OBJECTIVES

// Focus Points of CMS

// Portions of OIG 2015 Work Plan

// Inpatient Compliance Hot Topics

// Outpatient Compliance Hot Topics
FOCUS POINTS OF CMS

// Comprehensive Error Rate Testing (CERT) 2014
- AICD Insertion for Ischemic Cardiomyopathy (NCD 100.3.20.4) – Documentation Requirements – CHF status, and PH of AMI – effective 2005
- Dementia/Depression – female admitted from nursing home, crying, depressed. No documentation she was a “danger to herself” or others
- Single vs. Dual Chamber Pacemaker (NCD 20.8) – No documentation of consideration of a single-chambered pacemaker. CHF not documented as a factor, no documentation of risk of atrial fibrillation without dual-chambered pacemaker – effective 2004
- Post TKA, transferred to rehab for 4-day stay that could have been provided in the acute care setting

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FOCUS POINTS OF CMS

// Psychiatric Admissions - WPS LCD L34679 – Effective 6/15/14, Admission Criteria (Severity of Illness) Missouri
Examples of inpatient admission criteria include (but are not limited to):
1. Threat to self requiring 24-hour professional observation
   a) suicidal ideation or gesture within 72 hours prior to admission
   b) self mutilation (actual or threatened) within 72 hours prior to admission
   c) chronic and continuing self destructive behavior (e.g., bulimic behaviors, substance abuse) that poses a significant and/or immediate threat to life, limb, or bodily function.
FOCUS POINTS OF CMS

// Psychiatric Admissions, Cont’d

- **Failure of outpatient psychiatric treatment** so that the beneficiary requires 24-hour professional observation and care. Reasons for the failure of outpatient treatment could include:
  a) Increasing severity of psychiatric symptoms;
  b) Noncompliance with medication regimen due to the severity of psychiatric symptoms;
  c) Inadequate clinical response to psychotropic medications;
  d) Due to the severity of psychiatric symptoms, the patient is unable to participate in an outpatient psychiatric treatment program.

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FOCUS POINTS OF CMS

// Total Knee Arthroscopy Documentation

- Pain, level of pain, worsening pain
- Pain increased with activity
- Pain interferes with ADLs
- Pain w/passive ROM
- Limited ROM
- Crepitus
- Joint swelling, effusion
- [http://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00002843](http://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00002843)
FOCUS POINTS OF CMS

// Total Knee Arthroscopy Documentation, Cont’d
An X-ray with at least two of the following:
✓ Subchondral cysts
✓ Subchondral sclerosis
✓ Periarticular osteophytes
✓ Joint subluxation
✓ Joint space narrowing
Failed trial of NSAIDS or inability to tolerate other medication. Trial of PT or external joint support (walker, cane, etc.), >= 12 weeks, did not tolerate PT.

FOCUS POINTS OF CMS

// Total Knee Arthroscopy Documentation
✓ Antalgic gait
Need to submit hospital H&P and order for inpatient admission. Also need physician office progress notes that includes:
☐ Documentation of worsening symptoms, not relieved by conservative measures
☐ Documented confirmation that the replacement surgery was discussed and agreed upon by both the provider and the patient.
FOCUS POINTS OF CMS

// Modifier -59

OIG issued report in November 2005 on “Use of Modifier 59 to Bypass Medicare’s National Correct Coding Initiative Edits”

- OIG recommended that carriers perform pre- and post-payment reviews of modifier -59 use, as well as update their claims processing systems to ensure they bill the modifier with the correct code in a pair.
- Since then, the OIG has continued to study modifier -59 and make recommendations to CMS on how to ensure providers use it correctly. CMS continued to offer guidance on its use, and indicated to OIG in December 2009 that it would explore development of a system edit for modifier -59.

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FOCUS POINTS OF CMS

// Modifier -59

Transmittal 142, dated August 14, 2014 documents the 2013 Comprehensive Error Rate Testing (CERT) data projected a $320 million error rate in physician claims and $450 million in facility claims appended with modifier 59. The Centers for Medicare and Medicaid Services (CMS) indicate that four new modifiers will be implemented in January 2015 in an attempt to better identify inappropriate claims.

MLN Matters® Number: SE1503, dated January 5, 2015 states: “Please note that providers may continue to use the -59 modifier after January 1, 2015, in any instance in which it was correctly used prior to January 1, 2015”.
FOCUS POINTS OF CMS

// Modifier -59

- **XE** – Separate encounter, A service that is distinct because it occurred during a separate encounter. This modifier should only be used to describe separate encounters on the same date of service.
- **XS** – Separate Structure, A service that is distinct because it was performed on a separate organ/structure.
- **XP** – Separate Practitioner, A service that is distinct because it was performed by a different practitioner.
- **XU** – Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service.

PORTIONS OF OIG 2015 WORK PLAN

// New Inpatient Admission Criteria

- CMS anticipates one-day stays will arise in the context of death, transfer, or departure against medical advice.
- If patient improves more rapidly than expected, CMS states such instances must be clearly documented and the initial expectation of a hospital spanning two or more midnights must have been reasonable in order for this circumstance to be an acceptable inpatient admission under Part A.
PORTIONS OF OIG 2015 WORK PLAN

// Inpatient Claims for Mechanical Ventilation
- Coding Clinic Guidelines Date Back to 1991
- Coders Must Refer to Respiratory Flow Sheets, Actual Start and Extubation Time
- Number of Hours Spent Weaning Patient Counts
- Rounding of Hours Requirement is not Specified. When in Doubt, do not Round Up (Example: 25 minutes, do not count as one hour)
- Data Mine and Identify Cases with LOS < 2 days in which ICD-9-CM Procedure Code 96.71 was Billed

PORTIONS OF OIG 2015 WORK PLAN

// New vs. Established Patient
- Not a requirement for Emergency Room, not required for hospital-based billing since January 1, 2014
- OIG report included dates of service from 2012
- Historical data will need to be audited internally
- Average overpayment is $24 for each encounter
INPATIENT COMPLIANCE HOT TOPICS

// New Inpatient Admission Criteria

- Certification no longer required as of 1/1/15
- Beneficiaries whose care is expected to last fewer than 2 nights should be treated as outpatient
- One-day stays are subject to review
- Zero to one midnight stays would be rare and unusual exceptions
- ICU label is applied to a wide variety of services and patient assignment cannot be specific to hospital location

INPATIENT COMPLIANCE HOT TOPICS

// New Inpatient Admission Criteria, Cont’d

- Mitigate risks that usually start in the Emergency Department
- Utilize Utilization Review (UR) in the Emergency Department
- UR reviews all daily inpatient surgery schedules to catch any outpatient surgeries scheduled inappropriately as inpatient
- Train surgery schedulers to review surgery CPT code, research and notify UR if problems (IP only procedure list)
- Assess the current UR processes, UR Plan and UR physician members and determine if needed assistance and intervention is required
INPATIENT COMPLIANCE HOT TOPICS

// Hospital Acquired Conditions (HACs)


- HACs are conditions that CMS considers reasonably preventable as opposed to conditions that are present on admission (POA).

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INPATIENT COMPLIANCE HOT TOPICS

// Hospital Acquired Conditions (HACs), Cont’d

- CMS finalized two domains in the 2015 inpatient prospective payment system (IPPS) regulation, and based 35% of the HAC score on the first domain Patient Safety Indicator-90 (PSI-90) which includes serious complications and 65% on the second domain which includes catheter-associated urinary tract infections, surgical site infections and central line bloodstream infections.

- Hospitals receive zero to 10 points for each measure, 10 being worst. Those hospitals with a score of 7.25 or above are included in the top 25%. These facilities may be subject for payment reduction by 1% for all hospital discharges occurring on or after October 1, 2014.
INPATIENT COMPLIANCE HOT TOPICS

// Hospital Acquired Conditions (HACs), Cont’d

- POA Reporting Effective October 1, 2007 – Assess the timing of when the condition presented – Billing Requirement
- October 1, 2008 – Payment impact on conditions not present on admission
- POA defined as present at time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including ER, observation, our outpatient surgery are considered POA

INPATIENT COMPLIANCE HOT TOPICS

// HAC Documentation Tips from NGS Medicare

- POA Diagnoses: Physicians should document all conditions that develop during an outpatient encounter (ER, observation, outpatient surgery) prior to IP admission
- HAC diagnoses acquired during IP stay should be well documented
- Hospital coders should work with physicians with any unclear, conflicting or missing documentation (physician queries) prior to claim submission
- OIG Work Plan 2013 included audit of POA reporting
OUTPATIENT COMPLIANCE HOT TOPICS

// Observation Services – Reporting Hours

- Begins at the clock time documented in the patient’s medical record, which coincides with the time that observation care is initiated in accordance with a physician’s order.
- Ends when all medically necessary interventions and or related services of care have been completed.
- Round to nearest hour. Example: if patient started receiving observation care at 3:03 PM (nursing assessment) and discharged at 9:45 PM, then “7” units (G0378) would be reported to Medicare.

OUTPATIENT COMPLIANCE HOT TOPICS

// Observation Services – Reporting Hours, Cont’d

- Observation Hours 0-30 minutes = 0 Units
- Observation Hours 31-59 minutes = 1 Unit

**Note:** To be reported, observation hours must meet or exceed 8 hours.

*Medicare Claims Processing Manual, Chapter 4, Section 290*

- Monitor and audit physicians that utilize observation for outpatient scheduled procedures or admit to observation post-operatively without documented complications – OIG Work Plan for 2013
OUTPATIENT COMPLIANCE HOT TOPICS

// Observation Services – Charge Capture

Diagnostic and Therapeutic Procedures During Observation

• Infusions and injections should be reported with a line item date of service on the day they are provided. In addition, only one initial drug administration service is to be reported per access site per encounter, including an encounter when observation services span > one calendar day

• “Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy).”

Medicare Claims Processing Manual, Chapter 4, Section 290.2.2

OUTPATIENT COMPLIANCE HOT TOPICS

// Observation Services – Charge Capture, Cont’d

“In situations where such a procedure interrupts active monitoring and results in two or more distinct periods of observation services, hospitals should record for each period of observation services the beginning and ending times during the hospital outpatient encounter. Hospitals should add the length of time for the periods of observation services together to determine the total number of units reported on the claim for the hourly observation services.”
OUTPATIENT COMPLIANCE HOT TOPICS

// Observation Services – Drug Administration Services

CMS FAQ 2725 – May a hospital report drug administration services, such as therapeutic infusions, hydration services, or intravenous injections, furnished during the time period when observation services are being reported?

OUTPATIENT COMPLIANCE HOT TOPICS

// Observation Services – Drug Administration Services, Cont’d

If the hospital determines that active monitoring is part of a drug administration service furnished to a particular patient and separately reported, then observation services should not be reported with HCPCS G0378 for that portion of the drug administration time when active monitoring is provided.

- *Example:* complex drug infusion titration may require active monitoring and IV hydration may not
Facility billing guidelines should be designed to correlate the intensity of hospital services to the different levels of effort represented by the codes. Coding guidelines should be based on facility resources (nursing interventions), should be clear to facilitate accurate payments, should only require documentation that is clinically necessary for patient care, and should not facilitate up coding or gaming. **2009 CMS Final Rule**

Facility reporting should not mirror the professional (physician) reporting.

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**American College of Emergency Physicians (ACEP) ED Facility Coding Guidelines**

http://www.acep.org/content.aspx?id=30428

- Contains possible interventions per level and supporting conditions (symptoms/examples) that support the interventions.
- Contains the possible interventions and supporting conditions for billing critical care codes 99291 (30-74 minutes) and 99292 (75-104 minutes).
OUTPATIENT COMPLIANCE HOT TOPICS

// Emergency Room Evaluation and Management – Facility Reporting, Cont’d

➢ ACEP guidelines are based on a number of staff interventions. Both the AHA/AHIMA Guidelines and ACEP guidelines fall into this category. This intervention model uses basic care interventions to report the lowest level of service, with higher levels assigned as complexity of hospital resources interventions increase.

OUTPATIENT COMPLIANCE HOT TOPICS

// Emergency Room Evaluation and Management – Facility Reporting – Critical Care

▪ Time-based
▪ Requires high-complexity decision making to support vital organ system failure (central nervous, circulatory, or respiratory failure, shock, renal, hepatic, and/or metabolic failure)
▪ Documentation of hospital staff performing critical care services, start and stop times
▪ Educate ED coding professionals
OUTPATIENT COMPLIANCE HOT TOPICS

// Emergency Room Evaluation and Management – Facility Reporting – Critical Care, Cont’d

- Services not separately billable – interpretation of cardiac output measurements, chest x-rays, pulse oximetry, blood gases, gastric intubation, vent management, vascular access
- Any other additional procedures provided during critical care time are separately reportable
- The time required to perform CPR (CPT 92950) is NOT included in critical care time but both may be billed separately if there is documentation of at least 30 minutes of critical care

*CPT Assistant, September 2012*

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FINAL THOUGHTS

// Copy and Paste in the EHR - Risks

- Inaccurate or outdated information that may adversely impact patient care
- Inability to identify authors or what they thought
- Inability to identify when the documentation was created
- Inability to accurately support or defend E/M codes for professional billing notes
- Internally inconsistent progress notes
- Unnecessarily lengthy progress notes
- Redundant information

[http://library.ahima.org/xpedio/groups/secure/documents/ahima/bok1_049706.pdf](http://library.ahima.org/xpedio/groups/secure/documents/ahima/bok1_049706.pdf)
REFERENCES

// http://www.medicare.gov/hospitalcompare/HAC-reduction-program.html
// Medicare Claims Processing Manual, Chapter 4, Section 290.2.2
// http://www.acep.org/content.aspx?id=30428
// CPT Assistant, September 2012

DISCLOSURE

// Information contained in this presentation is informational only & is not intended to instruct hospitals & physicians on how to use, or bill for health care procedures. Hospitals & physicians should consult with their respective insurers, including Medicare fiscal intermediaries & carriers, for specific information on proper coding & billing for health care procedures. Additional information may be available from physician specialty societies & hospital associations. Information contained in this presentation is not intended to cover all situations or all payers' rules & policies. Reimbursement laws, regulations, rules & policies are subject to change.
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