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BKD National Health Care Group

BKD CODING/BILLING BOOTCAMP - HOSPITAL FOCUS TRAINING

National Rural Health Resource Center

Delta Region Community Health Systems Development Program

Thursday, March 20, 2019 – 9:00 to 11:00 CT

Paula Archer, RHIA

TALKING POINTS FOR TODAY

- Emergency Department (ED) Charge Capture
- Outpatient Observation Charge Capture
- CPT Coding – Infusions and Injections
- ICD-10-CM Coding
- Provider-Based Clinic – G0463
- Compliance
- Modifiers
- Registration
- Final Thoughts

ED CHARGE CAPTURE

- Facility vs. Professional – What's the difference?

- ❑ CPT code book originally intended to be used by physicians
- ❑ For facility coding, CMS instructed words "physician," "provider", and "supervised by the physician" should be omitted when interpreting code descriptions in CPT
- ❑ According to CPT – "A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service"

ED CHARGE CAPTURE, PAGE 2

- Nursing Interventions and Acuity Levels
  - ✓ No correlation between facility ED levels and physician levels of service
  - ✓ Facility ED coding reflects resources used by the facility to provide patient care
  - ✓ Professional ED coding are determined by complexity and intensity of the provider who performed the work
  - ✓ No national guidelines to report ED evaluation and management (E/M) services
  - ✓ CMS expects that hospitals internal guidelines (acuity sheets) would include the following 11 principles:

ED CHARGE CAPTURE, AGAIN

1) Coding guidelines follow the intent of the CPT code description
2) Based on hospital facility resources
3) Clear to facilitate accurate payments
4) Meet HIPAA requirements
5) Require documentation that is necessary for patient care
6) Should not facilitate up coding
7) Written and recorded, well documented

ED CHARGE CAPTURE, CONTINUED

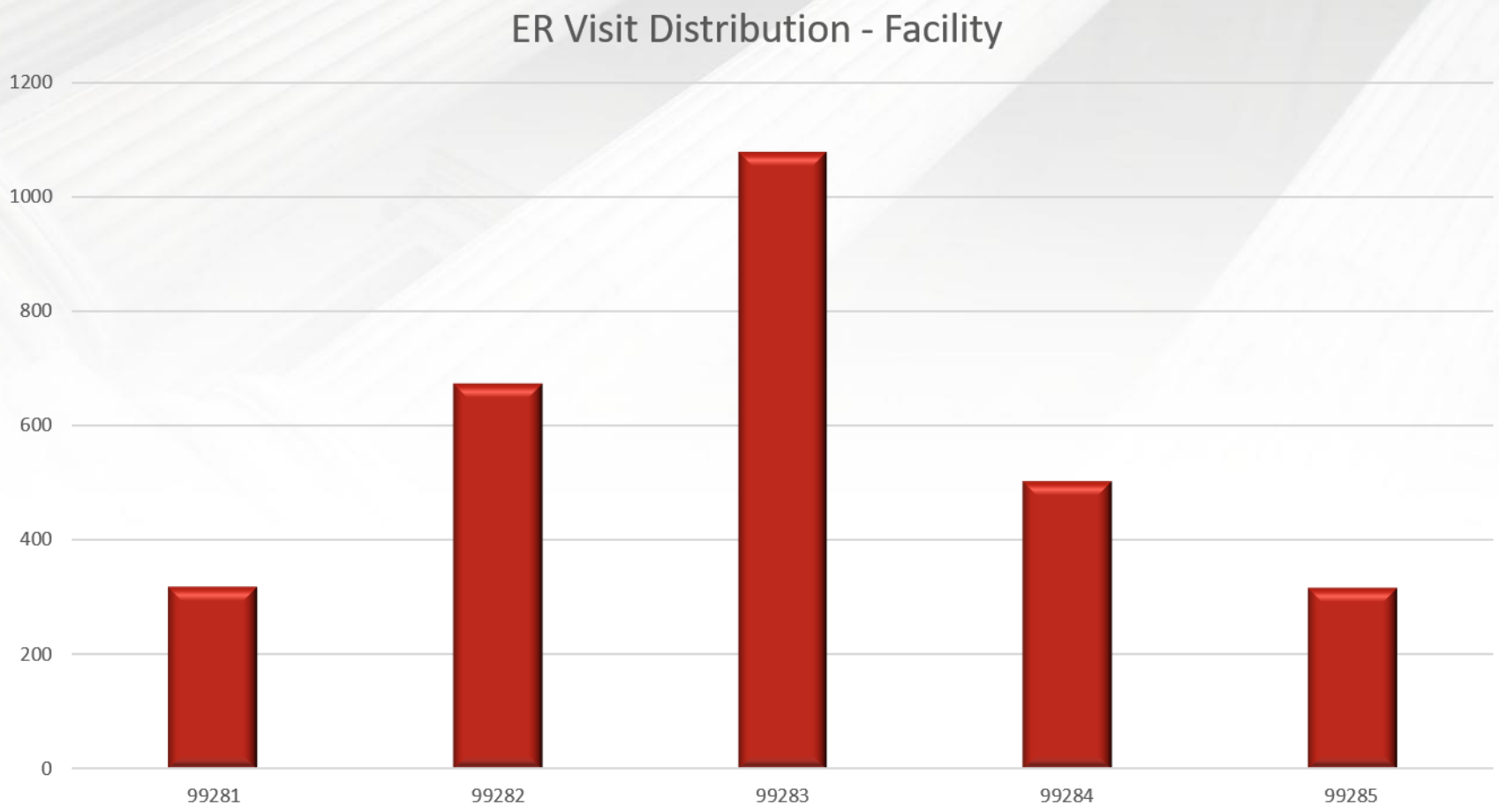
8) Applied consistently across patients
9) Should not change with great frequency
10) Readily available for CMS or MAC reviews
11) Result in coding decisions that could be verified by other hospital staff

REFERENCE: 2008 OPPS Final Rule

ED CHARGE CAPTURE, FURTHER

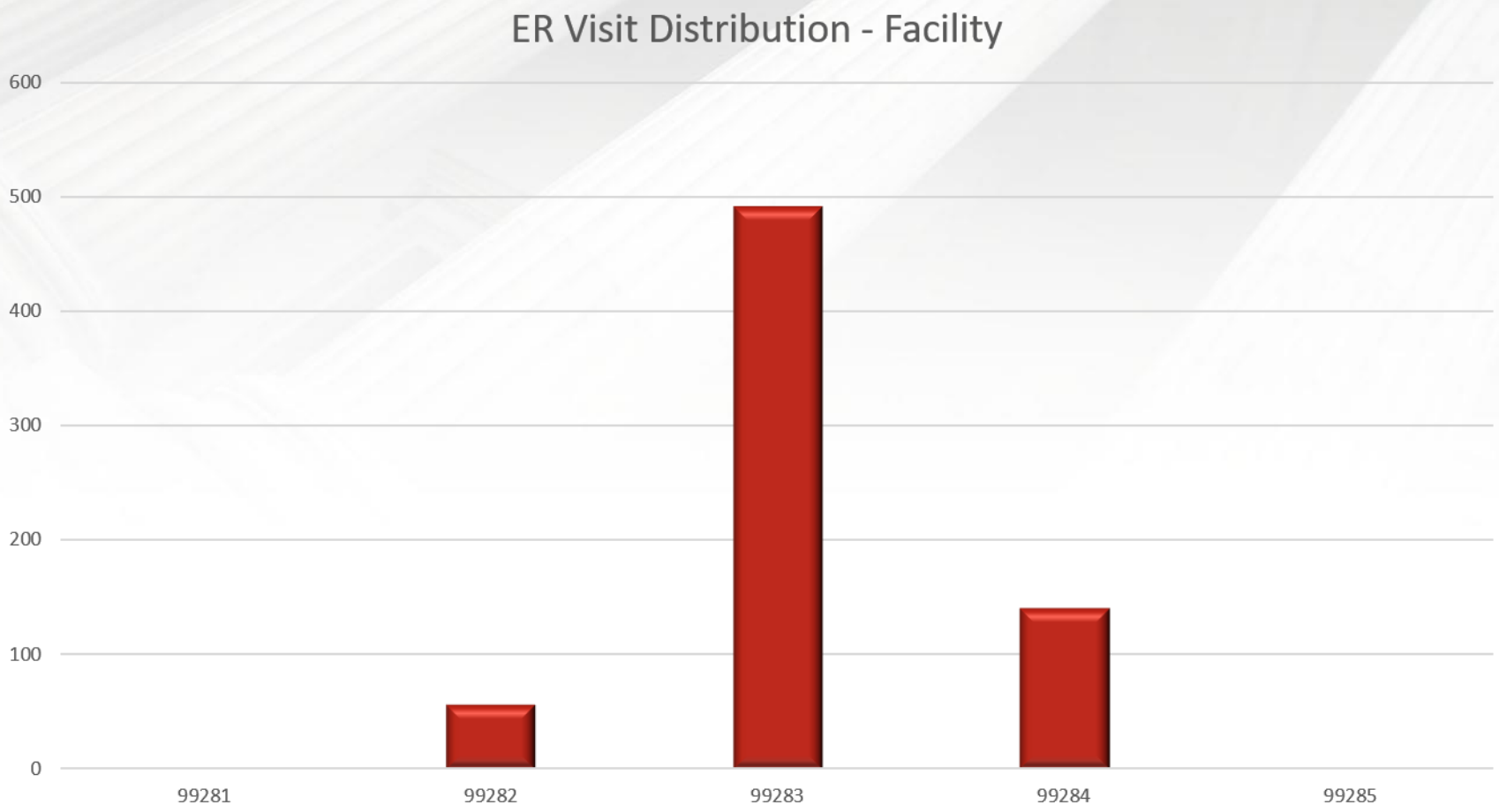
"We will hold each facility accountable for following its own system for assigning the different levels of HCPCS codes. As long as the services furnished are documented and medically necessary and the facility is following its own system, which reasonably relates the intensity of hospital resources to 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 code reported on the bill. Therefore, we would not expect to see a high degree of correlation between the code reported by the physician and that reported by the facility."
-65 FR 18451, April 7, 2000

ED CHARGE CAPTURE, ONCE MORE

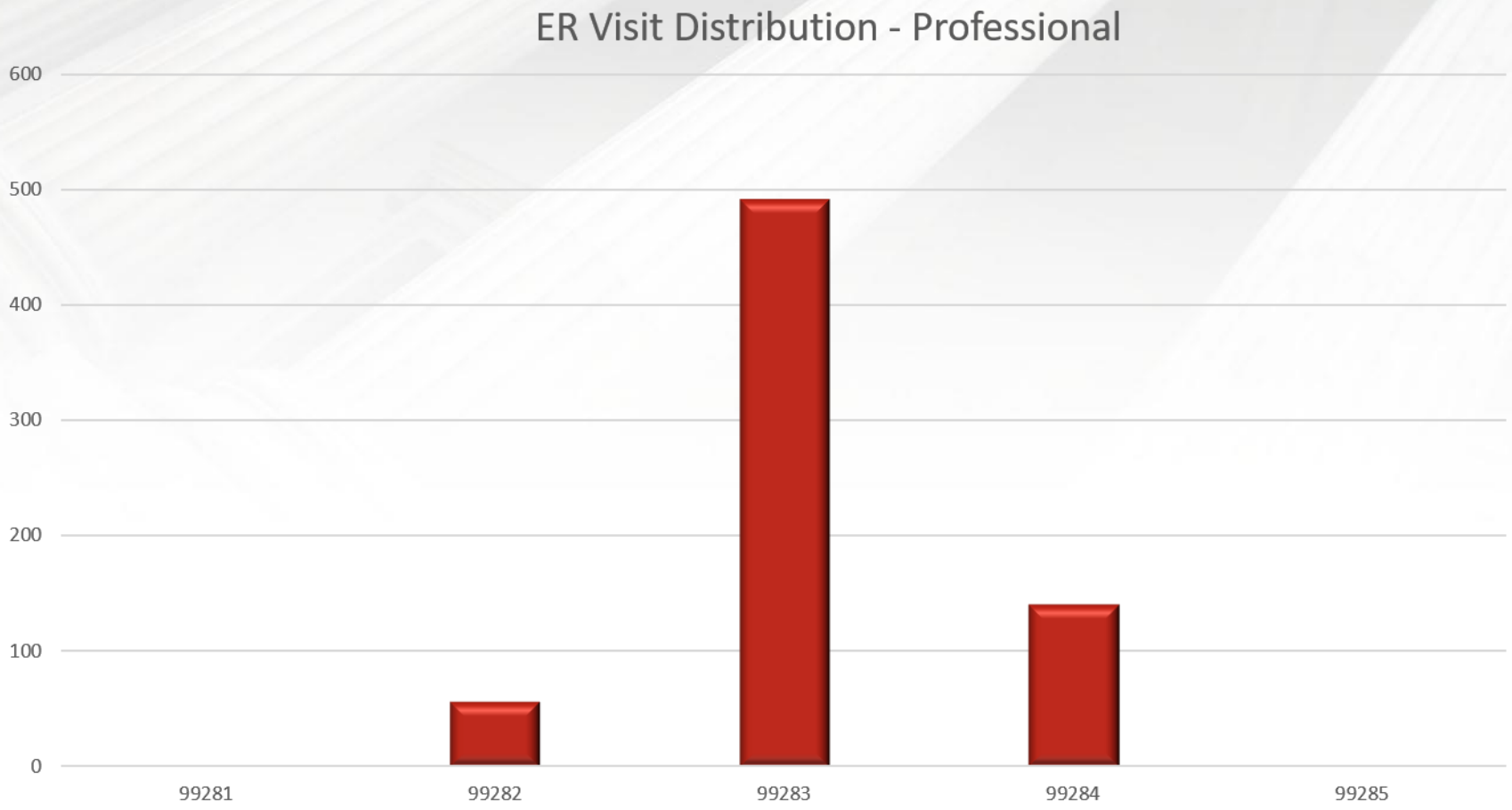


ED CHARGE CAPTURE, ADDITIONALLY

ED CHARGE CAPTURE, EXTENDED



ED CHARGE CAPTURE, FINAL



POLLING QUESTION 1

Hospital reporting of Emergency Department (ED) Evaluation and

Management (E/M) services are reported based on?

a. A physician's work

b. Nursing interventions

c. 1995 or 1997 CMS E/M guidelines

d. Not sure

OUTPATIENT OBSERVATION CHARGE CAPTURE

REFERENCE: *Medicare Claims Processing Manual, Chapter 4, Section 290 – Outpatient Observation Services*

- Commonly ordered for patients who present to the ED and will require a period of treatment or monitoring in order to make a decision regarding admission or discharge
- Decision is typically made within 48 hours
- Report hours (units) under RC 762
- Physician's order
- Observation time begins at the time that coincides with the time that observation care is initiated
- Round to the nearest hour

OUTPATIENT OBSERVATION CHARGE CAPTURE, CONTINUED

- Standing orders following outpatient surgery are not recognized
- Cannot be billed concurrently with diagnostic or therapeutic services (require active monitoring)
- May deduct average length of time of the interrupting procedure from the total duration a patient receives observation services
- Observation time ends (physician order) but may include all necessary services up until the patient is discharged.
- May not include time waiting in hospital for transportation home

OUTPATIENT OBSERVATION CHARGE CAPTURE, FINAL

- APC C-8011 (comprehensive observation services)
  - No major procedure (SI=T) on the same day or 1 day prior and no status J codes on the claim
  - 8 or more units of G0378 (observation services, per hour)
  - A clinic visit HCPCS code G0463 OR a Level 4 or 5 Type A ED visit (CPT code 99284 or 99285)OR a Level 5 Type B ED visit (HCPCS code G0384) OR a direct referral for observation (G0379) OR critical care (CPT code 99291) provided by a hospital in conjunction with observation services
  - All additional services will be bundled into APC 8011 and paid one rate

Does not apply to critical access hospitals

COMMON OBSERVATION CHALLENGES

- All patients should be placed in observation until reviewed
- When does Observation start
- Charging for injections and infusions
- Billing for a patient with >48 hours of Observation
- Separately monitored procedures (actual times vs. policy
- considerations)
- Observation is not a place, it’s a level of care

CPT CODING – INFUSIONS AND INJECTIONS

- An INFUSION is defined as any substance infused through any type of line for greater than 15 minutes and up to one hour
- An IVP PUSH is an infusion of 15 minutes or less OR an injection in which the clinician that administers the substance/drug is continuously present
- An INJECTION is any intramuscular, subcutaneous or intra-arterial injection
- There is one initial code in each category based on primary reason for encounter
- Only one initial code reported by encounter, no matter how many drugs are administered

POLLING QUESTION 2

When a patient is in observation status and is formally admitted as an inpatient, how should the Hospital bill?

a. One UB-04 with TOB 111 (inpatient)

b. One UB-04 with TOB 131 (outpatient) and one UB-04 TOB 111

c. Not sure

CPT CODING – INFUSIONS AND INJECTIONS, CON'T.

Was a continuous infusion provided?

If a continuous service was provided, report all units as performed on the date the service started. For continuous services that last beyond midnight, use the date on which the service began and report the total units of time provided continuously. For example, if intravenous hydration as described by codes 96360 and 96361 is given from 11:00 pm to 2:00 am, code 96360 would be reported once for the first hour and code 96361 would be reported twice (once for each additional hour of hydration intravenous infusion).

Was the infusion discontinued?

Any disruption in service creates a new initial service. For example, a patient receives one hour-long drug infusions at 10:00 pm and 2:00 am on sequential dates. No new IV is started and the same drug is infused each time. In this example, because the infusion is not a continuous service, code 96365 would be reported once for each date of service.

CPT CODING – INFUSIONS AND INJECTIONS, AGAIN

REFERENCE: *CMS Publication 100-4 Medicare Claims Processing Manual Chapter 4 Section 230.2 B for facilities states*:

"Drug administration services are to 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 vascular access site per encounter, including during an encounter where observation services span more one calendar day".

CPT CODING – INFUSIONS AND INJECTIONS, ONCE MORE

DOCUMENTATION REQUIREMENTS

- Clear indication of patient name, date of birth, and date of service
- Name of drug injected
- Dosage of injection given
- Route of administration
- Signed and dated physician order to include the drug name, dosage, route of administration and duration of treatment
- Progress notes to support the medical necessity of treatment
- Reminder: Certain injection procedures (i.e., epidural steroid injections) also require documentation of previous conservative therapies that were tried and failed.

REFERENCE: *WPS - Missouri*

CPT CODING – INFUSIONS AND INJECTIONS, FURTHERMORE

Start and Stop Times

- CMS doesn't provide specific guidance about what should or should not be reported. Providers should check to see if their Medicare Administrative Contractor (MAC) has a policy about this and if so, follow it. If your MAC has no policy on this, then adhering to CPT guidelines is the most appropriate course of action.
- However, MACs have their own guidelines for reporting infusions without documented stop times. Some MACs simply reiterate the *CPT Manual* and indicate that an IV push can be reported. Others say an infusion can be reported only if it can be determined from the documentation that the service was more than 15 minutes in length.
- The American Medical Association (AMA) recommends that providers document start and stop times but does not say this documentation is required.
- There is no statement about stop times being required; however, it is implied that this is the best practice to ensure appropriate billing.
- Per the *Medicare Claims Processing Manual*, Chapter 4, codes should be reported in accordance with CPT guidelines. CPT instructions are to use the actual time over which the infusion is administered to the beneficiary for time-specific drug administration codes.

CPT CODING – INFUSIONS AND INJECTIONS,

What is Hydration? Hydration is defined as the replacement of necessary fluids via an IV infusion which consists of pre-packaged fluid and electrolytes. Some of the solutions utilized in administration of hydration services are:

- Saline solutions,
- D5W(dextrose 5% water),
- Hypotonic solution,
- Ringer Lactate, and
- Distilled water

REFERENCE: *Coding Clinic for HCPCS, 1st Qtr., 2012, page 1*

CPT CODING – INFUSIONS AND INJECTIONS, ONGOING

Hydration

- CPT code 96360 (31 minutes to 1 hour)
- CPT code 96361 (each additional hour)
- Hydration for < 30 minutes not reportable

The hydration codes were created to report specific therapeutic interventions undertaken when a patient presents with *dehydration and volume loss* requiring the administration of necessary intravenous fluid. The medical necessity for hydration services should be clearly documented in the health record. These codes should not be used to report infusion of drugs or other substances other than intravenous infusions of prepackaged fluid with or without electrolytes.

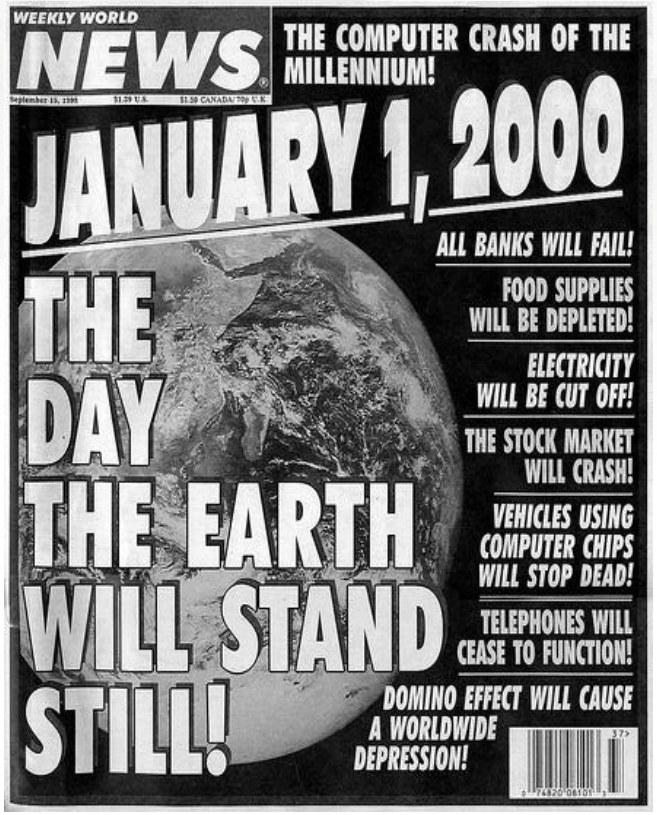
CPT CODING – INFUSIONS AND INJECTIONS, FINAL

The following infusion circumstances do **not** represent hydration and should not be reported using any CPT code:

- When the purpose of the infusion was to accommodate a therapeutic IV piggyback through the same IV access as a free-flowing IV to safely infuse the agent;
- When the fluid was used as the dilutent to mix the drug (i.e., the fluid is the vehicle in which the drug is administered);
- *When the fluid is used to "keep open" the IV line prior or subsequent to another infusion; and*
- When IV fluids are allowed to continue to run during the administration of the chemotherapy or therapeutic agent

ICD-10-CM CODING

Remember October 1, 2015?



ICD-10-CM CODING, CONTINUED

Assumed Causal Relationships in ICD-10

The term “with” now defined as a causal relationship. Previously providers had to “link” conditions such as hypertension and congestive heart failure

ICD-10-CM CODING, ONGOING

Reporting Additional Diagnoses

Definition of "other diagnoses" are additional conditions that affect patient care in terms of requiring:

- Clinical evaluation; or
- Therapeutic treatment; or
- Diagnostic procedures; or
- Extended length of hospital stay; or
- Increased nursing care and/or monitoring

ICD-10-CM CODING, ONCE MORE

Reporting Additional Diagnoses

- If a previous condition is documented in the discharge summary that has no bearing on the current stay, should not be coded unless hospital policy
- Abnormal findings such as lab, x-ray, pathology and other diagnostic tests are not coded unless provider documents clinical significance
- Uncertain diagnoses documented as “probable”, “suspected”, “likely”, “questionable”, “possible”, or “still need to be ruled out” are coded as if existed or established *NOTE – this guidance does not pertain to coding in the outpatient setting*

ICD-10-CM CODING, FURTHERMORE

Respiratory Failure Sequencing

If both respiratory failure and another acute condition are both present on admission and both equally responsible for the admission, the guidelines regarding two or more diagnoses that equally meet the definition for principal diagnosis may be applied

ICD-10-CM CODING, EXTENDED

Systemic Inflammatory Response Syndrome (SIRS)

According to American College of Chest Physicians and the Society of Critical Care Medicine, clinical manifestations include:

- Fever > 100.4 or hypothermia with temperature < 98.6
- Leukocytosis, WBC count > 12,000
- Leukopenia, WBC count < 4,000
- Tachycardia
- Hyperventilation

ICD-10-CM CODING, ANEW

Systemic Inflammatory Response Syndrome (SIRS)

SIRS, when documented with a non-infectious disease condition, the code for the underlying condition, such as injury, should be assigned, followed by code R65.10 (SIRS w/o acute organ dysfunction) or R65.11 (w/ organ dysfunction)

ICD-10-CM CODING, RECURRENT

Body Mass Index (BMI), Depth of Non-Pressure Ulcers, Pressure Ulcer Stages, Coma Scale –

Code assignment may be based on medical record documentation from clinicians who are not the patient's provider. Associated diagnoses (overweight, obesity, pressure ulcer) must be confirmed by the provider.

ICD-10-CM CODING, REPEATED

Malnutrition – Focus of OIG

ICD-10-CM codes 261 and 262

- Must have documentation consisting of meeting the definition of "additional diagnoses"

https://www.nutritioncare.org/Guidelines_and_Clinical_Resources/Toolkits/Malnutrition_Toolkit/Definitions/

ICD-10-CM CODING, ADDITIONALLY

American Society for Parenteral and Enteral Nutrition (ASPEN) Guidelines

- Nutritionally at-risk adults
- Involuntary loss of 10% or more of unusual body weight within 6 months
- Involuntary loss or gain of 10 pounds within 6 months
- BMI < 18.5 or > 25
- Increased metabolic requirements
- Altered diets or diet schedules
- Inadequate nutrition intake, food nutrition > 7 days

ICD-10-CM CODING, FINAL

Are You Ready for ICD-11?

AHIMA CODEWRITE March 2019 Publication

"As you can imagine, there have been many advancements in medicine and the science of disease over the past 30 years, and ICD-10 is now outdated from both a clinical and classification perspective. A decision was made in 2007 to begin work on ICD-11 to better operate in today's electronic environment and capture more information, especially for morbidity cases".

POLLING QUESTION 3

In order to code a secondary diagnosis, the condition should require what?

a. Therapeutic treatment

b. Diagnostic studies

c. Increased nursing care or monitoring

d. All of the above

PROVIDER BASED CLINIC – G0463

PROVIDER BASED CLINIC – G0463, PAGE 2

- Effective in CY 2014 HCPCS code G0463, Hospital outpatient clinic visit for assessment and management of a patient, will be reported by the hospitals only to represent any clinic visit provided under the OPPS. Additionally, no longer will CMS recognize the distinction of new or established patient clinic visits. Under the OPPS all clinic visits will be reported utilizing the new HCPCS G code, regardless of whether or not the patient has been registered as an inpatient or outpatient of the hospital within the last 3 years prior to a visit.

PROVIDER BASED CLINIC – G0463, AGAIN

- "CAHs may bill the new G-code for clinic visits (facility service) but they are not required to. CMS has no edits that would prevent CAHs from being paid if they billed CPT® codes 99201 – 99205 and 99211 – 99215 for the facility service of the clinic visit. Their payment would also not be affected as they are paid at reasonable cost. For physician services rendered in a Method II CAH during a clinic visit, the MPFS coding (which are the CPT codes) should be used."

PROVIDER BASED CLINIC – G0463, ONCE MORE

The Medicare Benefit Policy Manual, Chapter 6 defines a hospital technical visit as:

"A hospital outpatient "encounter" is a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient".

PROVIDER BASED CLINIC – G0463, CONTINUED

A clinic visit code should not be automatically charged whenever the patient sees a nurse or other member of the hospital staff. According to CMS Transmittal A-01-80, hospitals can charge a separate clinic visit code (with modifier 25) only if a significant, separately identifiable technical visit is performed during the same encounter as another service or treatment.

PROVIDER BASED CLINIC – G0463, FURTHER

- If there is a significant, separately identifiable visit performed on the same date as a procedure, modifier 25 may be appended to report this circumstance in all practice settings. Complete documentation of all services performed and appropriate use of modifier 25 can ensure that patient encounters and procedures performed on the same day are correctly reimbursed

COMPLIANCE

COMPLIANCE
REGULATIONS
REGULATION
SUPERANNUATION
AUSTRALIA
STANDARDS
INFORMATION
FINANCIAL
NUMBER
DATA
UK
RISK
SIGNIFICANT
COMMISSION
STANDARD
DUE
APRA
INTERNATIONAL
COMPLY
LAWS
LAW
SMALL
REGIME
CONTINUE
GOVERNMENT
FUNDS
DEFINITIONS
SENTENCING
USA
LICENSING
ACT
GOVERNANCE
ENSURE
DEMANDS
PUBLIC
ENVIRONMENT
PROTECTION
MANAGEMENT
AUTHORITY
USE
INCREASING
RELATED
RELEVANT
MEANS
SERVICES
RESOURCES
DEFINED
CORPORATE
NEW
VALIDATING
NEED
REGULATORS
INDUSTRY
AGENCY
PRODUCTS
TRUSTEES
SAFRANES-OXLEY
USED
AUSTRALIAN
SEE

COMPLIANCE, CONTINUED

The Office of Inspector General (OIG) has developed a series of voluntary compliance program guidance documents directed at various segments of the health care industry, such as hospitals, nursing homes, third-party billers, and durable medical equipment suppliers, to encourage the development and use of internal controls to monitor adherence to applicable statutes, regulations, and program requirements.

https://www.oig.hhs.gov/compliance/compliance-guidance/index.asp

https://www.oig.hhs.gov/authorities/docs/cpghosp.pdf

COMPLIANCE, AGAIN

Program Guidance for Hospitals published February 23, 1998

"While it may require significant additional resources or reallocation of existing resources to implement an effective compliance program, the OIG believes that the long term benefits of implementing the program outweigh the costs".

COMPLIANCE, ONCE MORE

Comprehensive Compliance Program should include the following seven elements:

1) Standards of conduct, commitment to compliance
2) Compliance officer
3) Regular education and training programs for employees
4) Maintenance of a process (hotline) to receive complaints
5) System to respond to allegations
6) Use of audits, or other techniques to monitor compliance
7) Investigation and remediation of identified problems

COMPLIANCE, FURTHERMORE

Some Areas of Concern:

- ❑ Billing of services not provided
- ❑ Providing medically unnecessary services
- ❑ Up coding
- ❑ Duplicate billing
- ❑ Unbundling
- ❑ Billing for discharge in lieu of transfer

POLLING QUESTION 4

When may a Hospital issue an Advanced Beneficiary Notice (ABN) due to medical necessity?

a. Procedure is experimental and investigational

b. Not indicated for diagnosis or treatment for the case

c. More than the number of services Medicare will allow

d. All of the above

COMPLIANCE, MORE

COMPLIANCE, EXTENDED

Program for Evaluating Payment Patterns Electronic Report (PEPPER)

https://pepper.cbrpepper.org/

What Is PEPPER?

PEPPER provides hospital-specific statistics for Medicare severity diagnosis-related groups (MS-DRGs) and discharges that may be at high risk for payment errors. PEPPER can support a hospital's compliance efforts by pinpointing where the institution is an outlier for the identified risk areas, assisting in spotlighting both potential overpayments and underpayments.

COMPLIANCE, ADDITIONALLY

PEPPER also includes target areas outside of MS-DRG reporting:

- ❑ 30-Day Readmission
- ❑ 3-Day Skilled Nursing Facility-Qualifying Admission
- ❑ One-day medical stays
- ❑ One-day surgical stays
- ❑ Emergency department evaluation and management visits

COMPLIANCE, MOREOVER

Outpatient Excisional Debridement is the sharp removal of tissue at the wound margin or at the wound base until *viable tissue is removed*. Coders report excisional debridement codes (CPT codes 11042-11047) based on the deepest layer of viable tissue removed.

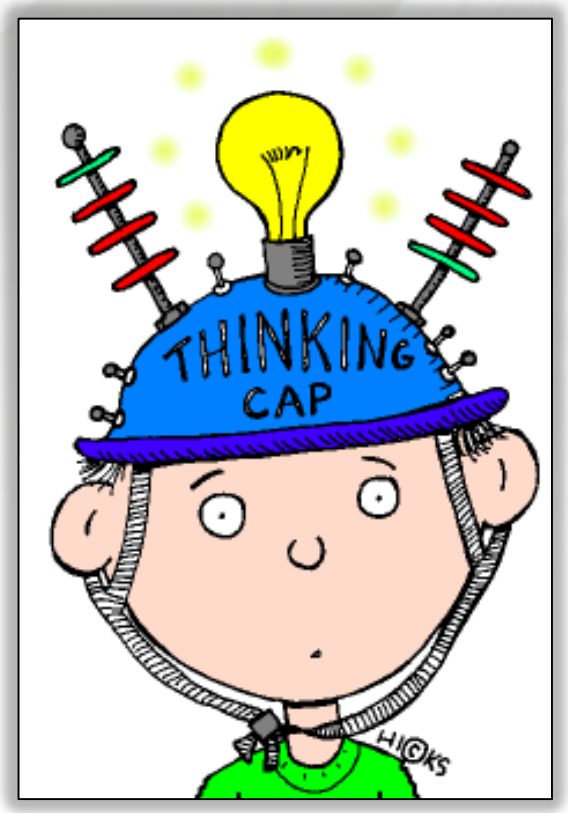
COMPLIANCE, FINAL

Outpatient Excisional Debridement

- Wound length, width, depth
- Type of debridement (excisional, non-excisional)
- Cutting away of devitalized tissue (necrotic)
- Instrument used (scalpel, scissors)
- Depth to which wound was debrided (skin and subcutaneous, muscle, tendon, bone, other)

FINAL THOUGHTS

- Keep current on CMS instructions for detailed billing & potential payment issues through list serves & newsletters
- Provide ongoing training for internal staff training on billing & coding guideline changes
- Monitor provider documentation & compliance with service criteria
- Perform internal testing of UB-04 detailed billing, coding & provider documentation during routine compliance audits



REGISTRATION

Don’t Miss Opportunities to Get it Right and Collect!

Obtain complete and accurate patient information

- Demographic
- Insurance
- Medical

Notify patient of co-pay due and collect

Investigate other potential coverage sources

REGISTRATION, CONTINUED

Metrics&Best Practice Targets

Physician authorization compliance 95% compliance

Inpatient admissions error ratio < 3% error

Outpatient registration error ratio < 3% error

Point-of-Service Collections Collect 50% of estimated patient portion at the POS

% of pre-registered inpatient accounts 40%

% of pre-registered outpatient accounts 20%

MODIFIER USAGE GUIDELINES

- Not all procedure codes require modifiers
- Use of modifiers eliminates appearance of unbundling and duplicate billing
- Not appropriate if narrative description of procedure applies to different body parts or indicates multiple occurrences
- Indicate special circumstances

MODIFIER 25

- Significant, separately identifiable E/M service
- Only reported with E/M service when the same physician on the same day performed a diagnostic medical or surgical and/or therapeutic medical or surgical procedure is performed

MODIFIER 52

- Identified interrupted or reduced radiology exams or other diagnostic services
  - Code to the extent of the procedure performed
  - If no code exists, report the intended code
  - Cannot be submitted with E/M services

Example: Patient is scheduled for a GI series (CPT 74240). The radiology exam could not be completed because the patient could not tolerate the barium.

- 74240 – 52

MODIFIER 73

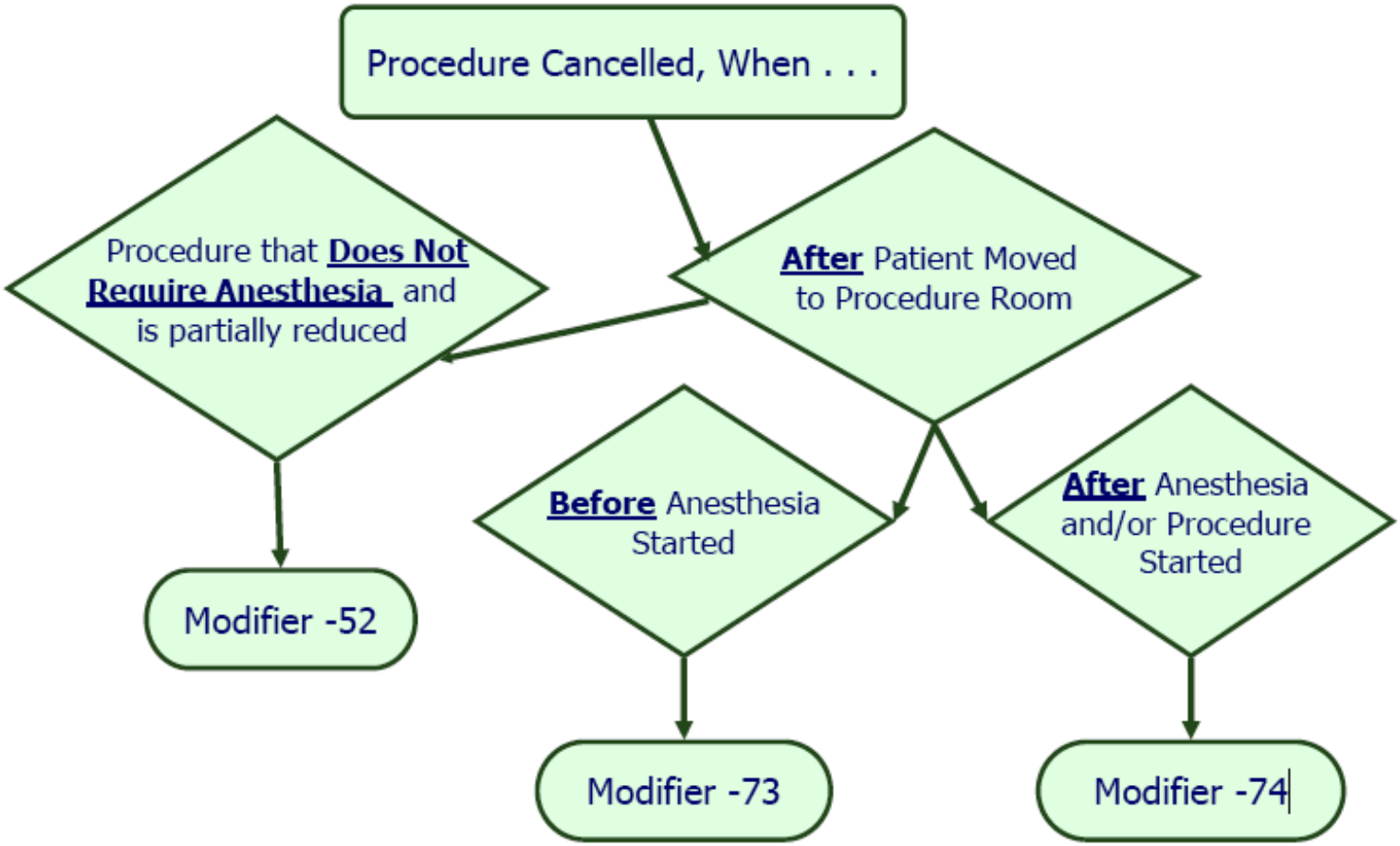
- Procedure is discontinued or canceled after patient has been prepared for surgery and/or prior to the induction of anesthesia
- Apply to procedures requiring anesthesia
- Apply when the well-being of the patient is threatened
- Procedure must be discontinued in the room where the procedure was to be performed in order to assign the modifier

MODIFIER 74

- Procedure is discontinued or canceled after administration of anesthesia or after the procedure has begun
- Apply when the well-being of the patient is threatened
- Procedure must be discontinued in the room where the procedure was to be performed in order to assign modifier

AHIMA 2008 Audio Seminar Series

PROCEDURE MAP



MODIFIER 59

- OIG and CMS contractor scrutiny
- Prevents improper payment when incorrect code combinations are reported
- NCCI edits are published by CMS and can be found online at

http://www.cms.hhs.gov/NationalCorrectCodInitEd/

MODIFIERS LT, RT AND 50

- LT and RT - Identifies procedures that can be performed on paired organs
- LT and RT - Appended when a procedure is performed on *only one side*
- Modifier 50 – bilateral procedures performed during same operation session
- Modifier 50 – Only for paired organs
- Modifier 50 – Not used with procedures when the description indicates “unilateral” or “bilateral”, or multiple occurrences

QUESTIONS?

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