Top 10 Things a Compliance Professional Needs to Know About Coding

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Agenda

- ✓ What is Coding?
- ✓ Abbreviations
- ✓ ICD-10
- ✓ Prospective Payment Systems
- ✓ Coding Lingo
- ✓ When Do I Use What?
- ✓ Medicare Alphabet
- ✓ Documentation, Coding and Reimbursement
- ✓ My Coding Top 10
- ✓ Overlap of Issues
- ✓ Coding/Audit Tips
- ✓ Compliance Audit Process

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What is Coding?

Medical coding is the transformation of healthcare diagnosis, procedures, medical services, and equipment into universal medical alphanumeric codes. The diagnoses and procedure codes are taken from medical record documentation, such as transcription of physician's notes, laboratory and radiologic results, etc.

-American Academy of Professional Coders (AAPC)

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Abbreviations

ICD=International Classification of Diseases
- 9-ninth revision
- 10-tenth revision
- CM-Clinical Modification
- PCS-Procedural Coding System

CPT=Current Procedural Terminology
- 4-fourth revision
- Also called HCPCS level I

HCPCS Level II=Healthcare Common Procedural Coding System

E/M=Evaluation and Management

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ICD-10

Replaced ICD-9-CM

In the U.S., ICD-10 was effective on October 1, 2015

Procedural coding in the inpatient setting uses ICD-10-PCS

Procedural coding in the outpatient setting and Physician services use CPT

ICD-10-CM and ICD-10-PCS significantly increased the specificity of codes and expanded many codes

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Prospective Payment Systems

A Prospective Payment System (PPS) is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service.
-CMS

Some Examples:

- Medical Severity Diagnosis Related Group (MSDRG)-Inpatient Hospital Claims
- All-Payor Group (APG)-Outpatient Hospital Claims (ED/ASU/Clinic)
- Home Health Resource Group (HHRG)-Home Health Claims
- Resource Utilization Group (RUG)-Skilled Nursing Facility Claims
- Case Mix Group (CMG)-Inpatient Rehabilitation Facility

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Coding Lingo

Principal Diagnosis=Defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

Complication/Comorbidity (CC) and Major Complication/Comorbidity (MCC)= *complication* is a condition that develops while in the hospital that prolongs the length of stay. A *comorbidity* is a pre-existing medical condition that impacts the treatment a patient may receive and could also prolong the length of stay.

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Coding Lingo (continued)

Chief Complaint (CC)=a concise statement that describes the symptom, problem, condition, diagnosis, or reason for the patient encounter. The CC is usually stated in the patient's own words. For example, patient complains of upset stomach, aching joints, and fatigue. The medical record should clearly reflect the CC.

Medical Decision Making (MDM)=refers to the complexity of establishing a diagnosis and/or selecting a management option, which is determined by considering these factors:

- The number of possible diagnoses and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed
- The risk of significant complications, morbidity, and/or mortality as well as comorbidities associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options

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When Do I Use ICD-9, ICD-10, ICD-10-PCS, CPT, HCPCS?

ICD-9-CM-extinct however when auditing inpatient hospital and outpatient hospital claims, you need to use this system for claims billed before 10/1/2015.

ICD-10-CM-for inpatient hospital, outpatient hospital and physician office diagnosis coding beginning 10/1/2015

ICD-10-PCS-for inpatient hospital procedure coding beginning 10/1/2015

CPT-for outpatient hospital and physician services coding

HCPCS-for outpatient hospital and physician office coding of health care equipment and supplies not identified by the HCPCS level I, CPT codes (Drugs, Supplies, etc…)
-Majority of modifiers live here

Remember-no matter what codes you are using, you must always code from Physician or applicable physician extender documentation

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Medicare Alphabet

Part A= certain inpatient services in hospitals and Skilled Nursing Facilities and some Home Health services

Part B= designated practitioners' services. Outpatient care and certain other medical services, equipment, supplies and drugs that Part A does not cover

Part C= Medicare Advantage Plans

Part D= Medicare prescription drug coverage

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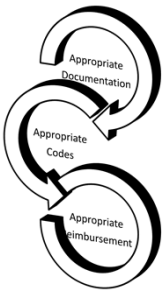
Documentation, Coding and Reimbursement



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My Coding Top 10

10.Kwashikor
9.Radiation Therapy
8. Infusion and Injection Coding
7. Post Acute Services
6. Sepsis
5.Cardiac Catherizations
4. Unbundling
3. Modifiers
2. Time-Based Evaluation and Management Codes
1. Documentation

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10-Kwashikor

Kwashikor	Setting/Medicare Part	Problem	Controls
Severe malnutrition. Rarely seen in the U.S.	Mainly Inpatient coding (Part A).	Extremely high reimbursement for this diagnosis. in ICD-9-CM "malnutrition" indexed to Kwashikor, it wasn't until you looked in the tabular portion of the book that the coder realized that it was incorrect.	• Run population of billed inpatient Part A claims to see if Kwashikor diagnosis is billed. • If so, audit documentation to see if documented diagnosis is consistent with billed codes. • Refund overpayments. • Educate coders and physicians. • Query policies.

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9-Radiation Therapy

Radiation Therapy	Setting/Medicare Part	Problem	Controls
Treatment of a disease with x-ray radiation.	Can be Inpatient and outpatient coding Part A and Part B.	Can be highly complex treatment with equally complex coding rules.	• Make sure that when choosing to audit any part of the Radiation Therapy billing/coding the auditor is well versed in Radiation therapy; preferably certified in coding of this specialty.

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8-Infusion and Injection Coding

Infusion and Injection Coding	Setting/Medicare Part	Problem	Controls
Infusion: Administration of diagnostic, prophylactic, or therapeutic intravenous (IV) fluids and/or drugs given over a period of time. -AHIMA Injection: Injection delivers a dosage in one "shot" rather than over a period of time. -AHIMA	Outpatient-ED, Observation. Medicare Part A.	• Can be difficult to determine administration method. • Need to understand and use AMA Hierarchy. • Infusions must have start and stop times documented. • Heavily reliant on documentation of physician, PA, NP and nurses.	• Run population of billed outpatient Part A claims with Infusion/Injection CPT codes billed. • Audit documentation to see if documentation supports billed codes (time and hierarchy) • Refund overpayments. • Educate coders and physicians. • Validate policy.

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7-Post Acute Services

Post Acute Services	Setting/Medicare Part	Problem	Control
Skilled Nursing Facilities, Home Health, and Hospice.	SNF, Home Health, Hospice Part A & Part B.	Often times have different rules for Medicare than traditional "Part A". Own prospective payment system (HHRGs, RUGs).	• Make sure that when choosing to audit billing/coding the auditor is well versed in the specialty; preferably certified in coding of this specialty.

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6-Sepsis

Sepsis	Setting/Medicare Part	Problem	Control
A complication caused by the body's overwhelming and life-threatening response to infection, which can lead to tissue damage, organ failure, and death.-CDC.	Most likely Part A; inpatient hospital.	• Can be difficult to diagnose. • Documentation of sepsis can take many forms. • Sepsis definition is ever-changing. • Don't need definitive proof to have a diagnosis of sepsis-can be clinical picture.	• Run population of billed inpatient Part A Sepsis claims. • Audit documentation to see if documented diagnosis is consistent with billed codes. • Refund overpayments. • Educate coders and physicians. • Validate policy.

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5-Cardiac Catherizations

Cardiac Catherization	Setting/Medicare Part	Problem	Control
A procedure used to diagnose and treat cardiovascular conditions. A tube (catheter) is inserted into the heart to conduct diagnostic tests. Coronary angioplasties, also are done using cardiac catheterization.	Part A (outpatient hospital) and Part B (physician services).	• Highly scrutinized area by the government. • Room for documentation and coding errors. • Patient must meet medical necessity.	• Run population of billed outpatient Part A and Part B claims. • Audit documentation to see if documented diagnosis and procedure is consistent with billed codes. • Refund overpayments. • Educate coders and physicians. • Validate policy.

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4-Unbundling

Unbundling	Setting/Medicare Part	Problem	Control
Occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code.-CMS	Part A (outpatient hospital) and Part B (physician services).	• Highly scrutinized area by the government. • Room for coding errors related to documentation. • Very easy to unbundle-just add modifier -59.	• Run population of billed outpatient procedures for Part A and Part B claims. • Audit documentation to see if documented procedures are consistent with billed codes and procedures are coded appropriately according to NCCI edits. • Make sure modifier -59 is used appropriately. • Refund overpayments. • Educate coders and physicians. • Validate policy.

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3-Modifiers

Modifier	Setting/Medicare Part	Problem	Control
Two digit numeric or alphanumeric characters that are appended to CPT and HCPCS Level II codes. A modifier provides a means to indicate that a service or procedure was altered by specific circumstances, without changing the definition of the code.	Part A (outpatient hospital) and Part B (physician services).	• Highly scrutinized area by the government. • Room for coding errors related to documentation. • Many modifiers have similar meanings.	• Run population of billed outpatient procedures for Part A and Part B claims. • Audit documentation to see if documented procedures are consistent with billed codes and are coded appropriately. • Make sure modifiers are used appropriately. • Refund any overpayments. • Educate coders and physicians. • Validate policy.

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2-Timed E/M Codes

Timed E/M Codes	Setting/Medicare Part	Problem	Control
The more complex the visit, the higher the level of code you may bill within the appropriate category. The three key components when selecting the appropriate level of E/M services provided are history, examination, and medical decision making. Visits that consist predominately of counseling and/or coordination of care are an exception to this rule. For these visits, time is the key or controlling factor to qualify for a particular level of E/M services. -CMS	Part B (physician services).	• Highly scrutinized area by the government. • If time is not documented, it is not billable.	• Run population of billed timed E/M codes. • Audit documentation to see if required time is appropriately documented. • Refund any overpayments. • Educate coders and physicians. • Validate policy.

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1-Documentation

Documentation	Setting/Medicare Part	Problem	Control
Clear and concise medical record documentation is critical to providing patients with quality care and is required for you to receive accurate and timely payment for furnished services. -CMS	Part A (inpatient and outpatient hospital) and Part B (physician services).	• Documentation counts!	• Run population of billed claims • Audit documentation to see if documentation. matches the codes billed. • Refund any overpayments. • Educate coders and physicians.

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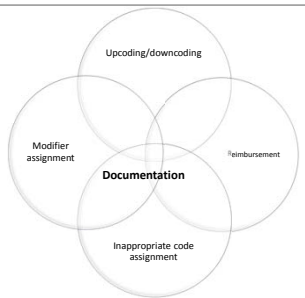
Overlap of Issues



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Coding / Audit Tips

People generally feel nervous when audited
- Transparency is key

Try to look at the whole picture
- Not just the task at hand

Limit the timeframe/objectives of the audit
- Audit should be a snapshot in time
- Don't bite off more than you can chew
- Clear and concise objectives

Choose an appropriate audit sample
- Probe audits are best to start routine audits
- Implement routine monitoring

Understand the subject matter
- Use knowledgeable coders/auditors

Used recognized resources
- AHA Coding Clinic
- CPT Assistant
- Official Coding Guidelines

When in doubt about documentation…Query

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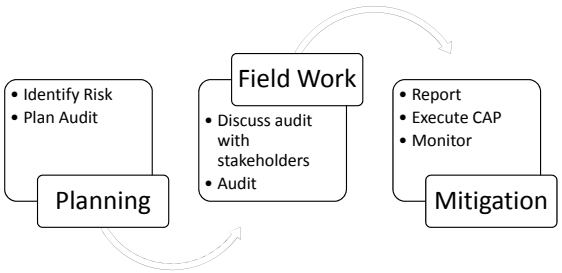
Compliance Audit Process



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Resources

www.cms.gov

www.aapc.com

www.ahima.org

www.cdc.gov

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Questions?

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Thank You

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