National Congress on Health Care Compliance

Coding for Compliance Professionals

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February 5, 2003

PRICEWATERHOUSECOOPERS

Today's Discussion

- Review the various settings, definitions, code systems, terminology and reimbursement used to submit:
  - ✓Physician Professional services
  - ✓Hospital Technical services
- Highlight common pitfalls

Medicare Fee of Service

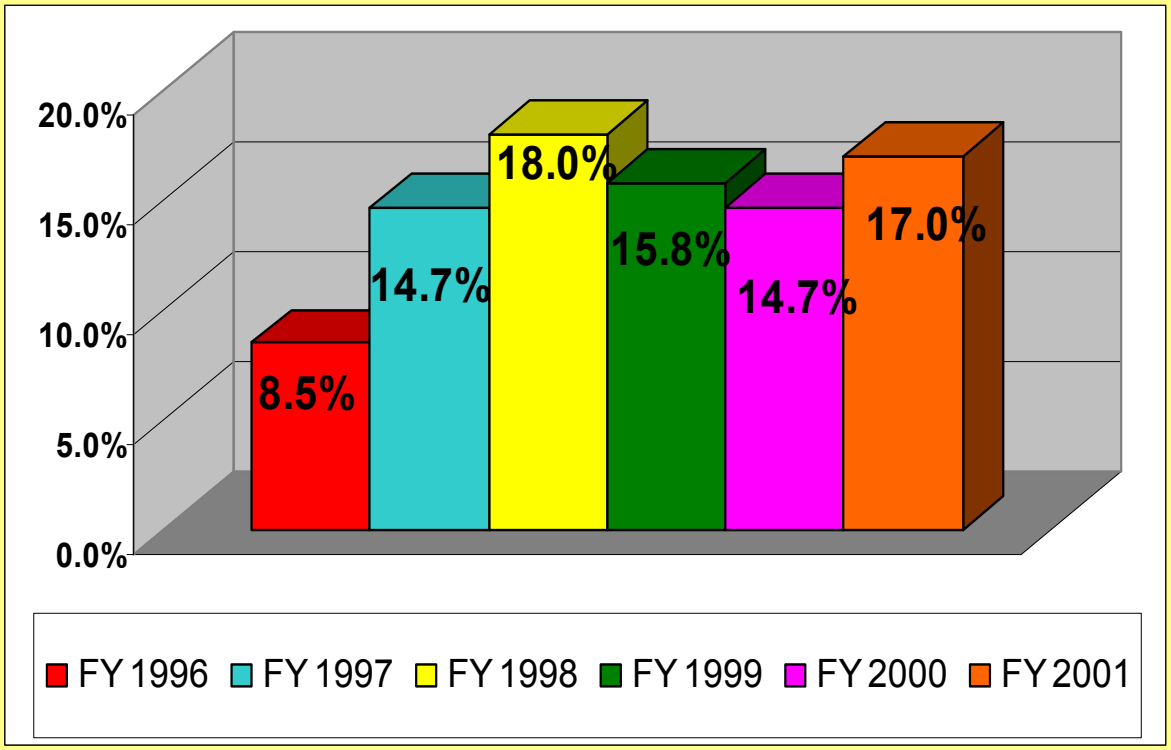
FY 01 Improper Payment

- **Documentation Errors**
  - YR 2001 = 42.9%
  - YR 2000 = 36.4%
- **Medically Unnecessary Services**
  - YR 2001 = 43.2%
  - YR 2000 = 43.0%
- **Coding Errors**
  - YR 2001 = 17.0%
  - YR 2000 = 14.7%
- **Non-covered Services and Miscellaneous Errors**
  - YR 2001 = -3.1%
  - YR 2000 = 5.9%

Source: DHHS, 2/15/2002, Improper Fiscal Year 2001 Medicare Fee-for-Service Payments (A-17-01-02002)

Coding Errors FY 01

(Estimated total of $2 Billion)
***Physician and PPS claims were 90% of coding errors** of the 6 year period*



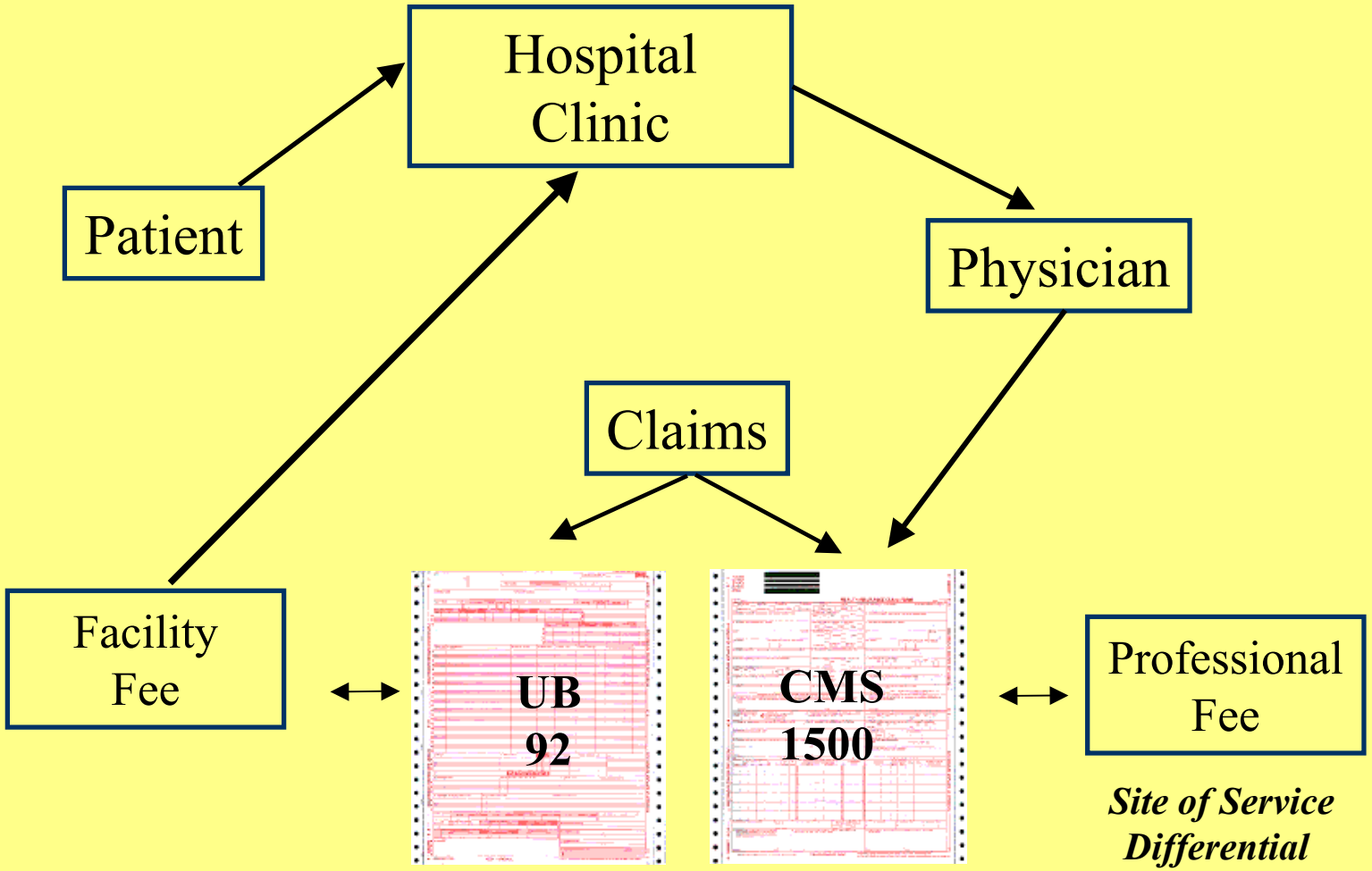
Source: Improper FY 01 Medicare Fee-for-Service Payment

Physician Professional Services Discussion

- ✓ Hospital Outpatient vs Free-Standing Office Claim Process
- ✓ Part B Carrier Process
- ✓ Coding Systems Overview
- ✓ Common Nomenclature and Terminology
- ✓ CMS 1500 Form
- ✓ Common Pitfalls
- ✓ Questions/Answers

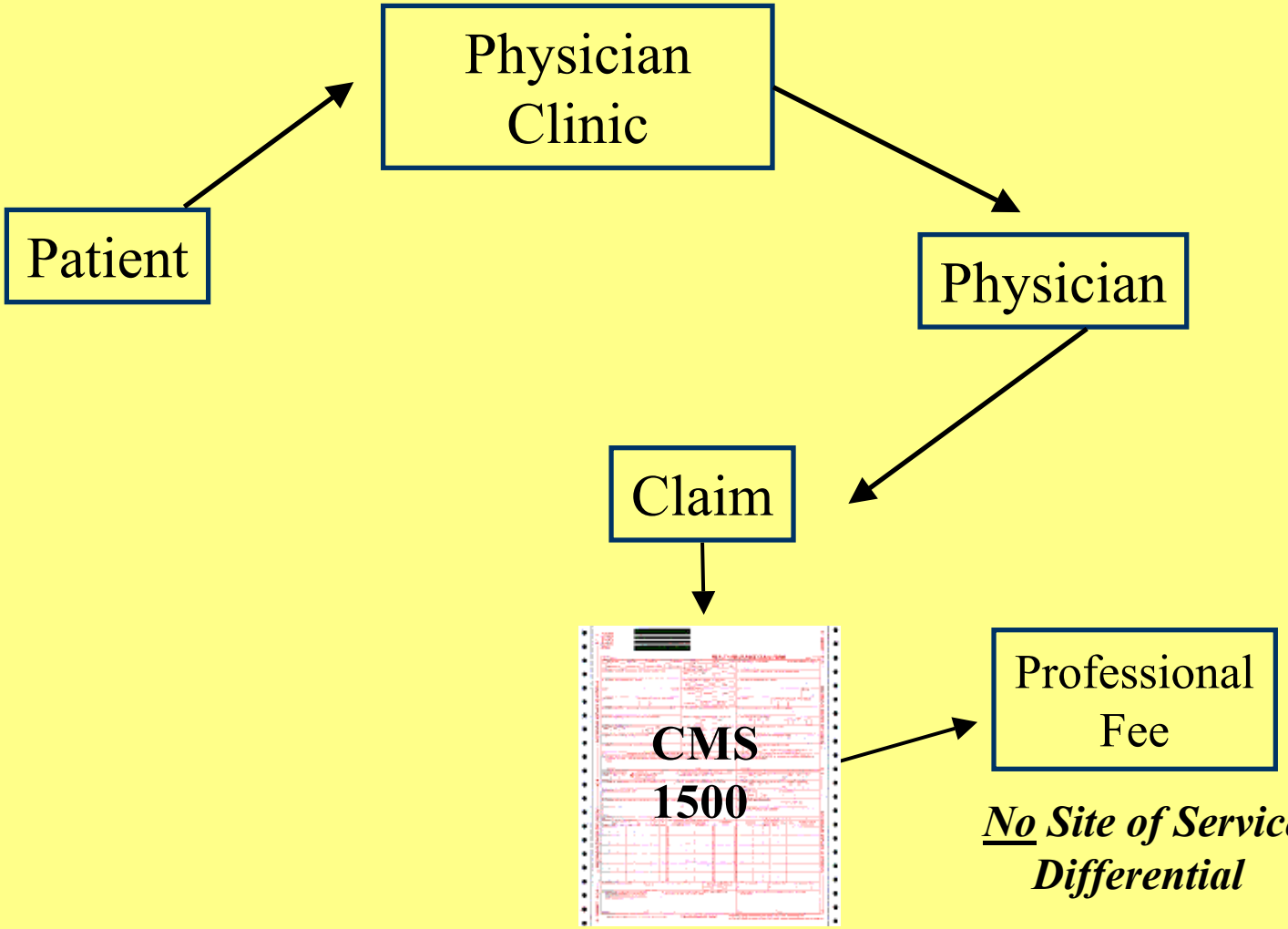
Hospital Outpatient Claim Process

Place of Service "22" Hospital Outpatient Clinic



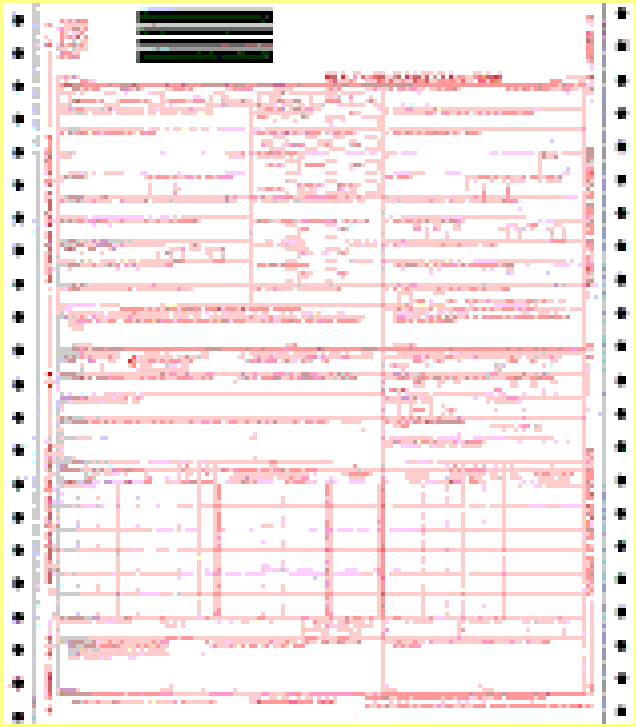
Free-Standing Claim Process

Place of Service "11" Outpatient Clinic



Physician Professional Services

- Understanding Physician Professional Services
  - ✓ Part B Carrier processes
  - ✓ Coding Classifications
    - – CPT 4
    - – ICD-9-CM
    - – HCPCS Level II
  - ✓ CMS 1500 Form
  - ✓ Place of Service
  - ✓ Type of Service



Part B Carrier Processes

- ***The Medicare* Program** is divided into two parts: Part A or Hospital/Inpatient and Part B or Physician or Outpatient Services
- Part B covers physician services, DME, outpatient hospital services, x-rays, lab tests, home health, ambulance, etc.
- Medicare Part B covers individuals 65 years of age and older (also covers patients with certain disabilities) and is voluntary for those individuals willing to pay a small premium
- Develop Local Medical Review Policies (LMRP)

CPT-4: Overview

- ***CPT-4*** is the American Medical Association's Current Procedural Terminology, Fourth Edition (first level of HCPCS codes)
  - ✓ Published annually by the AMA - proprietary
  - ✓ Transforms medical services and procedures into 5 digit numeric codes
  - ✓ Communicates "what" service was provided
  - ✓ Divided into 6 major sections
  - ✓ CPT 2003 contains 8,262 codes
    - – 428 code changes in 2003
  - ✓ Contains 2-digit numeric modifiers

ICD-9-CM: Overview

- ***ICD-9-CM*** is the International Classification of Diseases, Ninth Revision, Clinical Modification
  - ✓ Updated annually in October by CMS and public domain
  - ✓ Contains 3, 4 and 5 digit codes
  - ✓ Contains diagnosis and procedure codes
  - ✓ Arranged by diseases, injuries, and causes of death according to established criteria
  - ✓ 3 Volumes
    - Volume 1 contains the Tabular List of Diseases and Injuries
    - Volume 2 contains the Alphabetic Index of Diseases and Injuries
    - Volume 3 includes the Tabular List and Alphabetic Index to Procedures - used for facility billing
  - ✓ Only Volumes 1 and 2 are used for physician professional services
  - ✓ Communicates "why" the service was provided

HCPCS Level II: Overview

- ***HCPCS Level II*** is the acronym for Healthcare Financing Administration Common Procedure Coding

  - ✓ National codes published annually CMS and public domain
  - ✓ Codes consist of an alphanumeric code – a letter from A through V followed by four digits
    - J1160, injection digoxin, up to 0.5 mg
  - ✓ Grouped by the type of supply or service they represent
    - Home Health, Rehabilitation
    - Injections-Chemotherapeutic Drugs
    - Orthotics/Prosthetics
    - Durable Medical Equipment
  - ✓ Used by Medicare and private payers

Physician Professional Services

- Common Nomenclature & Terminology
  - ✓ Relative Value Units
  - ✓ Professional, Technical and Global Services
  - ✓ Global Surgery Package
  - ✓ Correct Coding Initiative
  - ✓ Level of Service and E/M Codes
  - ✓ Unbundling
  - ✓ Upcoding
  - ✓ Medical Necessity
  - ✓ Linking/Sequencing Diagnosis Codes
  - ✓ Starred procedures
  - ✓ Modifiers

Resource Based Relative Value System

- ***RBRVS*** was developed by Harvard University's Public Health Department and was developed to produce uniform, nationwide policies, a national fee schedule and new CPT codes (E/M)
  - ✓ Compares the time, effort, risk and related overhead costs of providing patient medical care and performing surgical procedures
  - ✓ There are three separate values: physician work, practice expense and malpractice insurance
  - ✓ The Medicare Fee Schedule is made up of the relative value units for each service, a geographic adjustment factor and a national conversion factor (enacted by Congress on a yearly basis)

Relative Value Units (RVU)

- Medicare Physician Fee Schedule
- Federal Register
- Relative Value Units
  - ✓ Work, Practice Expense, Malpractice
  - ✓ Conversion Factor $36.1992
  - ✓ GPCIs (Geographic Practice Cost Indices)
- Professional, Technical and Total Component
- Facility vs. Non-facility setting
- Status Indicators

Professional, Technical and Global Services

- Certain procedures have both a professional and technical component and many of these procedures have companion codes.
  - ✓ -26 (Professional Component) identifies only the physician's work
  - ✓ -TC (Technical Component) contains everything except that portion that must be reported by the physician (ie., facility charges, equipment, supplies, technicians)
  - ✓ Global Service – both the professional and technical component

Key Definitions

- Facility
  - ✓ POS "22" Outpatient Hospital
  - ✓ A portion of the hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

- Non-facility
  - ✓ POS "11" Office
  - ✓ Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

Provider Based Status

- Relationship between a main provider and a provider based-entity or a department of a provider, remote location of a hospital, or satellite facility, that complies with the provisions.

- Requirements for all:
  1. Same licensure (if available in State)
  2. Integrated clinical services
  3. Financial integration
  4. Public awareness
  5. Meets obligation of hospital outpatient departments

Provider Based Status (continued)

- Requirements if off-campus:
  - ✓ Ownership and control
  - ✓ Administration and supervision
  - ✓ Location in immediate vicinity

- Additional criteria if facility is "off-campus" and operated under management contract

- Joint venture must be:
  - ✓ Partially owned by at least one provider
  - ✓ Located on main campus of a provider that is an owner
  - ✓ Provider-based to provider whose campus the facility is located

Evaluation and Management Services with Place of Service Differential

ADDENDUM B.—RELATIVE VALUE UNITS (RVUs) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Fully implemented non-facility PE RVUs	Fully implemented facility PE RVUs	Malpractice RVUs	Fully implemented non-facility total	Fully implemented facility total	Global
99201		A	Office/outpatient visit, new	0.45	0.47	0.16	0.02	0.94	0.63	XXX
99202		A	Office/outpatient visit, new	0.88	0.77	0.33	0.05	1.70	1.26	XXX
99203		A	Office/outpatient visit, new	1.34	1.12	0.50	0.08	2.54	1.92	XXX
99204		A	Office/outpatient visit, new	2.00	1.51	0.74	0.10	3.61	2.84	XXX
99205		A	Office/outpatient visit, new	2.67	1.80	0.98	0.12	4.59	3.77	XXX
99211		A	Office/outpatient visit, est	0.17	0.38	0.06	0.01	0.56	0.24	XXX
99212		A	Office/outpatient visit, est	0.45	0.53	0.17	0.02	1.00	0.64	XXX
99213		A	Office/outpatient visit, est	0.67	0.69	0.24	0.03	1.39	0.94	XXX
99214		A	Office/outpatient visit, est	1.10	1.04	0.41	0.04	2.18	1.55	XXX
99215		A	Office/outpatient visit, est	1.77	1.36	0.66	0.07	3.20	2.50	XXX
99217		A	Observation care discharge	1.28	NA	0.45	0.05	NA	1.78	XXX
99218		A	Observation care	1.28	NA	0.45	0.05	NA	1.78	XXX
99219		A	Observation care	2.14	NA	0.75	0.08	NA	2.97	XXX
99220		A	Observation care	2.99	NA	1.06	0.11	NA	4.16	XXX
99221		A	Initial hospital care	1.28	NA	0.47	0.05	NA	1.80	XXX
99222		A	Initial hospital care	2.14	NA	0.77	0.08	NA	2.99	XXX
99223		A	Initial hospital care	2.99	NA	1.08	0.10	NA	4.17	XXX
99231		A	Subsequent hospital care	0.64	NA	0.24	0.02	NA	0.90	XXX
99232		A	Subsequent hospital care	1.06	NA	0.39	0.03	NA	1.48	XXX
99233		A	Subsequent hospital care	1.51	NA	0.55	0.05	NA	2.11	XXX
99234		A	Observ/hosp same date	2.56	NA	0.93	0.11	NA	3.60	XXX
99235		A	Observ/hosp same date	3.42	NA	1.21	0.13	NA	4.76	XXX
99236		A	Observ/hosp same date	4.27	NA	1.49	0.17	NA	5.93	XXX
99238		A	Hospital discharge day	1.28	NA	0.51	0.04	NA	1.83	XXX
99239		A	Hospital discharge day	1.75	NA	0.71	0.05	NA	2.51	XXX
99241		A	Office consultation	0.64	0.62	0.24	0.04	1.30	0.92	XXX
99242		A	Office consultation	1.29	1.03	0.50	0.09	2.41	1.88	XXX
99243		A	Office consultation	1.72	1.38	0.67	0.10	3.20	2.49	XXX
99244		A	Office consultation	2.58	1.83	0.98	0.13	4.54	3.69	XXX
99245		A	Office consultation	3.43	2.29	1.30	0.16	5.88	4.89	XXX

PC/TC and Global Values

ADDENDUM B.—RELATIVE VALUE UNITS (RVUS) AND RELATED INFORMATION—Continued

CPT [1]/ HCPCS [2]	MOD	Status	Description	Physician work RVUs [3]	Fully implemented non-facility PE RVUs	Fully implemented facility PE RVUs	Malpractice RVUs	Fully implemented non-facility total	Fully implemented facility total	Global
74000		A	X-ray exam of abdomen	0.18	0.56	NA	0.03	0.77	NA	XXX
74000	26	A	X-ray exam of abdomen	0.18	0.06	0.06	0.01	0.25	0.25	XXX
74000	TC	A	X-ray exam of abdomen	0.00	0.50	NA	0.02	0.52	NA	XXX
74010		A	X-ray exam of abdomen	0.23	0.62	NA	0.04	0.89	NA	XXX
74010	26	A	X-ray exam of abdomen	0.23	0.08	0.08	0.01	0.32	0.32	XXX
74010	TC	A	X-ray exam of abdomen	0.00	0.54	NA	0.03	0.57	NA	XXX
74020		A	X-ray exam of abdomen	0.27	0.68	NA	0.04	0.99	NA	XXX
74020	26	A	X-ray exam of abdomen	0.27	0.09	0.09	0.01	0.37	0.37	XXX
74020	TC	A	X-ray exam of abdomen	0.00	0.59	NA	0.03	0.62	NA	XXX
74022		A	X-ray exam series, abdomen	0.32	0.81	NA	0.05	1.18	NA	XXX
74022	26	A	X-ray exam series, abdomen	0.32	0.11	0.11	0.01	0.44	0.44	XXX
74022	TC	A	X-ray exam series, abdomen	0.00	0.70	NA	0.04	0.74	NA	XXX
74150		A	Ct abdomen w/o dye	1.19	5.79	NA	0.30	7.28	NA	XXX
74150	26	A	Ct abdomen w/o dye	1.19	0.42	0.42	0.05	1.66	1.66	XXX
74150	TC	A	Ct abdomen w/o dye	0.00	5.37	NA	0.25	5.62	NA	XXX
74160		A	Ct abdomen w/dye	1.27	6.94	NA	0.36	8.57	NA	XXX
74160	26	A	Ct abdomen w/dye	1.27	0.44	0.44	0.06	1.77	1.77	XXX
74160	TC	A	Ct abdomen w/dye	0.00	6.50	NA	0.30	6.80	NA	XXX
74170		A	Ct abdomen w/o&w dye	1.40	8.55	NA	0.42	10.37	NA	XXX
74170	26	A	Ct abdomen w/o&w dye	1.40	0.49	0.49	0.06	1.95	1.95	XXX
74170	TC	A	Ct abdomen w/o&w dye	0.00	8.06	NA	0.36	8.42	NA	XXX
74175		A	Ct angio abdom w/o&w dye	1.90	8.82	NA	0.38	11.10	NA	XXX
74175	26	A	Ct angio abdom w/o&w dye	1.90	0.76	0.76	0.06	2.72	2.72	XXX
74175	TC	A	Ct angio abdom w/o&w dye	0.00	8.06	NA	0.32	8.38	NA	XXX
74181		A	Mri abdomen w/o dye	1.46	11.15	NA	0.41	13.02	NA	XXX
74181	26	A	Mri abdomen w/o dye	1.46	0.51	0.51	0.04	2.01	2.01	XXX
74181	TC	A	Mri abdomen w/o dye	0.00	10.64	NA	0.37	11.01	NA	XXX
74182		A	Mri abdomen w/dye	1.73	13.36	NA	0.49	15.58	NA	XXX
74182	26	A	Mri abdomen w/dye	1.73	0.60	0.60	0.06	2.39	2.39	XXX
74182	TC	A	Mri abdomen w/dye	0.00	12.76	NA	0.43	13.19	NA	XXX
74183		A	Mri abdomen w/o&w dye	2.26	24.43	NA	0.84	27.53	NA	XXX
74183	26	A	Mri abdomen w/o&w dye	2.26	0.79	0.79	0.08	3.13	3.13	XXX
74183	TC	A	Mri abdomen w/o&w dye	0.00	23.64	NA	0.76	24.40	NA	XXX
74185		R	Mri angio, abdom w or w/o dy	1.80	11.27	NA	0.57	13.64	NA	XXX
74185	26	R	Mri angio, abdom w or w/o dy	1.80	0.63	0.63	0.08	2.51	2.51	XXX
74185	TC	R	Mri angio, abdom w or w/o dy	0.00	10.64	NA	0.49	11.13	NA	XXX

Payment Formula

- Payment = [(RVU work x GPCI work) +
- (RVU practice expense x GPCI practice expense) +
- (RVU malpractice x GPCI malpractice)] x Conversion Factor ($36.1992)

Example of Payment Calculation

- Simple Laceration Repair. CPT code 12001

  - ✓ Physician Office
    Work RVU (1.70) + Year 2001 Non-facility Practice Expense (1.89) + Malpractice RVU (.13) x conversion factor (38.2581) = $142.32.

  - ✓ Hospital Based Clinic
    Work RVU (1.70) + Year 2001 Facility Practice Expense (.79) + Malpractice RVU (.13) x conversion factor (38.2581) = $100.24

Global Surgical Package

- Payment for surgical procedures includes a "package" of services.
- Medicare includes:
  - ✓ Evaluation or consultation after decision to perform surgery
  - ✓ One day preoperative period covered under global surgical period
  - ✓ All operative services that are considered to be usual and necessary
  - ✓ 90-day postoperative period for major surgical procedures
  - ✓ 10-day postoperative period for minor surgical procedures
  - ✓ Any treatment of the same diagnosis or surgical encounter by the surgeon not requiring a return to the OR is include

Correct Coding Initiative (CCI)

- The CCI provides correct coding methodology and controls improper coding that leads to increased payments
- Implemented in two phases
  - ✓ Phase I contained 87,000 coding edits
  - ✓ Phase II released an additional 16,000 edits
- Version 9.0 effective 1/1/03
  - ✓ 20,265 changes in Version 9.0

Unbundling

- Unbundling/Fragmenting occurs when multiple procedure codes are billed for a procedure that is covered by a single code
  - ✓ Two types: unintentional and intentional
  - ✓ Fragmenting one service into component parts and billing each component
  - ✓ Reporting separate codes for related services
  - ✓ Breaking out bilateral procedures when one code is appropriate
  - ✓ Downcoding a service so an additional code can be billed

Level of Service and E/M Codes

- Evaluation and Management (E/M) Codes
  - ✓ Referred to as visit codes
  - ✓ All begin with "99" and are 5 digits
  - ✓ Various categories and levels of service
  - ✓ Defines the level of "intensity" of care
  - ✓ Comprised of key components
    - History
    - Exam
    - Medical Decision Making
  - ✓ Two sets of documentation guidelines currently in use (1995 and 1997)

Upcoding

- Upcoding continues to be a problem
- Addressed in OIG Workplan for FY02
- OIG Final Report to HCFA FY00 (dated 2/5/01) states:

  "Incorrect coding is the third highest error category this year, representing $1.7 billion in improper payments (the net of upcoding and downcoding)"

- E/M upcoding
  - ✓ Level and/or category of service
- Procedure upcoding

ICD-9-CM: Medical Necessity

- Defined by Centers for Medicare and Medicaid Services (CMS) as a "service that is reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member"

- Demonstrated by relationship of procedure codes (CPT-4) and diagnosis codes (ICD-9-CM) to support each other

  - ✓ Example: Biopsy for neoplasm of uncertain behavior

Linking/Sequencing Diagnosis Codes

- The primary diagnosis should indicate the reason the patient presented
- Link a single diagnosis code with a procedure code
  - ✓ Medicare does not have the capability to link more than one diagnosis code to a procedure
- Diagnosis codes must be taken to the highest level of known specificity

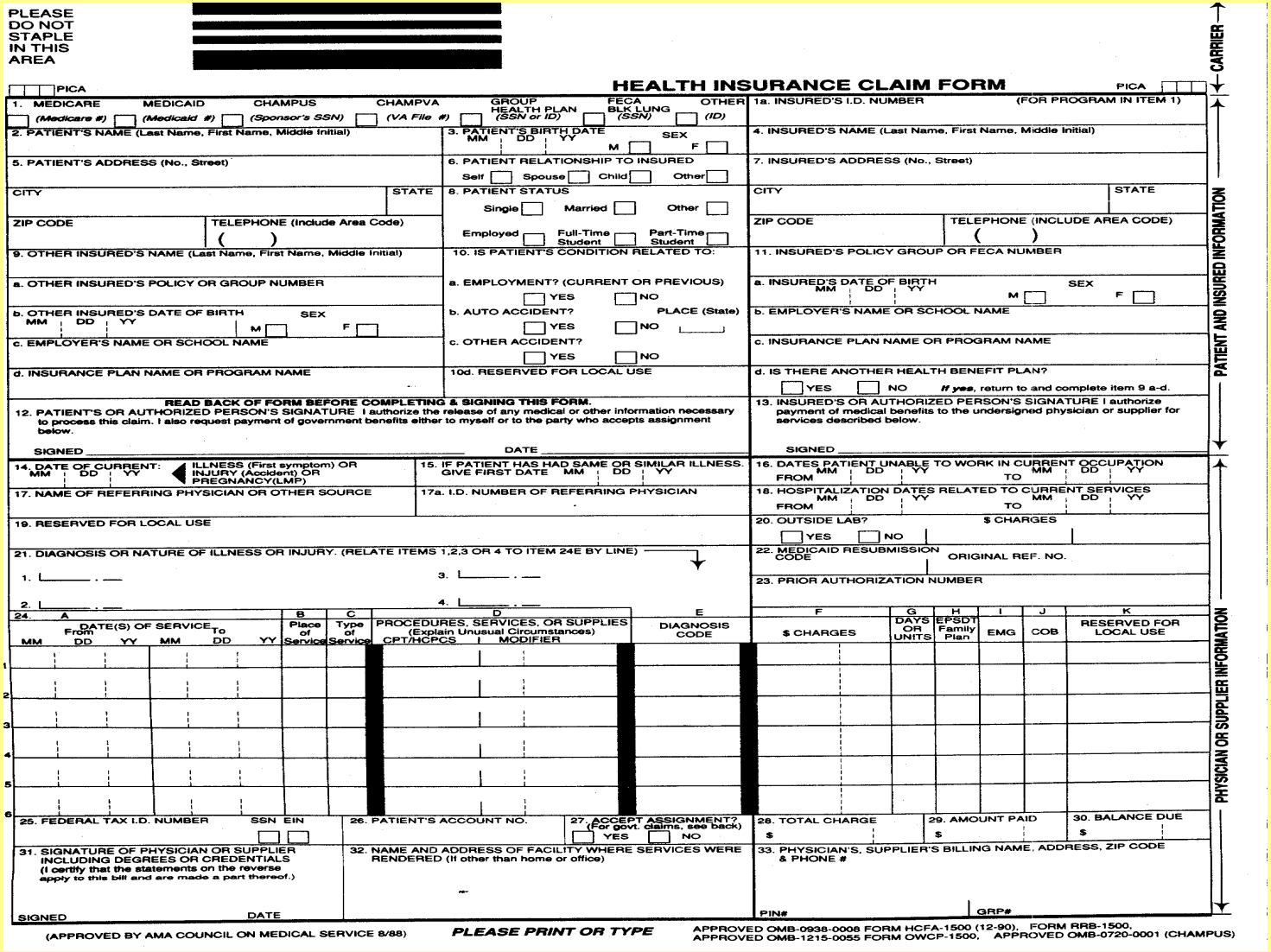
Starred (*) Procedures/Minor Surgical Procedures

- Medicare characterizes as:
  - ✓ Those procedures taking 5 minutes or less
  - ✓ Those involving relatively little medical decision-making once the need has been determined
  - ✓ Example: suturing of a small, simple laceration
- CPT characterizes as:
  - ✓ The service includes the surgical procedure only
  - ✓ Associated pre- and postoperative services are not included in the service

Modifiers

- Two character (numeric, alpha-numeric, or alpha) code appended to an E/M code or to a surgical procedure to provide specific information about that service (CPT Levels I, II, and III)
- Modifiers provide the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstances but not changed in its definition or code
- 31 numeric modifiers in CPT 2003

CMS 1500 Form



PLEASE DO NOT STAPLE IN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY | SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other; Employed | Full-Time Student | Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES | NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M F

b. AUTO ACCIDENT? YES | NO | PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES | NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES | NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES | NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES | NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) **PLEASE PRINT OR TYPE** APPROVED OMB-0938-0008 FORM HCFA-1500 (12-90), FORM RRB-1500. APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

Common Pitfalls

- Submitting claims with the incorrect Place of Service (POS) “11” versus “22”
- Submitting claims for both global types of services when there is a physician professional component only service (ie., chest x-ray interpretation, 71020-26)
- Submitting claims for services provided by ancillary personnel in POS “22” who are employees and included on the cost report
- Billing physician professional services “incident-to” billing in POS “22” which is not allowed

Common Aberrant Billing Practices

- Improper reporting of units on a surgical/medical procedure as if it were an anesthesia service
- Routinely reporting a higher level of service than was provided (e.,g reporting code 90937 "hemodialysis requiring repeated evaluation(s) when the patient is only evaluated once during dialysis"
- Improper use of procedure codes (e.g, critical care codes reported when patient is not critically ill and the physician was not in constant attendance)
- Deliberate efforts to circumvent Medicare guidelines (e.,g reporting false diagnosis and findings in order to obtain payment for routine foot care)

Source: CIGNA Medicare Part B
Chapter Five: Program Safeguards

Humana Says…

- Focus review on outlier physicians for high intensity E/M claims effective October 1, 2000.
  - ✓ **Any physician whose high intensity E/M claims coding practice are above the 75% percentile for their specialty**
  - ✓ **Review of the 8 specific high intensity E/M codes:**
    - New patient exams (99204-99205)
    - Established patient exams (99214-99215)
    - Consultations (99244 and 99245)
    - Emergency Room Services (99284-99285)
  - ✓ **Review bi-annually the list of participating and non participating physicians on the outlier list**

Source: http://www.humana**.com/**providers/bulletins.asp

Medicare Pays

- 42 CFR 482.24 (c)

  Providers must maintain records that contain sufficient documentation to justify diagnoses, admissions, treatments performed and continued care.

Hospital Technical Services

Today's Discussion

- Technical coding:
  - ✓Brief technical coding system overview
  - ✓Review the basics of the Medicare Prospective Payment Systems
  - ✓Don't teach me how to code, just tell me what I need to know
  - ✓Performing data analysis or what am I looking for?
  - ✓Questions/Answers

Hospital Technical Coding

- Understanding Hospital Technical Services

  - ✓ Hospital facility
  - ✓ Coding Classifications
    - CPT
    - ICD-9-CM
    - HCPCS Level II
  - ✓ Hospital Acute Care Inpatient, Outpatient and Inpatient Rehabilitation Services
  - ✓ CMS UB-92

Hospital Technical Coding

Coding is the process of extracting clinical information from the medical record for services rendered. This simple process includes:

- Proper documentation by the medical staff;
- Interpreting a myriad of coding guidelines that constantly change;
- Various coding guidelines and prospective payment systems complexities;
- A shortage of qualified coders and management personnel;
- Billing system integrity issues;
- Everything else
- Sounds simple, right?

Hospital Technical Coding

Hospital Inpatient Acute Care – Utilizes the ICD-9-CM coding scheme to assign a single DRG per encounter for services rendered

Inpatient Acute Rehabilitation Services – Utilizes a combination of ICD-9-CM coding, Rehabilitation Impairment Categories (RICs), functional measurements and age to determine the CMG to assign a single four-tier CMG per encounter for services rendered

Hospital Outpatient Services- Utilizes CPT procedural coding scheme to assign a APC per encounter with possible multi-APC assignment per encounter for services rendered

Hospital Technical Coding

Inpatient Acute Care

- Single setting
- Tightly organized structure
- Single unit of payment per claim – DRG
- Average 5-9 LOS
- Manageable number of
  - Claims
  - Codes
  - Registration points
- Higher cost per unit
- Strong historical data

Inpatient Rehab

- Single setting
- Often fragmented structure
- Single unit of payment per claim – CMG
- Longer LOS
- Relatively Fewer number of
  - Claims
  - Codes
  - Registration points
- Higher cost per unit
- Poor historical data

Outpatient Care

- Multiple settings
- Often decentralized
- Possible multiple units of payment per claim - APCs
- 24 Hours or less
- Large to huge number of
  - Claims
  - Codes
  - Registration points
- Relatively small cost per unit
- Poor historical data

UB-92 Billing Form

- ✓ Bill Type
- ✓ From and through Dates
- ✓ Date of Birth
- ✓ Sex
- ✓ Condition Codes
- ✓ Revenue Codes
- ✓ Revenue Code Description
- ✓ HCPCS/CPT Code
- ✓ Date of Service
- ✓ Number of Units
- ✓ Line item charge
- ✓ Diagnoses Codes
- ✓ Procedure Codes
- ✓ HIPAA standardization

Medicare Prospective Payment Systems

Hospital Acute Inpatient Care

One DRG is assigned to each inpatient stay.

- **Relative Weight (RW):** Each DRG is assigned a RW to reflect resource consumption.
- **Base Rate:** Dollar figure assigned by CMS to each hospital that is multiplied by the RW to determine the amount of reimbursement to the hospital per DRG.

Example:

Description	Rel Wt		Base Rate		Est. Payment
DRG 4 Spinal procedure	2.3184	**X**	$5,000	=	$11, 592

Medicare Prospective Payment Systems

Inpatient Rehabilitation Services

One CMG is assigned to each inpatient Rehab stay.

- **Relative Weight (RW):** Each CMG is assigned a RW to reflect resource consumption.
- **Federal Prospective Payments:** Each CMG has a separate reimbursement rate.

Example:

Description	Rel Wt		Tier	Est. Payment
CMG 0106 Stroke	1.1267	**X**	None	= $13,737.85
CMG C0106 Stroke	1.3951	**X**	Tier 1	= $17,010.45

Medicare Prospective Payment Systems

Outpatient Services

Multiple APCs are assigned for a single visit if multiple services are delivered in that visit.

- **Relative Weight (RW):** Each APC is assigned a relative payment rate based on the median costs of the services within the APC.
- Payment amounts will be discounted when more then one surgical service is performed during a single encounter. The APC with the highest weight will be reimbursed at 100% and all other procedures will be reimbursed at 50%.
- Certain O/P services are paid off of an established fee schedule (I.e. Laboratory)

What you need to know

Hospital Inpatient Services

Coding and Documentation Practices - Medicare Case Mix Index

- Recent trends have depicted hospitals CMI are decreasing
- Various OIG DRG-Creep investigations may have contributed to "coder conservatism"
- For most hospital providers a decrease in Medicare CMI by 1-3% will have significant bottom line impact
- Documentation practices and coding quality are critical to success
- Successful organizations have established Case Mix Management Committees in recent years

What you need to know- Case Mix Index Committee

To get a firm handle on CMI, hospitals' need a strong CMI Committee and solid information for analysis

CMI Committee should be composed of the following team members

- CFO (or designee)
- HIM Director
- Case Management Director
- Physician Champion
- V.P. Nursing
- Compliance Officer
- Decision Support

What you need to know - CMI Considerations Before You Start

- What is the history of the CMI (Total and Medicare) ?
- What are the politics surrounding having an effective Case Mix Management structure (departmental reporting, etc)
- What information is currently available to evaluate CMI from your decision support team/HIM (Doctor, Service Line, Illness Severity, etc)

What you need to know – CMI Management Committee

First Step Considerations before you draw conclusions:

- ✓ Prove out financial opportunity for improved revenue performance (impact of better coding versus physician documentation or both) and identify compliance risks
- ✓ Check your ego at the door ! Define roles for everyone's involvement, solicit outside facilitation if needed
- ✓ Isolate one time events or changes in CMI that are sometimes beyond your control (I.e increases in Tracheostomies, new service lines, etc)
- ✓ Know your volume changes between Medical vs. Surgical caseload (Generally Medical will decrease CMI – Surgical will increase)

What you need to know – Getting Started

How to get started:

- ✓ Assess current/historical information
  - Top 25 DRGs on annual basis
  - CC capture rates
  - OIG compliance benchmarks
  - Coding/documentation audits
  - Changes in surgical admissions
  - Changes in medical admissions
- ✓ Assess current coding and documentation practices
  - 50-100 records will provide sufficient information
  - Evaluate clinical/coding clinical documentation and coding
  - Evaluate query process
  - Quantify opportunity for improvement

What you need to know

Hospital Outpatient Services

- APC Coordination / CDM Maintenance / Coding
  - ✓ Hospitals (in general) have not responded quickly enough to address APCs
    - Difficulty with pass-thru updates
    - Difficulty making updates
      - Charge tickets
      - Clinical information systems
      - Charge description masters
      - Back-end scrubbers
  - ✓ LMRP denials at some hospitals are materially significant
  - ✓ Hospitals have seen significant increases in denials
    - Modifiers
    - LMRPs
    - CCI edits
    - Etc.

What you need to know- APC/CDM Coordination

Timely updates to CDM

- ✓ Dissemination of bulletins to impacted parties
- ✓ Identifying "impact" to patient care activities
  - Charge tickets
  - Charge entry screens
- ✓ Monthly meetings with CDM Committee
  - Updates
  - Action Plans
  - Testing
  - Follow-up
- ✓ Annual Updates of CDM
- ✓ Evaluations of denial trends and "Priorities For" follow up
- ✓ Monitor improvement

What you need to know- HIM Coding Quality Program

HIM Coding Quality

- Does your HIM department have an internal coding quality review process?
- Does the HIM department utilize a technology tool to identify potential coding errors?
- Do they target certain DRGs for review?
- What are the results of the reviews?
- What types of DRG changes are they making?
  - Principal diagnosis changes
  - Secondary diagnosis changes
- What is the most frequent type of change?
- Do they trend the results of the DRG re-assignments?
- Is the internal program complimented by ongoing external coding reviews?
- Are the activities and results of the quality review process shared with the compliance officer?

Physician query process

- Does the HIM department have a physician query process?
- How many cases are referred back to the physician due to documentation issues?
- How many DRG changes are made after the physicians are queried?
- What type of physician education is provided to the medical staff?

What you need to know- DNFB

Coding quality Vs DNFB

- DNFB activities almost always effects coding quality
- Are the data quality reviewers performing the functions they where hired to do?
- What percentage of medical records are actually reviewed for documentation and coding accuracy?
- Most people do not understand what a case mix index of 1.3 means, but they surely know what 13 million dollars of unbilled accounts are.

What you need to know- Coder Education

Coder Education

- Do the coders receive coding feedback and education on a regular basis.
- Is the education sessions focused on the trends identified during the on-going coding quality reviews
- Are the results of the education sessions monitored to determine if the education sessions were successful in correcting the coding issues?
- Do we have a plan?

Do We Have Plan

- Because a coding professional has excellent technical skills, there is no guarantee they have excellent analytical skills.
  - Excellent technical coding skills
  - Excellent analytical skills
  - Excellent management skills
  - Excellent people skills
  - Excellent communicator
  - Global thinker with an eye for detail
- HIM departments sometimes are unable to focus on identifying, correcting and monitoring coding issues due to various constraints
- Complement the technical skills of the coding staff by providing your expertise

Data Analysis

Who's looking at the data and what are they looking for?

- Finance?
- Reimbursement?
- Clinical outcomes department?
- HIM?

-If you do not know what is included in the DRG assignments, you do not know the possible errors that may be occurring.

-Perform a base line assessment to establish a starting point.

Data Analysis

Start with the following:

- OIG Work plan
- Complication /Comorbid (CC) Pairs
- OIG Targeted DRGs
- 10 Post Acute Care DRG Discharge Dispositions
- High weighted DRGs with short LOS and/or charges
- DRGs with single CCs
- Trend single CCs to identify potential trends
- Perform comparative analysis against MedPAR file and similar institutions
- Include HIM coding expert in the data analysis and DRG trending
- Document the approach, finding and recommendations of the activities

Data Analysis

Complication /Comorbid (CC) Pairs

144	OTHER CIRCULATORY SYSTEM DIAGNOSES W CC	1.2015	18	94.7 %	50.0 %	92.1 %
145	OTHER CIRCULATORY SYSTEM DIAGNOSES W/O CC	0.5899	1	5.2 %	100.0 %	7.8 %
146	RECTAL RESECTION W CC .	2.7764	3	100.0 %	0.0 %	79.4 %
147	RECTAL RESECTION W/O CC	1.5993	0	0.0 %	0.0 %	20.5 %
148	MAJOR SMALL & LARGE BOWEL PROCEDURES W CC	3.5332	44	97.7 %	20.4 %	86.9 %
149	MAJOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.5063	1	2.2 %	100.0 %	13.0 %
150	PERITONEAL ADHESIOLYSIS W CC	2.9483	12	75.0 %	41.6 %	80.3 %
151	PERITONEAL ADHESIOLYSIS W/O CC	1.3451	4	25.0 %	50.0 %	19.6 %
152	MINOR SMALL & LARGE BOWEL PROCEDURES W CC	1.9477	1	100.0 %	100.0 %	68.6 %
153	MINOR SMALL & LARGE BOWEL PROCEDURES W/O CC	1.1642	0	0.0 %	0.0 %	31.3 %
154	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES	4.3519	13	86.6 %	53.8 %	79.9 %
155	STOMACH, ESOPHAGEAL & DUODENAL PROCEDURES	1.3273	2	13.3 %	100.0 %	20.0 %

Should we be concerned?

Data Analysis

Review the details of the cases to identify a sample of medical records for a focused review

- Trend cases with single CCs
  - Atelectasis
  - Hyponatremia
  - Dehydration
- Shorter LOS
- Lower charges

The documentation and coding may be appropriate or it may not, wouldn't you want to know this?

Data Analysis

OIG Targeted DRGs

Weight Table	Year	DRG	Description	Hospital RW	Hospital Cases	Hospital %	MedPAR*	Hosp v MedPAR
Medicare	2002	14	SPECIFIC CEREBROVASCULAR DISORDERS EXCEPT TIA	1.1655	72	69.9%	69.8%	0.1%
		15	TRANSIENT ISCHEMIC ATTACK & PRECEREBRAL	0.7349	31	30.1%	30.2%	
		79	RESPIRATORY INFECTIONS & INFLAMMATIONS AGE >17 W	1.7094	76	53.1%	24.9%	28.2%
		89	SIMPLE PNEUMONIA & PLEURISY AGE >17 W CC	1.0601	67	46.9%	75.1%	
		87	PULMONARY EDEMA & RESPIRATORY FAILURE	1.4282	58	40.6%	8.0%	32.6%
		127	HEART FAILURE & SHOCK	1.0103	85	59.4%	92.0%	
		88	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	0.9127	37	86.0%	88.1%	-2.1%
		96	BRONCHITIS & ASTHMA AGE >17 W CC	0.7604	6	14.0%	11.9%	
		121	CIRCULATORY DISORDERS W AMI & MAJOR COMP,	1.5787	28	66.7%	67.2%	-0.5%
		122	CIRCULATORY DISORDERS W AMI W/O MAJOR COMP,	1.0241	14	33.3%	32.8%	

Data Analysis

Original Principal Diagnosis Frequency Report

Date Range 04/01/2002 - 09/30/2002 by Discharge Date

Payor : 1
AND Final DRG : 79

Original Principal Diagnosis	Total	Flagged	Avg LOS	Payor LOS	Average Charges
4820 K. PNEUMONIAE PNEUMONIA	1	0	23.0	7.6	$73,631
4821 PSEUDOMONAL PNEUMONIA	3	1	8.3	7.6	$29,679
48241 PNEUMONIA DUE TO STAPHYLOCCUS AUREUS	6	3	13.3	7.6	$36,372
48282 PNEUMONIA E COLI	1	0	6.0	7.6	$18,563
48283 PNEUMO OTH GRM-NEG BACT	14	14	7.0	7.6	$20,927
5070 FOOD/VOMIT PNEUMONITIS	49	6	9.6	7.6	$24,154
5111 BACT PLEUR/EFFUS NOT TB	2	0	11.0	7.6	$29,762
Total	76	24	9.5	7.6	$25,467

- Are you comfortable with these codes?
- Perform a medical record review to verify the documentation and coding are appropriate

Data Analysis

10 Post Acute Care DRGs

Original Discharge Disposition Frequency Report

Date Range 04/01/2002 - 09/30/2002 by Discharge Date

Final DRG : 14,113,209,210,211,236,263,264,429,483
AND Payor : Medicare

Original Discharge Disposition	Total	Flagged	Avg LOS	Payor LOS	Average Charges
Rehabilitation Facility	57	36	3.9	5.0	$27,307
Skilled Nursing Facility	47	12	11.7	5.9	$25,573
Home/Self Care	30	10	6.2	5.5	$13,655
Expired	18	2	22.3	13.5	$35,535
Home Health Services	8	2	10.0	6.9	$14,869
Other Facility	8	2	5.5	5.5	$19,168
Short Term Hospital	5	3	7.8	10.7	$24,856
Total	173	67	8.8	6.5	$24,302

DRG	Medical Rec #	DischDate	Admit #	Sex	Age	Coder	DischDisp	LOS	Payor	Addl Screen
14 TR	M000066037	05/10/2002	9080326	M	86	BRO	2/02	14	01/MC	

RW 1.1655
Payor LOS 4.8G
ISS 0.2794

DX 4321 20890 51881 5070 53190 2859 311 36250 41401 7993 73390 V4581 71590
PR

Charges $22,789

An 86 year old patient with an subdural bleed who was transferred to another acute care hospital after a 14 day LOS

Data Analysis

- What type of benchmarking will be helpful?
  - ✓MedPAR
  - ✓By DRG/APC/CMG
  - ✓By physician
  - ✓By Service
  - ✓By edit
  - ✓By denials
  - -Benchmark your data against yourself.
  - -What are your norms?
  - -What are the aberrant coding issues?
  - -Know your data!!!!!!!!!

What you need to know- Know your data

Know your data!!!!!!!!!

Before you can effectively make decisions based on your data, you better make sure your data is correct.

- Coding
- Documentation
- Charge capture
- Billing system integrity

Questions and Answers

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