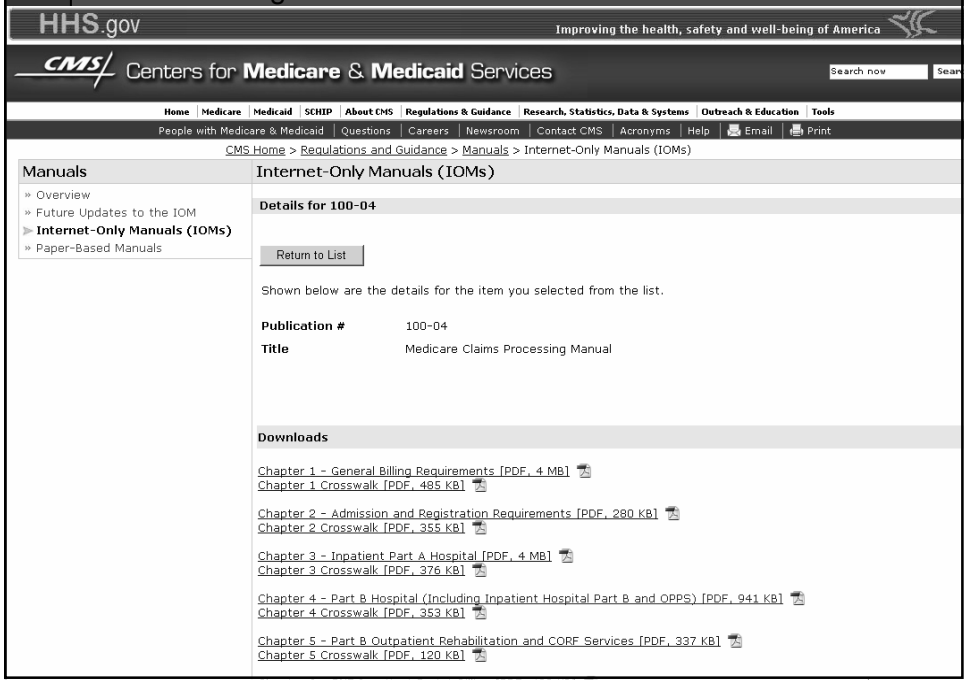
OPPS and/or APC Linked to Coding Systems

- 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

KNOW THE BASICS of HCPCS

- HCPCS = **H**ealthcare **C**ommon **P**rocedural **C**oding **S**ystem
  - Maintained by Medicare
  - Level I - AMA Current Procedural Terminology, (CPT) numeric codes
  - 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.

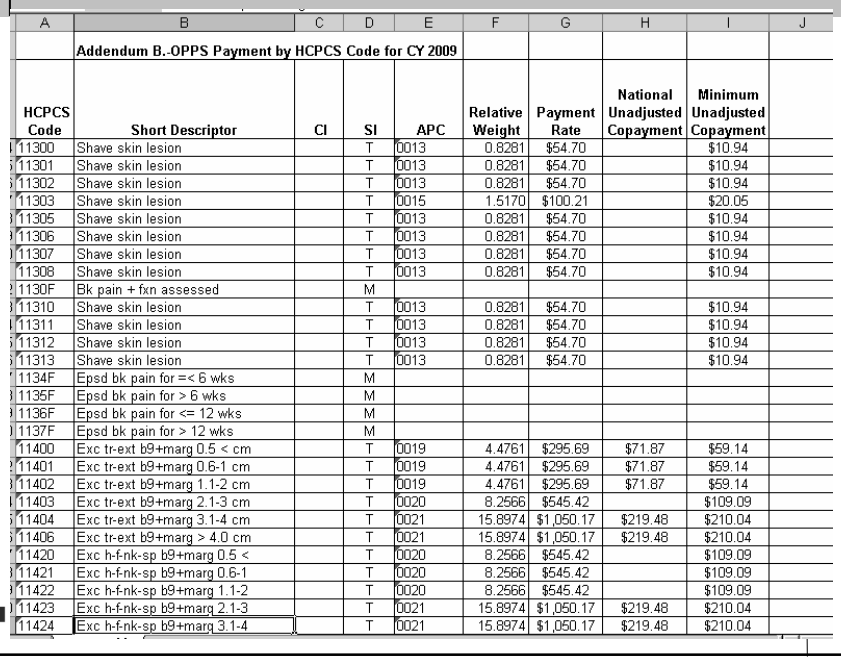
www.cms.hhs.gov/manuals



OPPS Status Indicators

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



A	B	C	D	E	F	G	H	I	J
	Addendum B.-OPPS Payment by HCPCS Code for CY 2009								
	HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	
	11300	Shave skin lesion		T	0013	0.8281	$54.70		$10.94	
	11301	Shave skin lesion		T	0013	0.8281	$54.70		$10.94	
	11302	Shave skin lesion		T	0013	0.8281	$54.70		$10.94	
	11303	Shave skin lesion		T	0015	1.5170	$100.21		$20.05	
	11305	Shave skin lesion		T	0013	0.8281	$54.70		$10.94	
	11306	Shave skin lesion		T	0013	0.8281	$54.70		$10.94	
	11307	Shave skin lesion		T	0013	0.8281	$54.70		$10.94	
	11308	Shave skin lesion		T	0013	0.8281	$54.70		$10.94	
	1130F	Bk pain + fxn assessed		M						
	11310	Shave skin lesion		T	0013	0.8281	$54.70		$10.94	
	11311	Shave skin lesion		T	0013	0.8281	$54.70		$10.94	
	11312	Shave skin lesion		T	0013	0.8281	$54.70		$10.94	
	11313	Shave skin lesion		T	0013	0.8281	$54.70		$10.94	
	1134F	Epsd bk pain for =< 6 wks		M						
	1135F	Epsd bk pain for > 6 wks		M						
	1136F	Epsd bk pain for <= 12 wks		M						
	1137F	Epsd bk pain for > 12 wks		M						
	11400	Exc tr-ext b9+marg 0.5 < cm		T	0019	4.4761	$295.69	$71.87	$59.14	
	11401	Exc tr-ext b9+marg 0.6-1 cm		T	0019	4.4761	$295.69	$71.87	$59.14	
	11402	Exc tr-ext b9+marg 1.1-2 cm		T	0019	4.4761	$295.69	$71.87	$59.14	
	11403	Exc tr-ext b9+marg 2.1-3 cm		T	0020	8.2566	$545.42		$109.09	
	11404	Exc tr-ext b9+marg 3.1-4 cm		T	0021	15.8974	$1,050.17	$219.48	$210.04	
	11406	Exc tr-ext b9+marg > 4.0 cm		T	0021	15.8974	$1,050.17	$219.48	$210.04	
	11420	Exc h-f-nk-sp b9+marg 0.5 <		T	0020	8.2566	$545.42		$109.09	
	11421	Exc h-f-nk-sp b9+marg 0.6-1		T	0020	8.2566	$545.42		$109.09	
	11422	Exc h-f-nk-sp b9+marg 1.1-2		T	0020	8.2566	$545.42		$109.09	
	11423	Exc h-f-nk-sp b9+marg 2.1-3		T	0021	15.8974	$1,050.17	$219.48	$210.04	
	11424	Exc h-f-nk-sp b9+marg 3.1-4		T	0021	15.8974	$1,050.17	$219.48	$210.04	

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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.

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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

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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

A	B	C	D	E	F
	Addendum E.-HCPCS Codes That Are Paid Only as Inpatient Procedures for CY 2009				
HCPCS Code	Short Descriptor	SI	CI		
20930	bone algrft morsel add-on	C			
20931	Sp bone algrft struct add-on	C			
20936	Sp bone agrft local add-on	C			
20937	Sp bone agrft morsel add-on	C			
20938	Sp bone agrft struct add-on	C			
20955	Fibula bone graft, microvasc	C			
20956	Iliac bone graft, microvasc	C			
20957	Mt bone graft, microvasc	C			
20962	Other bone graft, microvasc	C			
20969	Bone/skin graft, microvasc	C			
20970	Bone/skin graft, iliac crest	C			
21045	Extensive jaw surgery	C			
21141	Reconstruct midface, lefort	C			
21142	Reconstruct midface, lefort	C			
21143	Reconstruct midface, lefort	C			
21145	Reconstruct midface, lefort	C			
21146	Reconstruct midface, lefort	C			
21147	Reconstruct midface, lefort	C			
21151	Reconstruct midface, lefort	C			
21154	Reconstruct midface, lefort	C			
21155	Reconstruct midface, lefort	C			
21159	Reconstruct midface, lefort	C			
21160	Reconstruct midface, lefort	C			
21179	Reconstruct entire forehead	C			
21180	Reconstruct entire forehead	C			
21182	Reconstruct cranial bone	C			
21183	Reconstruct cranial bone	C			
21184	Reconstruct cranial bone	C			
21188	Reconstruction of midface	C			

Status Indicator - Packaged Services

- 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.

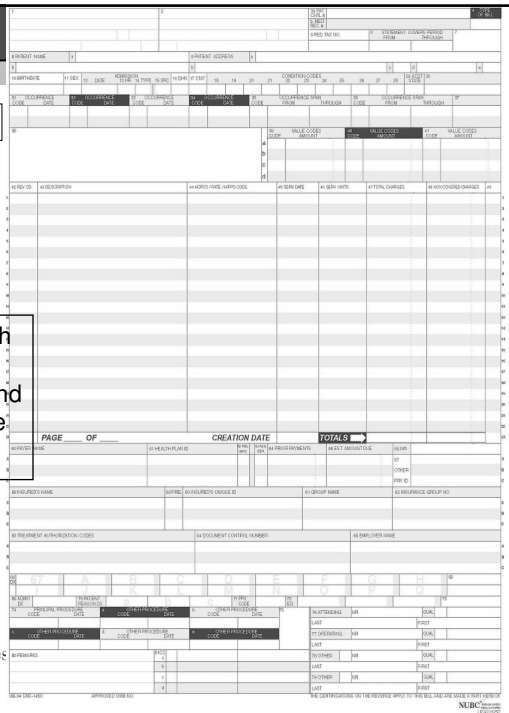
Claim Header Information

- 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).

Audit with the claim form



UB-04

Familiarize yourself with the various fields, and where the ICD-9-CM and HCPCS/CPT codes are located.

Revenue Codes

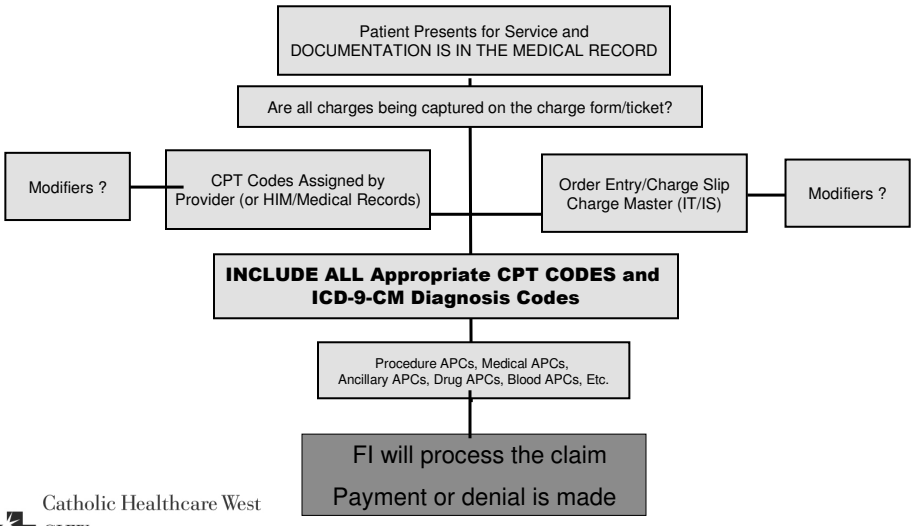
- Programmed into the CDM
- Required for proper claim process.
- Four digit number that identifies the main department service area.
  - Each number begins with a zero
  - Remaining three digits describe the location/area and specific service
- Providers have been instructed to provide detailed level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

HCPCS and CPT Procedure Codes Determine APC Assignment



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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.

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Develop CDM Standardization Policy

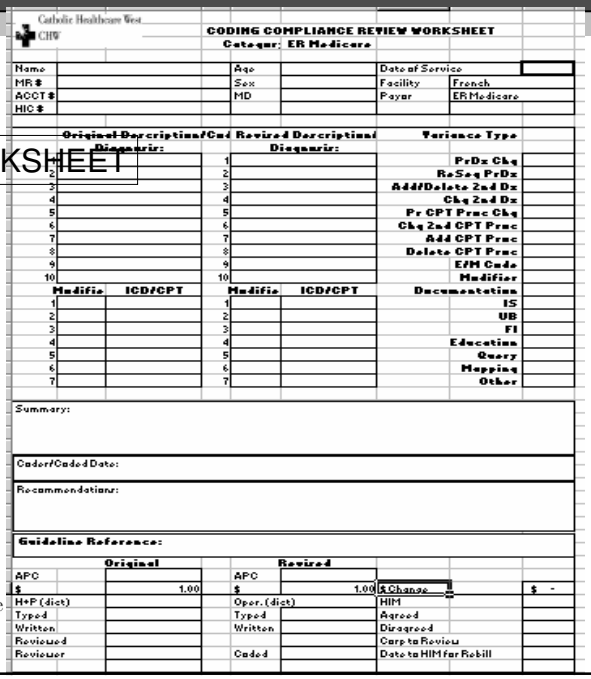
- Hospital CDM Responsibility - Hospitals will adopt standard CDM policies to clarify and facilitate maintenance of the Standard CDM.
- Departments working with System resources, will develop sufficient documentation for their standard CDM and will document their charging process.
- Standard CDM Structure - 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

AUDIT WORKSHEET



CODING COMPLIANCE REVIEW WORKSHEET
Category: ER Medicare

Name		Age		Date of Service	
MR #		Sex		Facility	French
ACCT #		MD		Payer	ER Medicare
HIC #					

	Original Description/Code Diagnosis:		Revised Description Diagnosis:		Variance Type	
1					PrDx Chg	
2					ReSeq PrDx	
3					Add/Delete 2nd Dx	
4					Chg 2nd Dx	
5					Pr CPT Proc Chg	
6					Chg 2nd CPT Proc	
7					Add CPT Proc	
8					Delete CPT Proc	
9					E/M Code	
10					Modifier	
	Modifie	ICD/CPT	Modifie	ICD/CPT	Documentation	
1					IS	
2					UB	
3					FI	
4					Education	
5					Query	
6					Mapping	
7					Other	

Summary:

Coder/Coded Date:

Recommendations:

Guideline Reference:

	Original		Revised			
APC			APC			
$	1.00		$	1.00	$ Change	$ -
H+P (dict)			Oper. (dict)		HIM	
Typed			Typed		Agreed	
Written			Written		Disagreed	
Reviewed					Corr to Review	
Reviewer			Coded		Date to HIM for Rebill	

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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.

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Review - Basics ED/ER E&M for Hospital Coding

- 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)

Evaluation and Management (E&M) CPT Code

- 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)

Level I 99281	Level II 99282	Level III 99283	Level IV 99284	Level V 99285
EXAMPLE			Extended care – Pt stable. Requires LVN or RN assessment & possible reassessment of condition.	Comprehensive. Possibly unstable. Requires RN assessment, reassessment and interventions.

OPPS Leveling Criteria

The Panel specifically recommended that we not differentiate among visit types (for example, new, established, and consultation visits) for the purposes of facility coding of clinic visits.

5. Adopt the ACEP facility coding guidelines as the national guidelines for facility coding of emergency department visits.

6. Develop guidelines for clinic visits that are modeled on the ACEP guidelines but are appropriate for clinic visits.

7. Implement these guidelines as interim and continue to work with appropriate organizations and stakeholders to develop final guidelines.

Proposed Rule

We reviewed the written comments, the oral testimony before the APC Panel, and the Panel's recommendations; we agreed that facility-coding guidelines should be implemented as soon as possible. We were particularly concerned that facilities be able to comply with HIPAA requirements. We announced that we have worked, and will continue to work, on this issue with hospitals, organizations representing hospitals, physicians, and organizations representing physicians. We noted that the AMA CPT Editorial Panel is not currently considering the issue of facility coding guidelines for clinic visits and that the earliest any CPT guidelines could be implemented would be in January 2004. Additionally, consistent with the intent of the outpatient prospective payment system, we wanted to ensure that reporting of hospital emergency and clinic visits is resource based.

After careful review and consideration of written comments, oral testimony and the APC Panel's recommendations, we proposed the following (for implementation no earlier than January 2004):

1. To develop five G codes to describe emergency department services: GXXX1—Level 1 Facility Emergency Services, GXXX2—Level 2 Facility Emergency Services, GXXX3—Level 3 Facility Emergency Services, GXXX4—Level 4 Facility Emergency Services,

4. To establish separate documentation guidelines for emergency visits and clinic visits.

With regard to the documentation guidelines, our primary concerns were to make appropriate payment for medically necessary care, to minimize the information collection and reporting burden on facilities, and to minimize any incentive to provide unnecessary or low quality care. We realized that many facilities use complaint or diagnosis driven care protocols and that current documentation standards do not include documentation of staff time or the complexity of diagnostic and therapeutic services provided. Therefore, in the interest of facilitating the delivery of medically necessary care in a clinically appropriate way, we believed that the potential drawbacks of each of the recommended sets of guidelines outweighed the potential benefits of creating uniformity and reproducibility. For example, any documentation system requiring counting or quantification of resource use has the potential to be burdensome, require clinically unnecessary documentation, and be susceptible to upcoding and gaming. Documentation systems using coding grids or a series of clinical examples for each level of service are subject to interpretation, may induce variability, may be overly complex and burdensome, and may result in disagreements with medical reviewers. We were also concerned that all the proposed guidelines allow counting of separately paid services (for example, intravenous infusion, x-ray, EKG, lab tests, and so forth) as "interventions" or "staff time" in determining a level of service. We believe that, within the constraints of clinical care and management protocols, the level of service for emergency and clinic visits should be determined by resource consumption that is not otherwise separately payable.

To address these concerns, in addition to reviewing written comments, oral comments, and the APC Panel recommendations, we also reviewed, for the proposed rule, the current distribution of paid emergency

codes 99284 and 99285. This pattern of coding is significantly different from physician billing for emergency services, which is skewed and peaks at CPT code 99284. We also noted that the median costs for successive levels of emergency visits show an expected increase across APCs.

With regard to clinic visits, we observed that more than 50 percent of the services were considered "single claims" meaning that they were billed without any other significant procedures such as diagnostic tests or therapeutic interventions. We also noted that the distribution of clinic visits is skewed with the majority being low-level clinic visits. This distribution was consistent with pre-OPPS billing patterns where many facilities billed all clinic visits as low level visits. However, the median costs for different levels of clinic services, while similar within an APC, did not show the expected increase across the clinic visit APCs.

Based on our review, on the current distribution of coding for emergency and clinic visits, and on our understanding that hospitals set charges for services based on the resources used to provide those services, we believed that an incremental approach to developing and implementing documentation guidelines for emergency and clinic visits was appropriate. For example, as hospitals became more familiar with the OPPS and with the need to differentiate emergency and clinic visits based on resource consumption, we would continue to review the advantages and disadvantages of detailed, uniform documentation guidelines. We planned to begin the development of uniform guidelines over the next year. If we were ready, we would propose the guidelines for comments in our Federal Register document for the CY 2004 update. For CY 2003, we proposed the following new codes:

Emergency Visits

Because, our data indicated that, in general, hospitals under the OPPS were reporting emergency visits

Emergency Room - Evaluation and Management Visits

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

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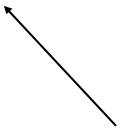
OPPS Payment - APCs for ED/ER E&M Visits

	A	B	C	D	E	F	G	H	I	J
	HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	
	99281	Emergency dept visit		V	0609	0.7972	$52.66	$12.70	$10.54	
	99282	Emergency dept visit		V	0613	1.3040	$86.14	$21.06	$17.23	
	99283	Emergency dept visit		V	0614	2.0694	$136.70	$34.50	$27.34	
	99284	Emergency dept visit		Q3	0615	3.2987	$217.91	$48.49	$43.59	
	99285	Emergency dept visit		Q3	0616	4.9032	$323.90	$72.86	$64.78	
	99288	Direct advanced life support		B						
	99289	Ped crit care transport	CH	D						
	99290	Ped crit care transport addl	CH	D						
	99291	Critical care, first hour		Q3	0617	7.3479	$485.39	$111.59	$97.08	
	99292	Critical care, add'l 30 min		N						



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OPPS ED/ER E&M

- 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.

CHW ED E&M LEVEL CRITERIA GUIDE

LEVEL 1 - CPT 99281	LEVEL 2 - CPT 99282	LEVEL 3 - CPT 99283
Minimal RN involvement	Limited RN care, single system	Intermediate RN care possible intervention
Disp: Discharge	Disp: Discharge	Disp: Discharge
Beyond triage, vital and DC instructions		Minimum level for Ambulance arrival
CARDIO-PULMONARY	**CARDIO-PULMONARY**	**CARDIO-PULMONARY**
No cardiac dx for this level	Hypertension	Arrhythmia Chronic
		Chest pain atypical w/no cardiac workup
		Costochondritis or chest wall pain
		Palpitations
EENT	**EENT**	**EENT**
Ear pain	Conjunctivitis	Cerumen impaction
Nosebleed non active	Eye discharge	Corneal abrasion
Sore throat/pharyngitis	Otitis media or externa	Epistaxis/nosebleed/controlled
Toothache - no abscess	Mono	Eye injury / Lost contact lens
	Sinusitis	Foreign body in eye, ear, nose or throat
	Strep throat	
	Stye Tonsillitis	
GASTRO-INTESTINAL	**GASTRO-INTESTINAL**	**GASTRO-INTESTINAL**
Hemorrhoids	Constipation Diarrhea	Abd pain Attention to G tube
	Nausea/vomiting	Colitis Gastric pain, Upper due to GERD
		Gastritis acute, unspecified
		Gastroenteritis
		GI Bleed/w coffee ground emesis or melena
		Impaction Irritable Bowel Syndrome
GENITO-URINARY/RENAL	**GENITO-URINARY/RENAL**	**GENITO-URINARY/RENAL**
No renal dx at this level	Dysuria	Cystitis acute/ UTI
	Urinary frequency/urgency	Epididymitis/prostatitis
	Urinary incontinence	Urinary retention Urinary tube attention
MUSCULOSKELETAL	**MUSCULOSKELETAL**	**MUSCULOSKELETAL**
Joint pain non-traumatic	Contusions - extremities	Back pain
Muscle aches	Dislocation resolved prior to admit	Fracture (finger, toe) Minor
	Gout	Sprains & strains (back, neck, ankle) Major
	Muscle spasm	Torso Contusion
	Sprains/strains, minor (finger,toe)	
NEURO	**NEURO**	**NEURO**
No neuro dx at this level	Numbness/Paresthesia	Bell's Palsy
		Dizziness/vertigo/labyrinthitis
		Headache Head injury w/o symptoms
		Shingles Tremors
OB/GYN	**OB/GYN**	**OB/GYN**
No OB dx at this level	Menstrual cramping - no pelvic exam	Abortion, threatened
		Ovarian Cyst Pelvic Exam*
		Pelvic inflammatory disease
		Sexually transmitted disease
		Vaginal bleed/hemmorage minimal
Psych	**Psych**	**Psych**
No psych dx at this level	No psych dx at this level	Anxiety Depression
		Panic attack
RESPIRATORY	**RESPIRATORY**	**RESPIRATORY**
Cold symptoms (running nose, cough etc) w/o fever	Bronchitis	Croup Dyspnea
	Hyperventilation - resolved	
	Upper resp tract infection	
SKIN	**SKIN**	
Abrasion	Foreign body simple (splinter)	
Insect bite, non-venomous	Herpes	
Suture removal w/o anesthesia	Local allergic reaction	
	Puncture wound extremity	
	Rash Scabies	
	Sunburn and 1 degree burns	
MISCELLANEOUS	**MISCELLANEOUS**	
Blood Draw Forensic/Legal	Fever	
Injection Follow up (ie: Rabies, Procrit)	Needle stick/exposure	
Medication refill		
School/Work Release		
Triage protocol - left without being seen (Use special ER Triage Charge, not Level 1)		

LEVEL 4 - CPT 99284	LEVEL 5 - CPT 99285	CRITICAL CARE - CPT 99291,99292**
Disp: Discharge, Admit	Disp:Acute Transfer, Admit or Disch	Dispdies in ED, Acute Transfer, ICU Admit, OR/Surgery
Minimum level for admission	Minimum level for admit to ICU or surgery	
CARDIO-PULMONARY	**CARDIO-PULMONARY**	**CARDIO-PULMONARY**
Acute Coronary Syndrome (ACS)	Anaphylaxis severe	Acute MI
Angina	Deep venous thrombosis	Aortic dissection
Arrhythmia new onset	Sepsis	Cardiac arrest
Chest pain/rule out cardiac origin	**EENT**	Cardiac tamponade
Congestive heart failure - stable	Epistaxis - with transfer out or to surgery	Hemophilia, ITP, TTP, leukemia or aplastic anemia
Hypertension Accelerated or Malignant	**GASTRO-INTESTINAL**	hypovolemic, anaphylactic)
Hypotension	Bowel obstruction	Leaking / ruptured aneurysm (thoracic,abdmnal)
Pleurisy	GI Bleed - unstable hypotensive	Precipitous Newborn
Syncope Tachycardia	**GENITO-URINARY/RENAL**	Resuscitation
EENT	Chronic Renal failure	Shock - any: Septic, Cardiogenic, Spinal
Epistaxis -multiple attempts to control	**MUSCULOSKELETAL**	**EENT**
Peritonsillar abscess	Cervical fracture Open fracture	No EENT dx for this level
GASTRO-INTESTINAL	Skull fracture Spinal fracture	**GASTRO-INTESTINAL**
Appendicitis Cholecystitis	**NEURO**	Acute hepatic failure GI Bleed w/shock
Cholelithiasis Diverticulitis	Headache w/neuro deficits	**GENITO-URINARY/RENAL**
GI Bleed - vomiting bright red blood/hematemesis	New onset Altered Mental Status	Acute Renal failure
Pancreatitis Ulcerative colitis	New onset of neurological deficits	**MUSCULOSKELETAL**
GENITO-URINARY/RENAL	Pediatric meningitis	Spinal cord injury
Hematuria Kidney stones	Transient ischemic attack (TIA)	**NEURO**
Pyelonephritis Renal colic	**OB/GYN**	Cerebrovascular accident (CVA) acute
MUSCULOSKELETAL	Active labor	Cerebral or intracranial hemorrhage any type
Clavicle fracture Closed fracture excluding minor	Ectopic pregnancy Sexual Assult	Head injury, unresponsive GCS < 8
C-spine precautions Dislocation	**Psych**	or w/new neuro deficits
NEURO	Psychosis,agitated or combative	Paralysis new onset
Altered Level of Consciousness (LOC)	Suicidal/ homicidal (5150)	Status epilepticus
Concussion	**RESPIRATORY**	**OB/GYN**
Meningitis adult Migraine	Hemo/Pneumothorax, except tension	Ruptured ectopic pregnancy
Seizure Syncope	Near drowning	**Psych**
OB/GYN	Pulmonary embolism	No psych dx at this level
Abortion Spontaneous	**SKIN**	**RESPIRATORY**
Vaginal Hemorrhage/bleeding- moderate to severe	Facial burns	Respiratory failure Status asthmaticus
Psych	Tar burns	Tension pneumothorax
Dementia Psychosis/non-combative	Venomous snake bite w/systemic response	**SKIN**
RESPIRATORY	2nd or 3rd degree burns > 1 area	None
Allergic reaction with airway compromise	**MISCELLANEOUS**	**MISCELLANEOUS**
Asthma Acute Exacerbation	Alcohol/drug withdrawal	Hyper/hypothermia life threatening
Emphysema/COPD Pleural effusion	Diabetic coma Diabetic ketoacidosis (DKA)	Traumatic injury(ies) life threatening
Pneumonia Pulmonary edema	Diabetes Mellitus uncontrolled	Thyroid storm or addisonian crisis
Smoke inhalation	Hypothermia	
SKIN	Pediatric transfer out	
Complex foreign body	Unconscious w/o vital function impairment	
Laceration(s) >10cm total		
3rd degree burns of 1 area, except face		
MISCELLANEOUS		

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Emergency Room E&M

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

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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

A	B	C	D	E	F	G	H	I	J
	Addendum B.-OPPS Payment by HCPCS Code for CY 2009								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	
12001	Repair superficial wound(s)		T	0133	1.3124	$86.70	$25.67	$17.34	
12002	Repair superficial wound(s)		T	0133	1.3124	$86.70	$25.67	$17.34	
12004	Repair superficial wound(s)		T	0133	1.3124	$86.70	$25.67	$17.34	
12005	Repair superficial wound(s)		T	0133	1.3124	$86.70	$25.67	$17.34	
12006	Repair superficial wound(s)		T	0133	1.3124	$86.70	$25.67	$17.34	
12007	Repair superficial wound(s)		T	0133	1.3124	$86.70	$25.67	$17.34	
12011	Repair superficial wound(s)		T	0133	1.3124	$86.70	$25.67	$17.34	
12013	Repair superficial wound(s)		T	0133	1.3124	$86.70	$25.67	$17.34	
12014	Repair superficial wound(s)		T	0133	1.3124	$86.70	$25.67	$17.34	
12015	Repair superficial wound(s)		T	0133	1.3124	$86.70	$25.67	$17.34	
12016	Repair superficial wound(s)		T	0133	1.3124	$86.70	$25.67	$17.34	
12017	Repair superficial wound(s)		T	0133	1.3124	$86.70	$25.67	$17.34	
12018	Repair superficial wound(s)		T	0133	1.3124	$86.70	$25.67	$17.34	
12020	Closure of split wound		T	0135	4.4306	$292.68		$58.54	
12021	Closure of split wound	CH	T	0134	3.4414	$227.34		$45.47	
12031	Intmd wnd repair s/tr/ext	CH	T	0133	1.3124	$86.70	$25.67	$17.34	
12032	Intmd wnd repair s/tr/ext	CH	T	0134	3.4414	$227.34		$45.47	
12034	Intmd wnd repair s/tr/ext	CH	T	0133	1.3124	$86.70	$25.67	$17.34	
12035	Intmd wnd repair s/tr/ext	CH	T	0133	1.3124	$86.70	$25.67	$17.34	
12036	Intmd wnd repair s/tr/ext		T	0134	3.4414	$227.34		$45.47	
12037	Intmd wnd repair s/tr/ext		T	0134	3.4414	$227.34		$45.47	
12041	Intmd wnd repair n-hf/genit	CH	T	0133	1.3124	$86.70	$25.67	$17.34	
12042	Intmd wnd repair n-hg/genit	CH	T	0133	1.3124	$86.70	$25.67	$17.34	
12044	Intmd wnd repair n-hg/genit	CH	T	0133	1.3124	$86.70	$25.67	$17.34	
12045	Intmd wnd repair n-hg/genit		T	0134	3.4414	$227.34		$45.47	
12046	Intmd wnd repair n-hg/genit		T	0134	3.4414	$227.34		$45.47	
12047	Intmd wnd repair n-hg/genit		T	0134	3.4414	$227.34		$45.47	
12051	Intmd wnd repair face/mm	CH	T	0133	1.3124	$86.70	$25.67	$17.34	

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

A	B	C	D	E	F	G	H	I	J
CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment	
23500	Treat clavicle fracture	CH	T	0129	1.5977	$105.54		$21.11	
23505	Treat clavicle fracture	CH	T	0139	19.8724	$1,312.75		$262.55	
23515	Treat clavicle fracture		T	0064	62.5691	$4,133.25	$835.79	$826.65	
23520	Treat clavicle dislocation	CH	T	0138	6.1479	$406.12		$81.23	
23525	Treat clavicle dislocation	CH	T	0138	6.1479	$406.12		$81.23	
23530	Treat clavicle dislocation		T	0063	42.8656	$2,831.66		$566.34	
23532	Treat clavicle dislocation		T	0062	25.4442	$1,680.82	$372.87	$336.17	
23540	Treat clavicle dislocation	CH	T	0129	1.5977	$105.54		$21.11	
23545	Treat clavicle dislocation	CH	T	0138	6.1479	$406.12		$81.23	
23550	Treat clavicle dislocation		T	0063	42.8656	$2,831.66		$566.34	
23552	Treat clavicle dislocation		T	0063	42.8656	$2,831.66		$566.34	
23570	Treat shoulder blade fx	CH	T	0129	1.5977	$105.54		$21.11	
23575	Treat shoulder blade fx	CH	T	0138	6.1479	$406.12		$81.23	
23585	Treat scapula fracture		T	0064	62.5691	$4,133.25	$835.79	$826.65	
23600	Treat humerus fracture	CH	T	0129	1.5977	$105.54		$21.11	
23605	Treat humerus fracture	CH	T	0139	19.8724	$1,312.75		$262.55	
23615	Treat humerus fracture		T	0064	62.5691	$4,133.25	$835.79	$826.65	
23616	Treat humerus fracture		T	0064	62.5691	$4,133.25	$835.79	$826.65	
23620	Treat humerus fracture	CH	T	0129	1.5977	$105.54		$21.11	
23625	Treat humerus fracture	CH	T	0139	19.8724	$1,312.75		$262.55	
23630	Treat humerus fracture		T	0064	62.5691	$4,133.25	$835.79	$826.65	
23650	Treat shoulder dislocation	CH	T	0129	1.5977	$105.54		$21.11	
23655	Treat shoulder dislocation		T	0045	15.5673	$1,028.36	$268.47	$205.68	
23660	Treat shoulder dislocation		T	0063	42.8656	$2,831.66		$566.34	
23665	Treat dislocation/fracture	CH	T	0138	6.1479	$406.12		$81.23	
23670	Treat dislocation/fracture		T	0064	62.5691	$4,133.25	$835.79	$826.65	
23675	Treat dislocation/fracture	CH	T	0129	1.5977	$105.54		$21.11	

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

Enter quantity of each nursing procedure performed. Note: Use E/M Level w/procedure if any (*) items are checked.

CDM #	QTY	CDM DESCRIPTION	CDM #	QTY	CDM DESCRIPTION
		ER TRIAGE			*ANOSCOPY/LARYNGOSCOPY DIAG
		ER LEVEL 1			*APPLICATION OF CAST
		ER LEVEL 2			*APPLICATION OF SPLINT
		ER LEVEL 3			*ARTERIAL PUNC/CATH/CANN
		ER LEVEL 4			*AVULSION NAIL PLATE EACH ADD
		ER LEVEL 5			*CHANGE CYSTOSTOMY TUBE COMPLEX
		*ER LEVEL1 W/PROCEDURE			*CHANGE TUBE SIMPLE
		*ER LEVEL 2 W/PROCEDURE			*CLOSE WOUND LATE COMPLEX
		*ER LEVEL 3 W/PROCEDURE			*CLOSE/PACK WND DEHISCEN SMPL
		*ER LEVEL 4 W/PROCEDURE			*COLPOCENTESIS
		*ER LEVEL 5 W/PROCEDURE			*CONTRL NOSEBLED/CHEM CAUTERY
		ER CRITICAL CARE 30-74MIN			*DEBR SKIN EA ADD 10%
		**ER CRITICAL CARE W/PROCEDURE			*DEBRID/AVULSION NAIL,EVAC HEMA
		ER EMTALA MED SCRN EXAM			*DEBRIDE OPEN FX W/FB REMOV
		ER EVIDENTIARY EXAM			*DEBRIDEMENT SKIN/SUBQ/MUS/BONE
		LEFT W/O BEING SEEN STAT			*DRESS/DEBRIDE BURN
		OBSERVATION STATISTIC			*EPIDURAL BLOOD PATCH
		ER BED STATISTIC			*EPISIOTOMY VAGINAL REPAIR
		INPT BED HOLD PER HOUR			*EXC NAIL MATRIX REM PHALANX
		ER OBSERVATION PER HOUR			*EXCISE/REPR NAIL; INGROWN
		ER WORKERS COMP 1ST HOUR			*FETAL NON-STRESS TEST
		ER WORKERS COMP EA ADD HOUR			*HEMORRHOID EXC/INC SIMPLE
		TAXI FARE			*INCISION/DRAINAGE/ASP COMPLEX
		ER PROCEDURES (not RIM coded)			*INCISION/DRAINAGE/ASP SIMPLE
		ADMIN OTHER IMMUN VACCINE ONE			*INJ NERVE/OTHR ASP/INJ JOINT
		ADMIN OTHER IMMUN VAC EA ADD			*INSERT CATH BLADDER
		IV INFUSION THERAPY 1ST HR			*INSERT OR REPL NONTUN/PICC W/O
		IV INFUSION THER ADD MAX 8			*INSERT PERITONL CATH/CANN TEMP
		INJECT TX/DX SUBQ/IM			*INS/REM TUN CV CATH/PERIP CVAD
		INJECT TX/DX INTRA-ARTERIAL			*INSERT TUNNEL CVAD
		INJECT TX/DX INTRAVENOUS			*INS/REPL TEMP PACER ELECTRODE
		INJECT ANTIBIOTIC IM			*INTUBATION ENDOTRACHEAL
		INJECT ANTIBIOTIC IM ADDL			*IRRIG/LAVG/INSTL BLADDER
		ADMIN HEP B VACCINE			*LACERATION REPAIR COMPLEX
		ADMIN INFLUENZA VACCINE			*LACERATION REPAIR CPLX ADD<5CM
		ADMIN PNEUMO VACCINE			*LACERATION REPAIR INTERMEDATE
		CONSCIOUS SEDATION IV/IM/INH			*LACERATION REPAIR SIMPLE
		CONSC SEDATION ORAL/RECTL/NASL			*LUMBAR PUNCTURE
		*EMERG ROOM CPR			*PERICARDIOCENTESIS INITIAL
		*CARDIOVERSION			*PLACE NEEDLE INTRAOSSEO INFUS
		THROMBOLYSIS, CORONARY IV			*PLACE/LAY NASO/OROGAS TUBE
		PACING TRANSCUTANEOUS			*REMOVE CERUMEN IMPACTED

Other Services to Charge/code for . . .

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

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".

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**

51700	Irrigation of bladder		T	0164	1.8697	$123.51		$24.71	
51701	Insert bladder catheter		X	0340	0.6462	$42.69		$8.54	
51702	Insert temp bladder cath		X	0340	0.6462	$42.69		$8.54	
51703	Insert bladder cath, complex		T	0126	1.0435	$68.93	$16.21	$13.79	
51705	Change of bladder tube		T	0164	1.8697	$123.51		$24.71	
51710	Change of bladder tube		T	0427	15.5994	$1,030.48		$206.10	

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

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CODING COMPLIANCE REVIEW WORKSHEET

Category ER Medicare

Name		Age	74	Date of Service	12/31/08
MR #		Sex	F	Facility	
ACCT #		MD		Payor	ER Medicare

	Original Description/Codes		Revised Description/Code		Variance Type	
	Diagnosis:		**Diagnosis:**			
1	462	1	same		**Pr CPT Proc Chg**	
2	276.51	2	same		**Chg 2nd CPT Proc**	
3	079.99	3	same		**Add CPT Proc**	
4	331.0	4	same		**Delete CPT Proc**	
5		5			**E/M Code**	
6		6			**Modifier**	
7		7			**IS**	
8		8			**UB**	
9		9			**CDM**	
10		10			**Mapping**	
	Modifier ICD/CPT		**Modifier ICD/CPT**		**Charging**	XXX
1	-25 99282	1	same		**Documentation**	
2	51702	2	P9612		**Billing**	
3		3			**IV Issues**	
4		4			**Other**	
5		5				
6		6				
7		7				

Summary: When foley cathether is inserted for the collection of a specimen only, then HCPCS code P9612 should be assigned. CPT 51702 is used for the therapeutic use of a foley (ie. Urinary retention).....*Note* no stop time documented for IV infusion of Normal Saline.

Coder/Coded Date:

Recommendations: Replace CPT 51702 with P9612.....Re-bill.

Guideline Reference:

	Original		**Revised**		
APC	340	APC			
$ (National)	42.69				
$ (Hospital)	47.89	$		$ Change	$ (48)

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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!

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			Category	ER Medicare			
Name			Age	54	Date of Service	01/08/09	
MR #			Sex	M	Facility		
ACCT #			MD		Payor	ER Medicare	
	Original Description/Codes			Revised Description/Cod		Variance Type	
	Diagnosis:			Diagnosis:			
1	724.5		1	No changes		Pr CPT Proc Chg	
2	722/90		2			Chg 2nd CPT Proc	
3	790.7		3			Add CPT Proc	
4	add'l as listed		4			Delete CPT Proc	xxx
5			5			E/M Code	
6			6			Modifier	
7			7			IS	
8			8			UB	
9			9			CDM	
10			10			Mapping	
	Modifier	ICD/CPT		Modifier	ICD/CPT	Charging	xxx
1	25	99283	1		okay	Documentation	
2		96372	2		delete	Billing	
3			3			IV Issues	
4			4			Other	
5			5				
6			6				
7			7				

Summary: A review of the documentation in this record indicates to this reviewer that the documentation is inadequate to support the charge for the therapeutic injection. The dictation says IV Dilaudid, the order sheet has "IM" circled, there is an entry for injections "I" without a drug name, and on the last page IV hydromorphone is documented.

Coder/Coded Date:

Recommendations: Delete the charge/code for the IM injection, 96372.

Guideline Reference:

	Original	Revised		
APC	436	APC		
$ (National)	24		0	
$ (Hospital)	26.84	$	0.00	$ Change $ (27)

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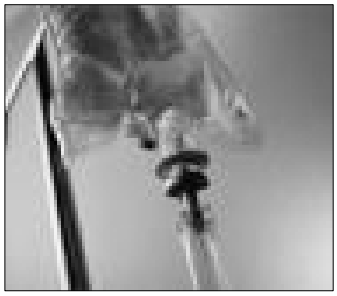
Injection/Infusion is complex – audit this area!!

Infusion / Hydration (single)



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

Push Injection

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

Is there an MD Order?

Addendum B.-OPPS Payment by HCPCS Code for CY 2009

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
96154	Interv hlth/behav, fam w/pt		Q3	0432	0.4065	$26.85		$5.37
96155	Interv hlth/behav fam no pt		E					
96360	Hydration iv infusion, init	NI	S	0438	1.1152	$73.67		$14.74
96361	Hydrate iv infusion, add-on	NI	S	0436	0.3768	$24.89		$4.98
96365	Ther/proph/diag iv inf, init	NI	S	0439	1.9470	$128.62		$25.73
96366	Ther/proph/diag iv inf addon	NI	S	0436	0.3768	$24.89		$4.98
96367	Tx/proph/dg addl seq iv inf	NI	S	0437	0.5469	$36.13		$7.23
96368	Ther/diag concurrent inf	NI	N					
96369	Sc ther infusion, up to 1 hr	NI	S	0438	1.1152	$73.67		$14.74
96370	Sc ther infusion, addl hr	NI	S	0437	0.5469	$36.13		$7.23
96371	Sc ther infusion, reset pump	NI	S	0436	0.3768	$24.89		$4.98
96372	Ther/proph/diag inj, sc/im	NI	S	0436	0.3768	$24.89		$4.98
96373	Ther/proph/diag inj, ia	NI	S	0437	0.5469	$36.13		$7.23
96374	Ther/proph/diag inj, iv push	NI	S	0437	0.5469	$36.13		$7.23
96375	Tx/pro/dx inj new drug addon	NI	S	0437	0.5469	$36.13		$7.23
96376	Tx/pro/dx inj new drug adon	NI	N					
96379	Ther/prop/diag inj/inf proc	NI	S	0436	0.3768	$24.89		$4.98
96401	Chemo, anti-neopl, sq/im	CH	S	0437	0.5469	$36.13		$7.23
96402	Chemo hormon antineopl sq/im	CH	S	0437	0.5469	$36.13		$7.23
96405	Chemo intralesional, up to 7	CH	S	0437	0.5469	$36.13		$7.23
96406	Chemo intralesional over 7		S	0438	1.1152	$73.67		$14.74
96409	Chemo, iv push, sngl drug		S	0439	1.9470	$128.62		$25.73
96411	Chemo, iv push, addl drug	CH	S	0438	1.1152	$73.67		$14.74
96413	Chemo, iv infusion, 1 hr	CH	S	0440	2.8454	$187.96		$37.60
96415	Chemo, iv infusion, addl hr	CH	S	0437	0.5469	$36.13		$7.23
96416	Chemo prolong infuse w/pump	CH	S	0440	2.8454	$187.96		$37.60
96417	Chemo iv infus each addl seq		S	0438	1.1152	$73.67		$14.74
96420	Chemo, ia, push tecnique		S	0439	1.9470	$128.62		$25.73

Is there documentation that the service was provided?

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

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ED/ER CDM – Linking the Charge to a Code

CDM and Charge #

(CPT Code)

60002763	INJ TX/DX/PRO IVP SEQ ADD	0	48	600	450	96375	217	0.00
60002771	INFUS IV HYDRATION 1ST HR	0	48	600	260	96360	514	0.00
60002789	INFUS HYDRAT EA ADDL HR	0	48	600	260	96371	144	0.00
60002797	INFUS TX/DX/PROPH 1ST HR	0	48	600	260	96365	514	0.00
60002805	INFUS TX/DX/PRO EA ADDL HR	0	48	600	260	96366	144	0.00
60002813	INFUS TX/DX SEQUEN 1ST HR	0	48	600	260	96367	514	0.00

Charging a unit of service on the ED charge form, links to a CPT code in the CDM above for billing and payment.

VACCINE/INJECTION/IV	*Qty*	*Code*
Infusion IV Hydration 1st HR		60002771
Infusion Hydrat Ea Add Hr		60002789
Infusion TX/DX/Proph 1st HR		60002797
Infusion TX/DX/Pro Ea Add Hr		60002805
Infusion TX/DX Sequen 1st HR		60002813

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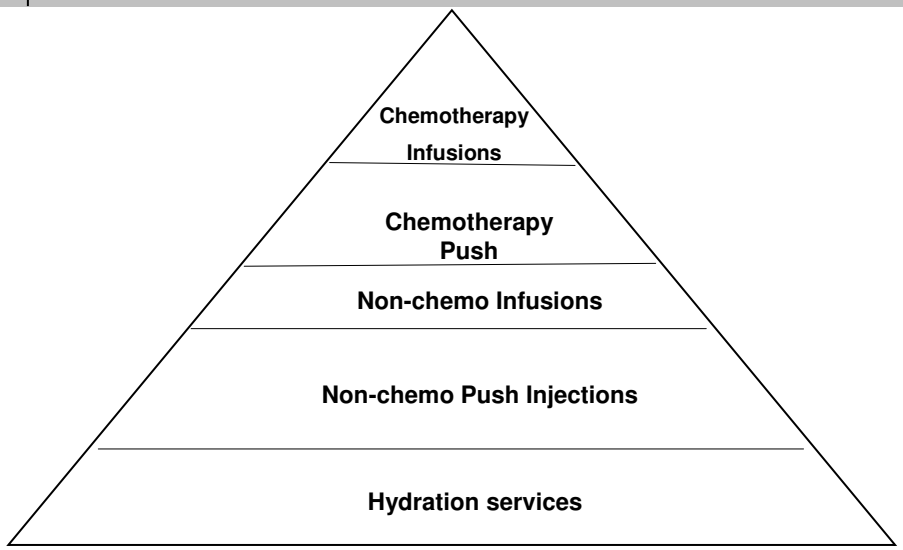
CPT Basics for Hydration and Infusion

- 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.

Infusion, Injection and Hydration Charge Hierarchy



Hydration, Therapeutic, Prophylactic and Diagnostic Injections and Infusion Codes – AMA CPT Language

- ► 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.

Terms and Definitions

- **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

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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)

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Example of Start & Stop Time …Hydration Best Practice

ACTIONS

TIME		INIT
	cardiac monitor	
	pulse oximeter O_2 _____ L via	
	Accu-Chek	
	ready for Dr eval. notified doctor / seen by Dr	
	restraints *see documentation*	
	alarms on and audible	
	procedural pause conducted	
	Active Time Out (Verified with MD / RN)	
	☐ 1. Pt. ID verified with 2 identifiers	
	☐ 2. Correct Procedure, Equipment, and Position Verified	
	☐ 3. Correct Site Verified	

MEDICATIONS

START	END	Medication	Dose	Route	Site	INIT
		Response: no change improved				
		Response: no change improved				
		Response: no change improved				
		Response: no change improved				
		Response: no change improved				
		Response: no change improved				

IV STARTS

START	END	#	site	gauge	attempts	complications	INIT

IV / MEDICATION INFUSION RECORD

Start Time	Solution / Med	IVPB	Rate ml / hr	Stop Time	Amount Infused	INIT
	Response: no change improved					
	Response: no change improved					
	Response: no change improved					

ADDITIONAL NOTES

INTAKE_____ **OUTPUT**_____

_____ IV / saline lock discontinued: **Total Amt Infused**_____

_____ Time_____Initials_____

PROPERTY TO:

_____ patient _____ family _____ security _____ safe _____ sec patient belongings list

DISPOSITION

_____ **discharged** *home police nursing home ME funeral home*

_____ verbal / written instructions / RX given to: *patient* _____

Infusion Audit

3					**Category**	**Infusion Medicare**			
4									
5	Name	Greene, Ruth		Age	83	Date of Service		12/04/08	
6	MR #	00177799		Sex	F	Facility	Marian		
7	ACCT #	F21065792		MD	DiCarlo	Payor	Infusion Medicare		
8									
9									
10		**Original Description/Codes**			**Revised Description/Code**		**Variance Type**		
11		**Diagnosis:**			**Diagnosis:**				
12	1	357.81		1	no recommended changes		**Pr CPT Proc Chg**		
13	2			2			**Chg 2nd CPT Proc**		
14	3			3			**Add CPT Proc**		
15	4			4			**Delete CPT Proc**	xx	
16	5			5			**E/M Code**		
17	6			6			**Modifier**		
18	7			7			**IS**		
19	8			8			**UB**		
20	9			9			**CDM**		
21	10			10			**Mapping**		
22		**Modifier**	**ICD/CPT**		**Modifier**	**ICD/CPT**	**Charging**	xx	
23	1		90765	1		okay	**Documentation**		
24	2		90766 x 2 units	2		90766 x 1 unit	**Billing**		
25	3			3			**IV Issues**		
26	4			4			**Other**		
27	5			5					
28	6			6					
29	7			7					
30									
31	Summary: The documentation in this record indicates the IVIG infusion was provided from 13:30 to 15:30 on 12/4/08. This is a								
32	total infusion time of 2 hours. Orders indicate IV Benadryl was ordered and there is a charge for the drug product on the claim.								
33	However, there is no documentation to show Benadryl was administered to the patient.								
34									
35	Coder/Coded Date:								
36									
37	Recommendations: Delete one unit of additional infusion and report 90766 x 1 unit. Discuss risk related to undocumented								
38	drug administration with FCL.								
39									
40									
41	**Guideline Reference:**								
42									
43		**Original**			**Revised**				
44	APC	437		APC	437				
45	$ (National)	50			25				
46	$ (Hospital)	55.92		$	27.96	$ Change		$ (28)	

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◀)

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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

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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)

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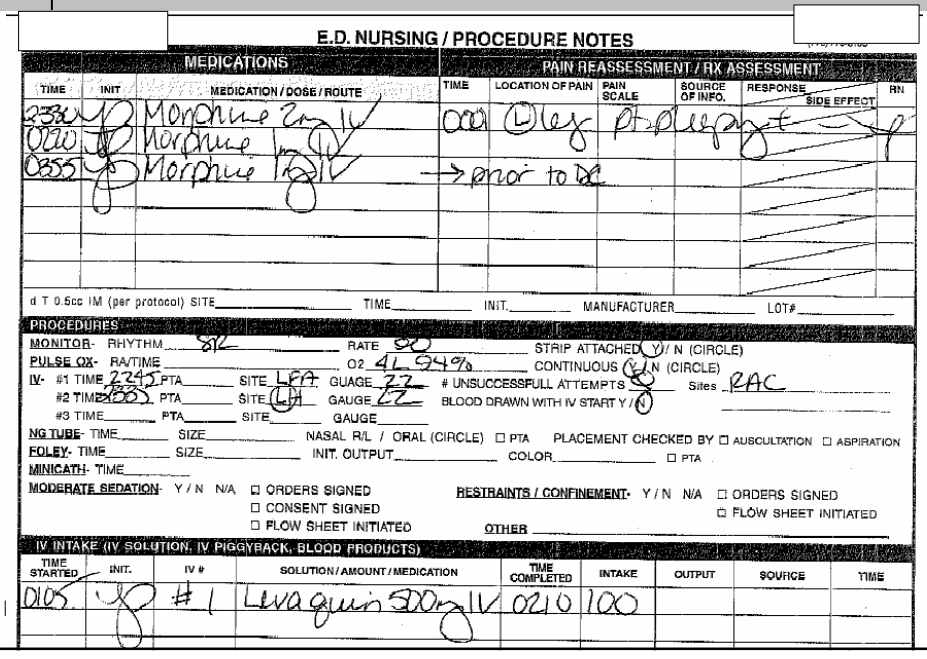
Example of Infusion Start & Stop Time …Best Practice



E.D. NURSING / PROCEDURE NOTES

MEDICATIONS

TIME	INIT	MEDICATION / DOSE / ROUTE
2330		Morphine 2mg IV
0220		Morphine 4mg IV
0355		Morphine 4mg IV

PAIN REASSESSMENT / RX ASSESSMENT

TIME	LOCATION OF PAIN	PAIN SCALE	SOURCE OF INFO.	RESPONSE / SIDE EFFECT	RN
000	(L) leg	pt plegnant			
	→ prior to DC				

d T 0.5cc IM (per protocol) SITE_____ TIME_____ INIT._____ MANUFACTURER_____ LOT#_____

PROCEDURES

MONITOR- RHYTHM SR RATE 90 STRIP ATTACHED (Y) / N (CIRCLE)
PULSE OX- RA/TIME _____ O2 4L 94% CONTINUOUS (Y) / N (CIRCLE)
IV- #1 TIME 2345 PTA_____ SITE LFA GUAGE 22 # UNSUCCESSFULL ATTEMPTS 0 Sites RAC
#2 TIME 0005 PTA_____ SITE LH GAUGE 22 BLOOD DRAWN WITH IV START Y / (N)
#3 TIME_____ PTA_____ SITE_____ GAUGE_____
NG TUBE- TIME_____ SIZE_____ NASAL R/L / ORAL (CIRCLE) ☐ PTA PLACEMENT CHECKED BY ☐ AUSCULTATION ☐ ASPIRATION
FOLEY- TIME_____ SIZE_____ INIT. OUTPUT_____ COLOR_____ ☐ PTA
MINICATH- TIME_____
MODERATE SEDATION- Y / N N/A ☐ ORDERS SIGNED ☐ CONSENT SIGNED ☐ FLOW SHEET INITIATED
RESTRAINTS / CONFINEMENT- Y / N N/A ☐ ORDERS SIGNED ☐ FLOW SHEET INITIATED
OTHER _____

IV INTAKE (IV SOLUTION, IV PIGGYBACK, BLOOD PRODUCTS)

TIME STARTED	INIT.	IV #	SOLUTION / AMOUNT / MEDICATION	TIME COMPLETED	INTAKE	OUTPUT	SOURCE	TIME
0105		#1	Levaquin 500mg IV	0210	100			

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

Infusion TX/DX/Proph 1st HR	1	60002797
Infusion TX/DX/Pro Ea Add Hr		60002805
Infusion TX/DX Sequen 1st HR		60002813
Transfuse Blood/Blood Comp		60000411
Needle Intraosseo Infuse		60001328
Admin Influenza Vaccine		60002524
Admin Pneumo Vaccine		60002532
Admin Hep B Vaccine		60002516
Infusion TX/Dx 1st HR, add'l site (mod -59	1	60002798

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

Addendum B.-OPPS Payment by HCPCS Code for CY 2009								
HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
96401	Chemo, anti-neopl, sq/im	CH	S	0437	0.5469	$36.13		$7.23
96402	Chemo hormon antineopl sq/im	CH	S	0437	0.5469	$36.13		$7.23
96405	Chemo intralesional, up to 7	CH	S	0437	0.5469	$36.13		$7.23
96406	Chemo intralesional over 7		S	0438	1.1152	$73.67		$14.74
96409	Chemo, iv push, sngl drug		S	0439	1.9470	$128.62		$25.73
96411	Chemo, iv push, addl drug	CH	S	0438	1.1152	$73.67		$14.74
96413	Chemo, iv infusion, 1 hr	CH	S	0440	2.8454	$187.96		$37.60
96415	Chemo, iv infusion, addl hr	CH	S	0437	0.5469	$36.13		$7.23
96416	Chemo prolong infuse w/pump	CH	S	0440	2.8454	$187.96		$37.60
96417	Chemo iv infus each addl seq		S	0438	1.1152	$73.67		$14.74
96420	Chemo, ia, push tecnique		S	0439	1.9470	$128.62		$25.73
96422	Chemo ia infusion up to 1 hr	CH	S	0440	2.8454	$187.96		$37.60
96423	Chemo ia infuse each addl hr		S	0438	1.1152	$73.67		$14.74
96425	Chemotherapy,infusion method	CH	S	0440	2.8454	$187.96		$37.60
96440	Chemotherapy, intracavitary	CH	S	0440	2.8454	$187.96		$37.60
96445	Chemotherapy, intracavitary	CH	S	0440	2.8454	$187.96		$37.60
96450	Chemotherapy, into CNS	CH	S	0440	2.8454	$187.96		$37.60
96521	Refill/maint, portable pump		S	0440	2.8454	$187.96		$37.60
96522	Refill/maint pump/resvr syst	CH	S	0439	1.9470	$128.62		$25.73
96523	Irrig drug delivery device		Q1	0624	0.6043	$39.92	$12.65	$7.99
96542	Chemotherapy injection	CH	S	0439	1.9470	$128.62		$25.73
96549	Chemotherapy, unspecified		S	0436	0.3768	$24.89		$4.98

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

Make sure the ED/ER Charge form is correct.

Enter quantity of each nursing procedure performed.

QTY	CDM #	CDM DESCRIPTION	CPT	MOD
		ER E/M LEVELS, CRIT CARE		
		LEFT W/O BEING SEEN STATISTICAL		
		ER LEVEL 1	99281	
		ER LEVEL 2	99282	
		ER LEVEL 3	99283	
		ER LEVEL 4	99284	
		ER LEVEL 5	99285	
		ER LEVEL1 W/PROCEDURE	99281	25
		ER LEVEL 2 W/PROCEDURE	99282	25
		ER LEVEL 3 W/PROCEDURE	99283	25
		ER LEVEL 4 W/PROCEDURE	99284	25
		ER LEVEL 5 W/PROCEDURE	99285	25
		ER EMTALA MED SCRN EXAM	99281	
		ER CRITICAL CARE 30-74MIN	99291	
		ER CRITICAL CARE W/PROCEDURE	99291	25
		ER PROCEDURES		
		INJ ANTIBIOTIC IM	90788	
		INJECT TX/DX INTRAVENOUS	90784	
		INJ TX/DX SUB-Q/IM	90782	
		IV INFUSION THERPY 1ST HR	90780	
		IV INFUS THER ADD HR MAX8	90781	
		INJ TX/DX INTRA-ARTERIAL	90783	
		ADMIN OTHER IMMUN VAC INITIAL	90471	
		ADMIN OTHER IMMUN VAC ADDITL	90472	
		ADMIN INFLUENZA VACCINE	G0008	
		ADMIN HEP B VACCINE	G0010	
		ADMIN PNEUMO VACCINE	G0009	

QTY	CDM #	CDM DESCRIPTION	CPT
		MUSC/SKEL/SKIN/WD/LACERAT	
		APPLICATION OF CAST	
		APPLICATION OF SPLINT	
		STRAPPING	
		WINDOWING/WEDGING OF CAST	
		REMOV/BIVALV CAST ARM/LEG	29705
		LACERATION REPAIR SIMPLE	
		LAC RPR INTERMEDATE	
		LACERATION REPAIR COMPLEX	
		LAC REPAIR CPLX ADD<5CM	
		REMOVE FOREIGN BODY SIMPLE	
		REMOVE FB INTERMEDIATE	
		REMOVE FB COMPLEX	
		REPR HAND/FINGER EXTENSOR	
		INCIS/DRAIN/ASPIR SIMPLE	
		INCIS/DRAIN/ASPIR COMPLEX	
		TX BURN 1ST DEGREE INITIAL	16000
		DRESS/DEBRIDE BURN	
		DEBRIDE SKIN/SUBQ/MUS/BONE	
		DEBRIDE SKIN EA ADD 10%	
		DEBRIDE OPEN FX W/FB REMOV	
		DEBRID/AVUL NAIL,EVAC HEMAT	
		AVULSION NAIL PLATE EA ADD	
		EXC NAIL MATRIX REM PHALANX	
		EXCISE/REPR NAIL; INGROWN	

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)

99201	Office/outpatient visit, new		V	0604	0.8277	$54.68		$10.94	
99202	Office/outpatient visit, new		V	0605	1.0439	$68.96		$13.80	
99203	Office/outpatient visit, new		V	0606	1.3585	$89.74		$17.95	
99204	Office/outpatient visit, new		V	0607	1.7192	$113.57		$22.72	
99205	Office/outpatient visit, new		Q3	0608	2.4477	$161.69		$32.34	
99211	Office/outpatient visit, est		V	0604	0.8277	$54.68		$10.94	
99212	Office/outpatient visit, est		V	0605	1.0439	$68.96		$13.80	
99213	Office/outpatient visit, est		V	0605	1.0439	$68.96		$13.80	
99214	Office/outpatient visit, est		V	0606	1.3585	$89.74		$17.95	
99215	Office/outpatient visit, est		Q3	0607	1.7192	$113.57		$22.72	

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

97597	Active wound care/20 cm or <		T	0015	1.5170	$100.21		$20.05
97598	Active wound care > 20 cm		T	0015	1.5170	$100.21		$20.05
97602	Wound(s) care non-selective	CH	T	0013	0.8281	$54.70		$10.94
97605	Neg press wound tx, < 50 cm		T	0013	0.8281	$54.70		$10.94
97606	Neg press wound tx, > 50 cm	CH	T	0013	0.8281	$54.70		$10.94

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

- **<u>Surgical Range CPT Code (10000-69999):</u>** 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

				Category	OPS Medicare			
Name			Age	49	Date of Service		12/11/08	
MR #			Sex	M	Facility			
ACCT #			MD		Payor	OPS Medicare		
	Original Description/Codes			Revised Description/Code		Variance Type		
	Diagnosis:			Diagnosis:				
1	726.10		1	same		Pr CPT Proc Chg	XXX	
2	401.9		2	same		Chg 2nd CPT Proc		
3	311		3	same		Add CPT Proc		
4			4			Delete CPT Proc		
5			5			E/M Code		
6			6			Modifier		
7			7			IS		
8			8			UB		
9			9			CDM		
10			10			Mapping		
	Modifier	ICD/CPT		Modifier	ICD/CPT	Charging		
1		23415	1	-RT	23412	Documentation		
2	-59	23120	2		same	Billing		
3	-59	29805	3		delete	IV Issues		
4			4			Other		
5			5					
6			6					
7			7					

Summary: Per OP Report - Patient had a suture repair of a chronic rotator cuff tear in addition a mumford procedure. Refer to Coders' Desk Reference definition of CPT code 23412 with includes both the repair of the rotator cuff in addition to incision of choroacromial ligament....In addition, per the NCCI Manual, when an arthroscopic procedure is converted to an open, then only the open procedure is reported.

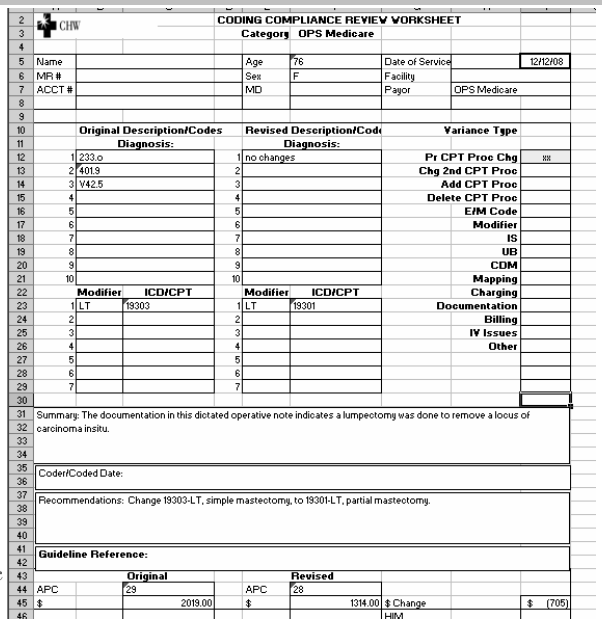
Coder/Coded Date: MRW/OODA 12/17/08

Recommendations: Replace CPT code 23415 with 23412-RT and delete CPT code 29805-59....Re-bill.

Guideline Reference: NCCI Manual Version 14.3 Chapter 4 / Coders' Desk Reference.

	Original		Revised		
APC	0041	APC			
$ (National)	971.56		0		
$ (Hospital)	1090.01	$	0.00	$ Change	$ (1,090)
				HIM	

OPS Auditing



CODING COMPLIANCE REVIEW WORKSHEET

Category OPS Medicare

Name		Age	76	Date of Service	12/12/08
MR #		Sex	F	Facility	
ACCT #		MD		Payor	OPS Medicare

	Original Description/Codes Diagnosis:		Revised Description/Code Diagnosis:		Variance Type	
1	233.0		no changes		Pr CPT Proc Chg	xx
2	401.9				Chg 2nd CPT Proc	
3	V42.5				Add CPT Proc	
4					Delete CPT Proc	
5					E/M Code	
6					Modifier	
7					IS	
8					UB	
9					CDM	
10					Mapping	
	Modifier	ICD/CPT	Modifier	ICD/CPT	Charging	
1	LT	19303	LT	19301	Documentation	
2					Billing	
3					IV Issues	
4					Other	
5						
6						
7						

Summary: The documentation in this dictated operative note indicates a lumpectomy was done to remove a locus of carcinoma insitu.

Coder/Coded Date:

Recommendations: Change 19303-LT, simple mastectomy, to 19301-LT, partial mastectomy.

Guideline Reference:

	Original	Revised		
APC	29	APC	28	
$	2019.00	$	1314.00	$ Change $ (705)

HIM

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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

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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?

  _____

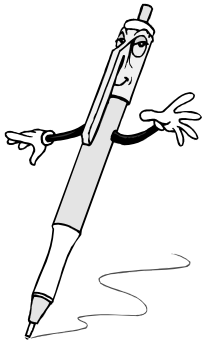
Case Example #2

- 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 a 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***.



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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

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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…

Questions

- Are there any questions?

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
- Current Procedural Terminology (CPT ®) 2009
- 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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