How Coding Impacts the Revenue Cycle

Topics to be Covered:

- How Coding Impacts the Revenue Cycle
- National Correct Coding Initiative
- Medically-Unlikely Edits
- AWV & IPPE with Separate E/M Visits
- Non-Specific Diagnosis Codes
- Denials & Rejections: Feedback
- CMS Updates
How Coding Impacts the Revenue Cycle

- Inpatient & Outpatient Claims
- Paid Claims and Denied Claims
- Overpayments and Underpayments
- Payer Medical Review Audits
- Medicare PSC/ZPIC Audits
- Medicare RAC Audits
- Medicare OIG Audits
- Medicare Cost Report Reopenings

National Correct Coding Initiative

- Promote National Correct Coding Methodologies
- Control Improper Coding /Improper Payments
- Based On Coding Conventions Defined In The -
  - CPT manual
  - National And Local Policies And Edits
  - Coding Guidelines Developed By National Societies
  - Analysis Of Standard Medical And Surgical Practices
  - review of current coding practices
### Points to Remember About Modifier -59:
- Just because you **can** use it doesn’t mean you **should** use it.
- If you don’t have documentation to support it’s application, **don’t use it**.
- Even if you have supporting documentation, there is no guarantee that the claim will be paid.
- There is also no guarantee that the claim will not be audited, i.e., records may be requested.
Medically-Unlikely Edits (MUEs)

- Reduce The Paid Claims Error Rate For Part B Claims
- Defined as the Maximum # Units Which a Provider Would Report Under Most Circumstances for a Single Beneficiary on a Single Date of Service
- *All HCPCS/CPT Codes Do Not Have An MUE
- Most MUEs Are Published
- *Other MUEs Are Confidential For Contractors Only
Medically-Unlikely Edits (MUEs)

<table>
<thead>
<tr>
<th>HCPCS/CPT Code</th>
<th>Outpatient Hospital Services MUE Values</th>
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<td>96369</td>
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How do you code subsequent infusions greater than 8 hours?

- CMS has established a limit of 8 units for CPT 96366
- Infusions greater than 8 hours are reported as –
  - 96366 with 8 units on the first line
  - Repeat 96366 with remaining units on second line

**CPT 96365**

100-04, Chapt. 4, §230.2(C) "Beginning in CY 2007, hospitals should report only one initial drug administration service, including infusion services, per encounter for each distinct vascular access site..."
**AWV & IPPE with Separate E/M Visits**

- Establishment of the individual’s medical/family history;
- Measurement of the individual’s ht, wt, bmi (or waist circumference, if appropriate), (BP), and other routine measurements as deemed appropriate, based on the medical and family history;
- Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual;
- Detection of any cognitive impairment that the individual may have;
- Review of an individual’s potential risk factors for depression;
- Review of the individual’s functional ability and level of safety, based on direct observation of the individual, or the use of appropriate screening questions or a screening questionnaire;
- Establishment of a written screening schedule for the individual, such as a checklist for the next 5 to 10 years, as appropriate;
- Establishment of a list of risk factors and conditions of which primary, secondary, or tertiary interventions are recommended or underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits;
- Provision of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management or community-based lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition; and,
- Any other element(s) determined appropriate by the Secretary through the NCD process.

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**AWV & IPPE with Separate E/M Visits**

- Review of the individual’s medical and social history with attention to modifiable risk factors for disease detection;
- Review of the individual’s potential (risk factors) for depression or other mood disorders;
- Review of the individual’s functional ability and level of safety;
- A physical examination to include measurement of the individual’s height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the examining physician or qualified NPP;
- Performance and interpretation of an electrocardiogram (EKG);
- Education, counseling, and referral, as deemed appropriate, based on the results of the review and evaluation services described in the previous 5 elements; and
- Education, counseling, and referral including a brief written plan, e.g. (a checklist or alternative) provided to the individual for obtaining the appropriate screening and other preventive services.
AWV & IPPE with Separate E/M Visits

99213 – Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:
1. An expanded problem focused history;
2. An expanded problem focused examination;
3. Medical decision making of low complexity.

AWV – Establishment of the individual’s medical/family history;
IPPE – A physical examination to include measurement of the individual’s height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the examining physician or qualified NPP;

Documentation must include at least two different additional elements to qualify for a separately identifiable E/M service.

Non-Specific Diagnosis Codes

› High Risk for Denials by Payers, especially Medicare
› CT Services are targeted due to high reimbursements
   • 959.01 Head injury, unspecified
› Laboratory Services also at risk
   • 789.00 Abdominal pain, unspecified site
› Physician Query Process should be implemented for all unspecified diagnoses
Denials & Rejections: Feedback

- Who Monitors Denied Claims?
- Who Determines Patterns/Trends of Denied Codes?
- Is Feedback Given to Clinical Staff/Physicians?
- Are Denials/Rejections Discussed at Revenue Cycle Mtg?
- Is HIM Staff an active participant in Rev. Cycle Committee?
- Does HIM Staff meet with Clinical Staff regularly?
- How does HIM communicate with Clinical Staff?
- Will HIM Staff be involved with physician education for ICD-10 implementation?

CMS Updates

- April 9, 2012: HHS announced proposed delay ICD-10 implementation from 10/1/13 to 10/1/14
- Self-Administered Drug Exclusion List Revisions (effective 10/15/12):
  - Icatibant (Firazyr™) (J3490)
  - Relistor (J3490)
  - liraglutide (Victoza™) (J3490)
  - tesamorelin (Egrifta™) (J3490)
  - apomorphine hydrochloride, 1 mg, (Apokyn®) (J0364)
  - certolizumab pegol, 1 mg (Cimzia®) (J0718)
  - brompheniramine maleate, per 10 mg (J0945)
  - immune globulin (Hizentra™), 100 mg (J1559)
  - immune globulin (Vivaglobin®) 100 mg (J1562)
  - papaverine HCL, up to 60 mg (J2440)
  - phentolamine mesylate, up to 5 mg (Regitine®) (J2760)
  - golimumab (Simponi®) (J3590)
  - peginterferon alfa-2b (Sylatron™) (J3590)
Administrative Law Judge (ALJ) decisions in recent months that uphold a claims administration contractor’s denial of inpatient services as not reasonable and necessary, but require the contractor to pay for the services on an outpatient basis and/or at an “observation level of care.” One representative example of these decisions indicates that:

“Medicare payment is not appropriate for inpatient hospital care services that were provided to the beneficiary from November 19 through 20, 2009. Appellant is entitled to downgraded payment at the rate of observation level of care for its services.”

1. When an ALJ decision is returned indicating the above situation they are to contact the provider of service to secure a new replacement outpatient claim with the appropriate HCPCS codes and line item charges representing rendered services, including observation, where appropriate. A line item charge for observation may only be included if there was an order for observation or the ALJ specifically indicates in their determination that payment for “observation care” or “including observation care” should be made.

When a new replacement outpatient claim is needed, a staff member from that area will contact the provider by phone to request it. Providers will be given a fax number to forward the hardcopy claim information to. The National Government Services Appeals department will complete all of the necessary actions to process the claim in the claims processing system. If a provider fails to respond to the Medicare contractors request for the new bill within 180 days from the date the contact is made, the case will be closed and the effectuation of the ALJ determination will be considered complete.

Effective for claims received on or after January 1, 2013, you must submit the National Provider Identifier (NPI) of the Attending Provider in the Attending Provider Name and Identifiers Field (FL76) of your claims. That NPI must not be your billing NPI, unless the claim is for institutional billing of influenza and pneumococcal vaccinations and their administrations when these are the only billed services on the claim or a roster billing of influenza and pneumococcal vaccinations and their administrations when these are the only billed services on the roster claim. Make sure that your billing staffs are aware of this requirement.

Institutional providers are required to indicate the Attending Provider Name and Identifiers for the patient’s medical care and treatment reported on institutional claims for any services other than non-scheduled transportation claims. Additionally, institutional providers are required on outpatient claims to send the Referring Provider NPI and name when the Referring Provider for the services is different than the Attending Provider.
Questions?

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