HCCA's 12TH ANNUAL COMPLIANCE INSTITUTE

APRIL 13–16, 2008 | NEW ORLEANS, LA | HILTON RIVERSIDE NEW ORLEANS

OPPS Coding Compliance Auditing - Process To Improve Accuracy and Meet Compliance

Health Care Compliance Association (HCCA)

New Orleans, LA

April 2008

HCCA

HEALTH CARE COMPLIANCE ASSOCIATION

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Speakers

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Disclaimer

- *Every reasonable effort has been taken to ensure that the educational information provided in today's presentation is accurate and useful. Applying best practice solutions and achieving results will vary in each hospital/facility situation.*

Goals/Objectives

- Review Coding Auditing and Monitoring program elements
- Discuss specific target CPT, Modifiers or APC's
- Optional action and recommendations to develop
- Look at aspects of auditing ED/ER and OPPS (Outpatient Prospective Payment System)

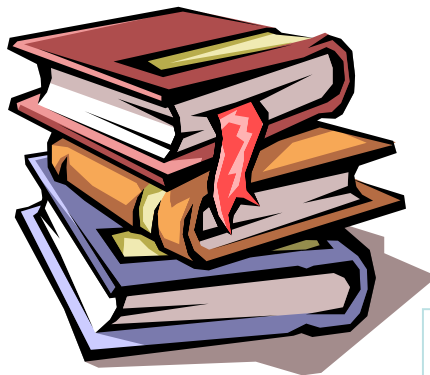
Auditing Resources

- ICD-9-CM Coding Book
- AHA *Coding Clinic on ICD-9-CM*
- AHA *Coding Clinic on HCPCS*
- AMA CPT Book
- AMA *CPT Assistant*
- Coder's Desk Reference - Ingenix
- OPPS Final Rule (CMS)
- OPPS Transmittal (usually release in January)
- OPPS Addendum B (CMS)
- OPPS Inpatient Only List

Audit ICD-9-CM on Outpatient Records/Accounts

- ICD-9-CM
  - International
  - Classification of
  - Diseases
  - 9th Revision
  - Clinical Modification

- The Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics revise, adds and deletes bi-annually and are implemented on April 1st and October 1st of each year.



HIM Coding assigns the ICD-9-CM Diagnosis Codes

Outpatient, Emergency Room Visits & ICD-9-CM Codes

- CMS does not use ICD-9-CM codes to determine APC payment, <u>but hospitals are still required to submit accurate diagnoses codes</u> since CMS will continue to assess the value of using diagnoses codes in future APC revisions, and diagnoses codes are still required to validate medical necessity of performed services/procedures.
  – Hospital HIM Coding staff are responsible for this

Understanding …. An Outpatient Hospital Encounter

- 42 CFR 210.2 Defines Hospital Outpatient. *Outpatient* means a person who has not been admitted as an inpatient but who is registered on the hospital or Critical Access Hospital (CAH) records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH. Medication therapy management patients are *registered outpatients of the hospital.*

Knowing … CMS Communications

- *“Shall" denotes a mandatory requirement*
- *"Should" denotes an optional requirement*
- Do you have a process in place for the dissemination of CMS Transmittal and memo’s?

Remember the above terms… may be contained within the HIM departmental policies?

OPPS Key Components

- Under OPPS there are key components to calculate payment or to deny.
- Under OPPS Medicare pays the hospital a rate-per-service basis.
  - This varies depending on the CPT/HCPCS codes
  - The CPT/HCPCS group into an APC (Ambulatory Payment Classification)
  - Thus there can be multiple APCs on a given claim for a given outpatient encounter

OPPS and/or APC Linked to Coding Systems

- Audit the following:
- ICD-9-CM Codes – diagnoses
  - Medical Necessity
- CPT surgical range codes – payment
- CPT Lab & Radiology - ?
- HCPCS codes - payment
- Revenue codes - payment
- Note: Existence of a code does not guarantee payment however

KNOW THE BASICS of HCPCS

- HCPCS = **H**ealthcare **C**ommon **P**rocedural **C**oding **S**ystem
    - Maintained by Medicare
  - Current Procedural Terminology (CPT- 4)
  - Level I - AMA Current Procedural Terminology, (CPT) numeric codes
  - Level II - (national codes) for physicians & non-physician services (alphanumeric)
  - Level III – no longer exist due to HIPAA standardize code sets
- Remember that CPT was developed by the American Medical Association (AMA) for physicians.

OPPS Status Indicators

- Payment status indicators and their descriptions that correlate to each CPT/HCPCS code
- These may be referenced annually in Addendum B of the Final Rule of the Outpatient Prospective Payment System (OPPS)
- Addendum B of the Final Rule of OPPS provides a detailed listing by HCPCS code and its assigned status indicator

OPPS Addendum B

	A	B	C	D	E	F	G	H	I
1	HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
486	11056	Trim skin lesions, 2 to 4	CH	T	0013	0.7930	50.51		10.10
487	11057	Trim skin lesions, over 4	CH	T	0015	1.4595	92.96		18.59
488	11100	Biopsy, skin lesion	CH	T	0013	0.7930	50.51		10.10
489	11101	Biopsy, skin add-on	CH	T	0013	0.7930	50.51		10.10
490	1110F	Pt lft inpt fac w/in 60 days		M					
491	1111F	Dschrg med/current med merge		M					
492	1116F	Auric/peri pain assessed		M					
493	1118F	GERD symps assessed 12 month	NI	M					
494	1119F	Init. Eval for condition	NI	M					
495	11200	Removal of skin tags		T	0013	0.7930	50.51		10.10
496	11201	Remove skin tags add-on		T	0015	1.4595	92.96		18.59
497	1121F	Subs. Eval for condition	NI	M					
498	1123F	ACP discuss/dscn mkr doc'd	NI	M					
499	1124F	ACP discuss-no dscnmkr doc'd	NI	M					
500	1125F	Amnt Pain noted; pain prsnt	NI	M					
501	1126F	Amnt Pain noted; none prsnt	NI	M					
502	1127F	New episode for condition	NI	M					
503	1128F	Subs. episode for condition	NI	M					
504	11300	Shave skin lesion	CH	T	0013	0.7930	50.51		10.10
505	11301	Shave skin lesion	CH	T	0013	0.7930	50.51		10.10
506	11302	Shave skin lesion		T	0013	0.7930	50.51		10.10
507	11303	Shave skin lesion		T	0015	1.4595	92.96		18.59
508	11305	Shave skin lesion		T	0013	0.7930	50.51		10.10
509	11306	Shave skin lesion		T	0013	0.7930	50.51		10.10
510	11307	Shave skin lesion		T	0013	0.7930	50.51		10.10
511	11308	Shave skin lesion		T	0013	0.7930	50.51		10.10
512	11310	Shave skin lesion		T	0013	0.7930	50.51		10.10
513	11311	Shave skin lesion		T	0013	0.7930	50.51		10.10
514	11312	Shave skin lesion		T	0013	0.7930	50.51		10.10
515	11313	Shave skin lesion	CH	T	0013	0.7930	50.51		10.10
516	11400	Exc tr-ext b9+marg 0.5 < cm		T	0019	4.3039	274.13	71.87	54.83
517	11401	Exc tr-ext b9+marg 0.6-1 cm		T	0019	4.3039	274.13	71.87	54.83
518	11402	Exc tr-ext b9+marg 1.1-2 cm		T	0019	4.3039	274.13	71.87	54.83
519	11403	Exc tr-ext b9+marg 2.1-3 cm		T	0020	8.6850	553.18		110.64
520	11404	Exc tr-ext b9+marg 3.1-4 cm		T	0021	16.1001	1025.48	219.48	205.10
521	11406	Exc tr-ext b9+marg > 4.0 cm		T	0021	16.1001	1025.48	219.48	205.10
522	11420	Exc h-f-nk-sp b9+marg 0.5 <		T	0020	8.6850	553.18		110.64

2008 FR Add B

Catholic Healthcare West CHW

OPPS Status Indicator & Descriptions - 2008

A Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than ambulance services; clinical diagnostic laboratory; non-implantable prosthetic and orthotic devices; EPO for ESRD patients; physical, occupational and speech therapy; routine dialysis services for ESRD patient provided in a certified dialysis unit of a hospital; diagnostic mammography; screening mammography.

B Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x, 13x and 14x).

C Inpatient only procedures

D Discontinued codes

E Item, codes and services that: (a) are not covered by Medicare based on statutory exclusion, (b) that are not covered by Medicare for reasons other than statutory exclusion, (c) that are not recognized by Medicare, but for which an alternate code for the same item or service may be permitted, (c) for which separate payment is not provided by Medicare.

F Corneal tissue acquisition; Certain CRNA service; and Hepatitis B vaccines

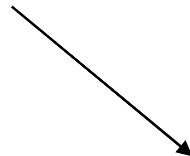
G Pass-through drugs and biologicals

Status Indicator C

- **C** = Inpatient Only Procedure
- *Not paid under OPPS*
- This is an important status indicator to screen for during the scheduling or pre-admission process for elective ambulatory surgeries.
- Work with your Admitting or OR Scheduling Departments.

Addendum E – Inpatient Only List

These procedure will not be paid under OPPS if performed as an outpatient. "C" status indicator



	A	B	C	D
1	HCPCS Code	Short Descriptor	SI	CI
56	01652	Anesth, shoulder vessel surg	C	
57	01654	Anesth, shoulder vessel surg	C	
58	01656	Anesth, arm-leg vessel surg	C	
59	01756	Anesth, radical humerus surg	C	
60	01990	Support for organ donor	C	
61	11004	Debride genitalia & perineum	C	
62	11005	Debride abdom wall	C	
63	11006	Debride genit/per/abdom wall	C	
64	11008	Remove mesh from abd wall	C	
65	15756	Free myo/skin flap microvasc	C	
66	15757	Free skin flap, microvasc	C	
67	15758	Free fascial flap, microvasc	C	
68	16036	Escharotomy; add'l incision	C	
69	19271	Revision of chest wall	C	
70	19272	Extensive chest wall surgery	C	
71	19305	Mast, radical	C	
72	19306	Mast, rad, urban type	C	
73	19361	Breast reconstr w/lat flap	C	
74	19364	Breast reconstruction	C	
75	19367	Breast reconstruction	C	
76	19368	Breast reconstruction	C	
77	19369	Breast reconstruction	C	
78	20660	Apply, rem fixation device	C	
79	20661	Application of head brace	C	
80	20664	Halo brace application	C	
81	20802	Replantation, arm, complete	C	

Catholic Healthcare West CHW

OPPS Status Indicator & Descriptions - 2008

H	Pass-through device categories; Brachytherapy sources; and Radiopharmaceuticals agents
K	Non-pass-through drugs, biologicals and radiopharmaceutical agents
L	Influenza vaccine; Pneumococcal Pneumonia vaccine
M	Items and services non billable to the fiscal intermediary
N	Items and services packaged into APC rates
P	Partial hospitalization
Q	Packaged services subject to separate payment under the OPPS payment criteria
S	Significant service, separately payable
T	Significant service, multiple procedure reduction applies
V	Clinic or emergency department visit
X	Ancillary service
Y	Non-implantable durable medical equipment

Status Indicator - Packaged Services

- Services having a status indicator of “N” are considered packaged or bundled into other services. The costs of these services are allocated to the APC, but are not paid separately.
- The relative weights for surgical, medical and other types of visits were developed to reflect packaged services in the APC-based fee.

Claim Header Information

- The header information must relate to the entire claim (billing form or called a UB) and must include the following:
  - From date;
  - Through date;
  - Condition code;
  - List of ICD-9-CM diagnosis codes;
  - Age;
  - Sex;
  - Type of bill; and
  - Medicare provider number.

Line Item Detail on the Claim

- Each line item contains the following information:
  - HCPCS code with up to 4 modifiers;
  - Revenue code;
  - Service date;
  - Service units; and
  - Charge ($)
- The CPT/HCPCS codes and modifiers are used as the basis of assigning the APCs. Not all line items will contain a CPT/HCPCS code. The line item service dates are used to subdivide a claim that spans more than 1 day into individual visits. The service units indicate the number of times a CPT/HCPCS code was provided (e.g., a lab test with a service unit of 2 means the lab test was performed twice).

Audit with the claim form

UB-04

Familiarize yourself with the various fields, and where the ICD-9-CM and HCPCS/CPT codes are located.

Revenue Codes

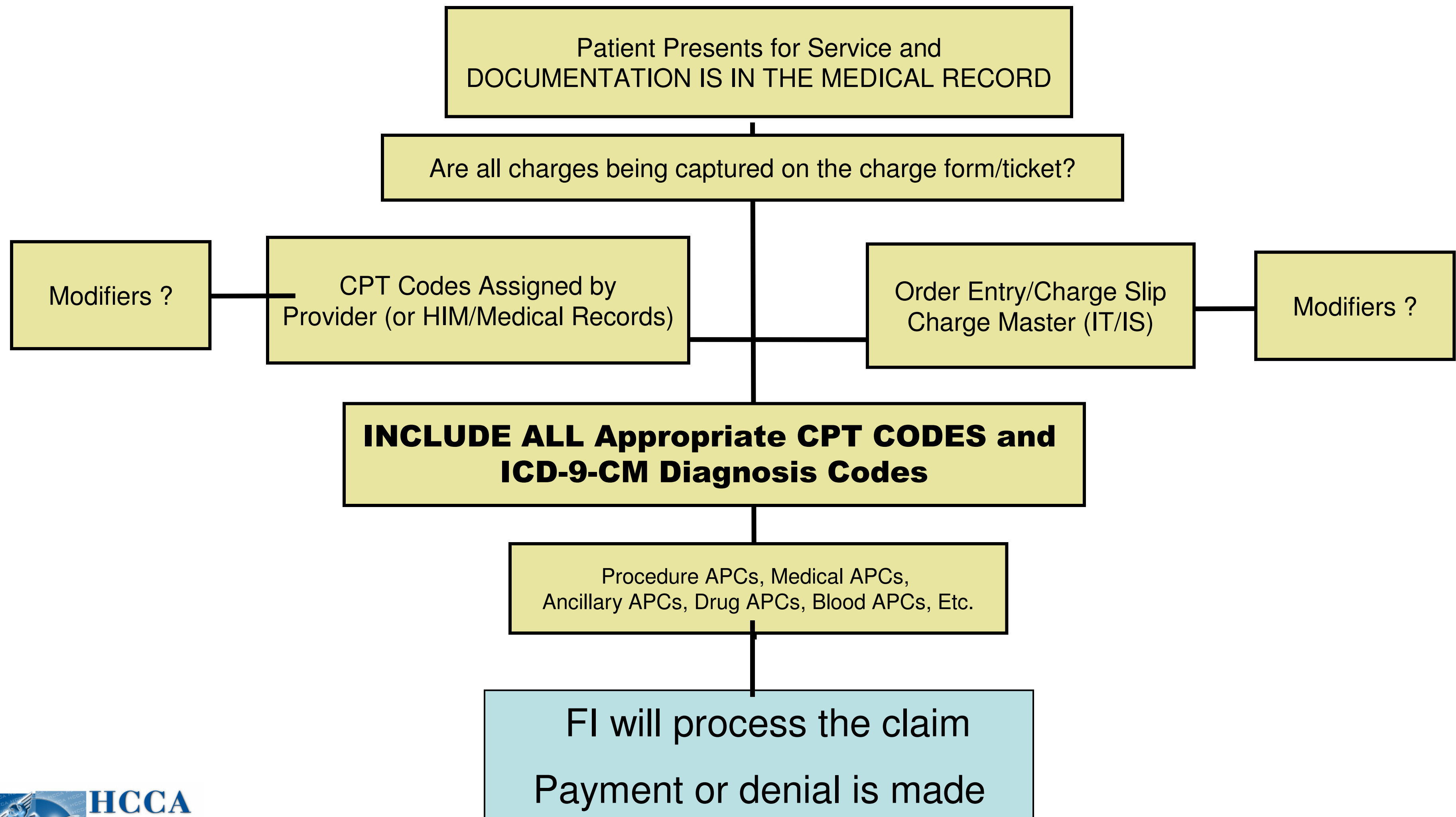
- Programmed into the CDM
- Required for proper claim process.
- Four digit number that identifies the main department service area.
  - Each number begins with a zero
  - Remaining three digits describe the location/area and specific service
- Providers have been instructed to provide detailed level coding for the revenue code series

What is an APC made of?

- CPT code
- Status indicator
- CI – Comment Indicator
- Copayment
- National payment
  - Each APC has a pre-established prospective payment amount associated with it.

"DATA DRIVEN SYSTEM!!

HCPCS and CPT Procedure Codes Determine APC Assignment



Coding or Charging??

- CDM = Charge Description Master
- Service code = Departmental number linked to a departmental service &/or treatment
- Description = Narrative title or description of the service/treatment.
  Printed on the CDM, encounter or charge sheet
- Revenue Code = A 3-digit code on the UB claim. This is typically linked to CPT codes and is an indicator of the service provided
    - 360 = Surgery
    - 750 = GI
- Units = Quantity or volume (for surgical range codes, this most often is (1) as the modifier can indicate multiples)
    - Pharmacy will utilize units field and also in Observation
- CPT Code = A 5-digit numeric code or HCPCS code, which is alphanumeric that describe procedures or services as listed in the AMA CPT book
- Price $ = The dollar amount billed to the payor or the patient for the service/treatment

Check with the CDM staff if you have questions.

Develop CDM Standardization Policy

- Hospital CDM Responsibility - Hospitals will adopt standard CDM policies to clarify and facilitate maintenance of the Standard CDM.
- Departments working with System resources, will develop sufficient documentation for their standard CDM and will document their charging process.
- Standard CDM Structure - Emphasis will be to simplify charge structures, subject to prevailing payment rules and regulations.
- Miscellaneous codes will be minimized and limited.
- Abbreviations and order of description will be standardized, where applicable.
- Best practice & policy is to have HIM "final" code CPT of 10000-69999 in the surgical range, based on clinical documentation. CPT codes for this range will reside in the Corporate Standard for reference purposes only.
- Price Setting - Prices may not be standardized between affiliates as part of the CDM standardization process.

Catholic Healthcare West
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CODING COMPLIANCE REVIEW WORKSHEET

Category: ER Medicare

Name		Age		Date of Service	
MR #		Sex		Facility	French
ACCT #		MD		Payor	ER Medicare
HIC #					

	Original Description/Code		Revised Description/		Variance Type
	Diagnosis:		Diagnosis:		
1		1		PrDx Chg	
2		2		ReSeq PrDx	
3		3		Add/Delete 2nd Dx	
4		4		Chg 2nd Dx	
5		5		Pr CPT Proc Chg	
6		6		Chg 2nd CPT Proc	
7		7		Add CPT Proc	
8		8		Delete CPT Proc	
9		9		E/M Code	
10		10		Modifier	

	Modifier	ICD/CPT		Modifier	ICD/CPT	Documentation	
1			1			IS	
2			2			UB	
3			3			FI	
4			4			Education	
5			5			Query	
6			6			Mapping	
7			7			Other	

Summary:

Coder/Coded Date:

Recommendations:

Guideline Reference:

	Original		Revised		
APC		APC			
$	1.00	$	1.00	$ Change	$ -
H+P (dict)		Oper. (dict)		HIM	
Typed		Typed		Agreed	
Written		Written		Disagreed	
Reviewed				Corp to Review	
Reviewer		Coded		Date to HIM for Rebill	

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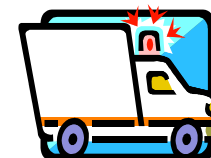
HEALTH CARE COMPLIANCE ASSOCIATION

Medicare OPPS – E&M visits

- Each facility is held accountable for following its own system for assigning the different levels of HCPCS codes. Facilities are in compliance with these reporting requirements as long as:
  - The services furnished are documented and medically necessary;
  - The facility is following its own system; **and**
  - The facility's system reasonably relates the intensity of hospital resources to the different levels of HCPCS codes.



Review - Basics ED/ER E&M for Hospital Coding

- An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention.
- The facility must be available 24 hours per day.
- CPT codes within 99281-99285 are to be assigned for each patient encounter/visit to the emergency room.
- No distinction is made between new and established patients in the ED.

AMA CPT Book 2006 Professional Edition, page 17

Evaluation and Management (E&M) CPT Code

- Under OPPS, criteria for E&M leveling needs to be established by the facility to capture resources.
  - There are no national guidelines yet.
  - This is coming in the future though.
    - AHIMA/AHA has a draft proposal.
- Many elements can be considered before finalizing the E&M level criteria.
  - i.e. Time, Diagnosis/complaint
- Utilizing a collaborative process developed ED/ER E&M visit/encounter leveling criteria.

Level of ED/ER Nursing Care via CPT Codes (E&M)

Level I 99281	Level II 99282	Level III 99283	Level IV 99284	Level V 99285
EXAMPLE			Extended care – Pt stable. Requires LVN or RN assessment & possible reassessment of condition.	Comprehensive. Possibly unstable. Requires RN assessment, reassessment and interventions.

OPPS Leveling Criteria

Federal Register / Vol. 67, No. 212 / Friday, November 1, 2002 / Rules and Regulations 66791

The Panel specifically recommended that we not differentiate among visit types (for example, new, established, and consultation visits) for the purposes of facility coding of clinic visits.

5. Adopt the ACEP facility coding guidelines as the national guidelines for facility coding of emergency department visits.

6. Develop guidelines for clinic visits that are modeled on the ACEP guidelines but are appropriate for clinic visits.

7. Implement these guidelines as interim and continue to work with appropriate organizations and stakeholders to develop final guidelines.

Proposed Rule

We reviewed the written comments, the oral testimony before the APC Panel, and the Panel's recommendations; we agreed that facility-coding guidelines should be implemented as soon as possible. We were particularly concerned that facilities be able to comply with HIPAA requirements. We announced that we have worked, and will continue to work, on this issue with hospitals, organizations representing hospitals, physicians, and organizations representing physicians. We noted that the AMA CPT Editorial Panel is not currently considering the issue of facility coding guidelines for clinic visits and that the earliest any CPT guidelines could be implemented would be in January 2004. Additionally, consistent with the intent of the outpatient prospective payment system, we wanted to ensure that reporting of hospital emergency and clinic visits is resource based.

After careful review and consideration of written comments, oral testimony and the APC Panel's recommendations, we proposed the following (for implementation no earlier than January 2004):

1. To develop five G codes to describe emergency department services: GXXX1—Level 1 Facility Emergency Services, GXXX2—Level 2 Facility Emergency Services, GXXX3—Level 3 Facility Emergency Services, GXXX4—Level 4 Facility Emergency Services,

4. To establish separate documentation guidelines for emergency visits and clinic visits.

With regard to the documentation guidelines, our primary concerns were to make appropriate payment for medically necessary care, to minimize the information collection and reporting burden on facilities, and to minimize any incentive to provide unnecessary or low quality care. We realized that many facilities use complaint or diagnosis driven care protocols and that current documentation standards do not include documentation of staff time or the complexity of diagnostic and therapeutic services provided. Therefore, in the interest of facilitating the delivery of medically necessary care in a clinically appropriate way, we believed that the potential drawbacks of each of the recommended sets of guidelines outweighed the potential benefits of creating uniformity and reproducibility. For example, any documentation system requiring counting or quantification of resource use has the potential to be burdensome, require clinically unnecessary documentation, and be susceptible to upcoding and gaming. Documentation systems using coding grids or a series of clinical examples for each level of service are subject to interpretation, may induce variability, may be overly complex and burdensome, and may result in disagreements with medical reviewers. We were also concerned that all the proposed guidelines allow counting of separately paid services (for example, intravenous infusion, x-ray, EKG, lab tests, and so forth) as "interventions" or "staff time" in determining a level of service. We believe that, within the constraints of clinical care and management protocols, the level of service for emergency and clinic visits should be determined by resource consumption that is not otherwise separately payable.

To address these concerns, in addition to reviewing written comments, oral comments, and the APC Panel recommendations, we also reviewed, for the proposed rule, the current distribution of paid emergency

codes 99284 and 99285. This pattern of coding is significantly different from physician billing for emergency services, which is skewed and peaks at CPT code 99284. We also noted that the median costs for successive levels of emergency visits show an expected increase across APCs.

With regard to clinic visits, we observed that more than 50 percent of the services were considered "single claims" meaning that they were billed without any other significant procedures such as diagnostic tests or therapeutic interventions. We also noted that the distribution of clinic visits is skewed with the majority being low-level clinic visits. This distribution was consistent with pre-OPPS billing patterns where many facilities billed all clinic visits as low level visits. However, the median costs for different levels of clinic services, while similar within an APC, did not show the expected increase across the clinic visit APCs.

Based on our review, on the current distribution of coding for emergency and clinic visits, and on our understanding that hospitals set charges for services based on the resources used to provide those services, we believed that an incremental approach to developing and implementing documentation guidelines for emergency and clinic visits was appropriate. For example, as hospitals became more familiar with the OPPS and with the need to differentiate emergency and clinic visits based on resource consumption, we would continue to review the advantages and disadvantages of detailed, uniform documentation guidelines. We planned to begin the development of uniform guidelines over the next year. If we were ready, we would propose the guidelines for comments in our Federal Register document for the CY 2004 update. For CY 2003, we proposed the following new codes:

Emergency Visits

Because, our data indicated that, in general, hospitals under the OPPS were reporting emergency visits

E&M When a Procedure is Performed – Modifier 25

- In order for a payor to recognize that the procedure was performed on the same date as the evaluation and management service and that it was separate and distinct, it is necessary to append modifier 25 to the E&M CPT code in order to be considered for separate payment.

- The ED/ER CDM should have separate line item charges to charge the E&M code with a modifier 25.
- It is important that you consistently apply this modifier.
- Medicare has stated that modifier 25 is required when a procedure with a status indicator of ‘S’ or ‘T’ has been coded and reported with an E&M CPT code.
  - Check OPPS Addendum B for a list of CPT codes and their status indicator

Examples of Assigned Modifier 25 in the ED/ER

- Example #1: 3-year-old patient seen in the ED/ER for a finger laceration due to a knife. The patient is examined and evaluated by the ED/ER physician. The decision is made to suture the 3 cm laceration on the index finger (simple closure).
- This would be CPT code 12002 along with E&M 99283 with 25 (according to hospital E&M criteria).

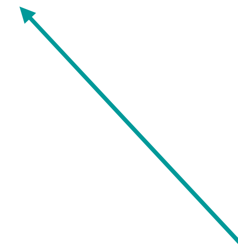
- Example #2: 67-year-old patient fell and hit their head, comes into the ED/ER complaining of dizziness and a headache. After examination and evaluation, a CT of the brain (CPT code 70450) is ordered and performed.
- The E&M CPT would be 99284 according to hospital's E&M leveling criteria. You would add the modifier 25 to the 99284.

Emergency Room - Evaluation and Management Visits

- Obtain the facility E&M leveling criteria when auditing.

OPPS Payment - APCs for E&M Visits

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99281	Emergency dept visit		V	0609	0.7970	50.76	12.70	10.15
99282	Emergency dept visit		V	0613	1.3137	83.67	21.06	16.73
99283	Emergency dept visit		V	0614	2.0750	132.17	34.50	26.43
99284	Emergency dept visit	CH	Q	0615	3.3377	212.59	48.49	42.52
99285	Emergency dept visit	CH	Q	0616	4.9535	315.51	72.86	63.10
99288	Direct advanced life support		B					
99289	Ped crit care transport		N					
99290	Ped crit care transport addl		N					
99291	Critical care, first hour	CH	Q	0617	7.3166	466.02	111.59	93.20



Evaluation and Management in the ED/ER

- Emergency room E&M section, 5 CPT codes will be used to assign visits to one of the following five (5) APCs:

CPT	TITLE	APC	RW	PMT
99281	Emergency dept visit CH	0609	0.7970	$50.76
99282	Emergency dept visit CH	0613	1.3137	$83.67
99283	Emergency dept visit CH	0614	2.0750	$132.17
99284	Emergency dept visit CH	0615	3.3377	$212.59
99285	Emergency dept visit CH	0616	4.9535	$315.51

OPPS ED/ER E&M

- In determining E&M level code assignment, CMS states "we will hold each facility accountable for following its own system for assigning the different levels of HCPCS (visit) 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 codes reported on the bill.

CHW ED E&M LEVEL CRITERIA GUIDE		
LEVEL 1 - CPT 99281	**LEVEL 2 - CPT 99282**	**LEVEL 3 - CPT 99283**
Minimal RN involvement	Limited RN care, single system	Intermediate RN care possible intervention
Disp: Discharge	Disp: Discharge	Disp: Discharge
Beyond triage, vital and DC instructions	**CARDIO-PULMONARY**	Minimum level for Ambulance arrival
CARDIO-PULMONARY	Hypertension	**CARDIO-PULMONARY**
No cardiac dx for this level	**EENT**	Arrhythmia Chronic
EENT	Conjunctivitis	Chest pain atypical w/no cardiac workup
Ear pain	Eye discharge	Costochondritis or chest wall pain
Nosebleed non active	Otits media or externa	Palpitations
Sore throat/pharyngitis	Mono	**EENT**
Toothache - no abscess	Sinusitis	Cerumen impaction
GASTRO-INTESTINAL	Strep throat	Corneal abrasion
Hemorrhoids	Stye Tonsillitis	Epistaxis/nosebleed/controlled
GENITO-URINARY//RENAL	**GASTRO-INTESTINAL**	Eye injury / Lost contact lens
No renal dx at this level	Constipation Diarrhea	Foreign body in eye, ear, nose or throat
MUSCULOSKELETAL	Nausea/vomiting	**GASTRO-INTESTINAL**
Joint pain non-traumatic	**GENITO-URINARY/RENAL**	Abd pain Attention to G tube
Muscle aches	Dysuria	Colitis Gastric pain, Upper due to GERD
NEURO	Urinary frequency/urgency	Gastritis acute, unspecified
No neuro dx at this level	Urinary incontinence	Gastroenteritis
OB/GYN	**MUSCULOSKELETAL**	GI Bleed/w coffee ground emesis or melena
No OB dx at this level	Contusions - extremities	Impaction Irritable Bowel Syndrome
Psych	Dislocation resolved prior to admit	**GENITO-URINARY/RENAL**
No psych dx at this level	Gout	Cystitis acute/ UTI
RESPIRATORY	Muscle spasm	Epididymitis/prostatitis
Cold symptoms (running nose, cough etc)	Sprains/strains, minor (finger,toe)	Urinary retention Urinary tube attention
w/o fever	**NEURO**	**MUSCULOSKELETAL**
	Numbness/Paresthesia	Back pain
SKIN	**OB/GYN**	Fracture (finger, toe) Minor
Abrasion	Menstrual cramping - no pelvic exam	Sprains & strains (back, neck, ankle) Major
Insect bite, non-venomous	**Psych**	Torso Contusion
Suture removal w/o anesthesia	No psych dx at this level	**NEURO**
	RESPIRATORY	Bell's Palsy
MISCELLANEOUS	Bronchitis	Dizziness/vertigo/labyrinthitis
Blood Draw Forensic/Legal	Hyperventilation - resolved	Headache Head injury w/o symptoms
Injection Follow up (ie: Rabies, Procrit)	Upper resp tract infection	Shingles Tremors
Medication refill		**OB/GYN**
School/Work Release	**SKIN**	Abortion, threatened
Triage protocol - left without being seen (Use	Foreign body simple (splinter)	Ovarian Cyst Pelvic Exam*
special ER Triage Charge, not Level 1)	Herpes	Pelvic inflammatory disease
	Local allergic reaction	Sexually transmitted disease
	Puncture wound extremity	Vaginal bleed/hemmorage minimal
	Rash Scabies	**Psych**
	Sunburn and 1 degree burns	Anxiety Depression
	MISCELLANEOUS	Panic attack
	Fever	**RESPIRATORY**
	Needle stick/exposure	Croup Dyspnea
	Hernia w/wo manual reduction	RSV Wheezing

LEVEL 4 - CPT 99284	LEVEL 5 - CPT 99285	CRITICAL CARE - CPT 99291,99292**
Disp: Discharge, Admit	Disp:Acute Transfer, Admit or Disch	Disp:dies in ED, Acute Transfer, ICU Admit, OR/Surgery
Minimum level for admission	Minimum level for admit to ICU or surgery	
CARDIO-PULMONARY	**CARDIO-PULMONARY**	**CARDIO-PULMONARY**
Acute Coronary Syndrome (ACS)	Anaphylaxis severe	Acute MI
Angina	Deep venous thrombosis	Aortic dissection
Arrhythmia new onset	Sepsis	Cardiac arrest
Chest pain/rule out cardiac origin	**EENT**	Cardiac tamponade
Congestive heart failure - stable	Epistaxis - with transfer out or to surgery	Hemophilia, ITP, TTP, leukemia or aplastic anemia
Hypertension Accelerated or Malignant	**GASTRO-INTESTINAL**	hypovolemic, anaphylactic)
Hypotension	Bowel obstruction	Leaking / ruptured aneurysm (thoracic,abdmnal)
Pleurisy		Precipitous Newborn
Syncope Tachycardia	GI Bleed - unstable hypotensive	Resuscitation
EENT	**GENITO-URINARY/RENAL**	Shock - any: Septic, Cardiogenic, Spinal
Epistaxis -multiple attempts to control	Chronic Renal failure	**EENT**
Peritonsillar abscess	**MUSCULOSKELETAL**	No EENT dx for this level
GASTRO-INTESTINAL	Cervical fracture Open fracture	**GASTRO-INTESTINAL**
Appendicitis Cholecystitis	Skull fracture Spinal fracture	Acute hepatic failure GI Bleed w/shock
Cholelithiasis Diverticulitis	**NEURO**	**GENITO-URINARY/RENAL**
GI Bleed - vomiting bright red blood/hematemesis	Headache w/neuro deficits	Acute Renal failure
Pancreatitis Ulcerative colitis	New onset Altered Mental Status	**MUSCULOSKELETAL**
GENITO-URINARY/RENAL	New onset of neurological deficits	Spinal cord injury
Hematuria Kidney stones	Pediatric meningitis	**NEURO**
Pyelonephritis Renal colic	Transient ischemic attack (TIA)	Cerebrovascular accident (CVA) acute
MUSCULOSKELETAL	**OB/GYN**	Cerebral or intracranial hemorrhage any type
Clavicle fracture Closed fracture excluding minor	Active labor	Head injury, unresponsive GCS < 8
C-spine precautions Dislocation	Ectopic pregnancy Sexual Assult	or w/new neuro deficits
NEURO	**Psych**	Paralysis new onset
Altered Level of Consciousness (LOC)	Psychosis,agitated or combative	Status epilepticus
Concussion	Suicidal/ homicidal (5150)	**OB/GYN**
Meningitis adult Migraine	**RESPIRATORY**	Ruptured ectopic pregnancy
Seizure Syncope	Hemo/Pneumothorax, except tension	**Psych**
OB/GYN	Near drowning	No psych dx at this level
Abortion Spontaneous	Pulmonary embolism	**RESPIRATORY**
Vaginal Hemorrhage/bleeding-moderate to severe	**SKIN**	Respiratory failure Status asthmaticus
Psych	Facial burns	Tension pneumothorax
Dementia Psychosis/non-combative	Tar burns	**SKIN**
RESPIRATORY	Venomous snake bite w/systemic response	None
Allergic reaction with airway compromise	2nd or 3rd degree burns > 1 area	**MISCELLANEOUS**
Asthma Acute Exacerbation		Hyper/hypothermia life threatening
Emphysema/COPD Pleural effusion	**MISCELLANEOUS**	Traumatic Injury(ies) life threatening
Pneumonia Pulmonary edema	Alcohol/drug withdrawal	Thyroid storm or addisonian crisis
Smoke inhalation	Diabetic coma Diabetic ketoacidosis (DKA)	
SKIN	Diabetes Mellitus uncontrolled	
Complex foreign body	Hypothermia	
Laceration(s) >10cm total	Pediatric transfer out	
3rd degree burns of 1 area, except face	Unconscious w/o vital function impairment	
MISCELLANEOUS		

Emergency Room E&M

CMS continues to hold facilities accountable for developing and consistently using their own E/M criteria.

It also states that the criteria must be valid, reasonable,and reliable. If it hasn't done so already, your facility must develop its own specific criteria that incorporate objectivity, measurability, and documentation requirements.

Don't incorporate procedures for which CMS pays separately in the E&M leveling criteria. Advise the ED to perform a spot check on claims to ensure that clinic documentation supports the visit level billed.

* Perform Charge reconciliation

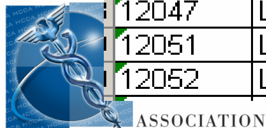
Overview of E&M CPT codes

- Utilize the leveling criteria.
- Based upon single or multiple presenting and established diagnosis, sign or symptoms
- One E&M CPT per visit.
- Select the E&M with "+ Procedure" on the charge form, for modifier 25 to be assigned, when visit includes the performance of a procedure.
- Documentation in the medical record must support the level.
- Charge entry is timely and accurate.

Procedures in the ED/ER

- Laceration Repair APCs – Addendum B

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
12001	Repair superficial wound(s)	CH	T	0133	1.2792	81.48	25.67	16.30
12002	Repair superficial wound(s)	CH	T	0133	1.2792	81.48	25.67	16.30
12004	Repair superficial wound(s)	CH	T	0133	1.2792	81.48	25.67	16.30
12005	Repair superficial wound(s)	CH	T	0133	1.2792	81.48	25.67	16.30
12006	Repair superficial wound(s)	CH	T	0133	1.2792	81.48	25.67	16.30
12007	Repair superficial wound(s)	CH	T	0133	1.2792	81.48	25.67	16.30
12011	Repair superficial wound(s)	CH	T	0133	1.2792	81.48	25.67	16.30
12013	Repair superficial wound(s)	CH	T	0133	1.2792	81.48	25.67	16.30
12014	Repair superficial wound(s)	CH	T	0133	1.2792	81.48	25.67	16.30
12015	Repair superficial wound(s)	CH	T	0133	1.2792	81.48	25.67	16.30
12016	Repair superficial wound(s)	CH	T	0133	1.2792	81.48	25.67	16.30
12017	Repair superficial wound(s)	CH	T	0133	1.2792	81.48	25.67	16.30
12018	Repair superficial wound(s)	CH	T	0133	1.2792	81.48	25.67	16.30
12020	Closure of split wound	CH	T	0135	4.5263	288.30		57.66
12021	Closure of split wound	CH	T	0135	4.5263	288.30		57.66
12031	Layer closure of wound(s)	CH	T	0134	2.1051	134.08	42.24	26.82
12032	Layer closure of wound(s)	CH	T	0134	2.1051	134.08	42.24	26.82
12034	Layer closure of wound(s)	CH	T	0134	2.1051	134.08	42.24	26.82
12035	Layer closure of wound(s)	CH	T	0134	2.1051	134.08	42.24	26.82
12036	Layer closure of wound(s)	CH	T	0134	2.1051	134.08	42.24	26.82
12037	Layer closure of wound(s)	CH	T	0134	2.1051	134.08	42.24	26.82
12041	Layer closure of wound(s)	CH	T	0134	2.1051	134.08	42.24	26.82
12042	Layer closure of wound(s)	CH	T	0134	2.1051	134.08	42.24	26.82
12044	Layer closure of wound(s)	CH	T	0134	2.1051	134.08	42.24	26.82
12045	Layer closure of wound(s)	CH	T	0134	2.1051	134.08	42.24	26.82
12046	Layer closure of wound(s)	CH	T	0134	2.1051	134.08	42.24	26.82
12047	Layer closure of wound(s)	CH	T	0134	2.1051	134.08	42.24	26.82
12051	Layer closure of wound(s)	CH	T	0134	2.1051	134.08	42.24	26.82
12052	Layer closure of wound(s)	CH	T	0134	2.1051	134.08	42.24	26.82



Laceration Repair description

- **CPT codes: 12001-12007** (12001, 12002, 12004, 12005, 12006, 12007)

12001 **12001** Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

- The physician sutures superficial lacerations of the scalp, neck, axillae, external genitalia, trunk, or extremities. A local anesthetic is injected around the laceration and the wound is thoroughly cleansed, explored, and often irrigated with a saline solution. The physician performs a simple, one-layer repair of the epidermis, dermis, or subcutaneous tissues with sutures. With multiple wounds of the same complexity and in the same anatomical area, the length of all wounds sutured is summed and reported as one total length.
- Report 12001 for a total length of 2.5 cm or less, 12002 for 2.6 cm to 7.5 cm, 12004 for 7.6 cm to 12.5 cm, 12005 for 12.6 cm to 20 cm, 12006 for 20.1 cm to 30 cm, and 12007 if the total length is greater than 30 cm.

Procedures in the ED/ER

- Fracture Care or Treatment

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment	
23180	Remove collar bone lesion		T	0050	29.1900	1859.23		371.85	
23182	Remove shoulder blade lesion		T	0050	29.1900	1859.23		371.85	
23184	Remove humerus lesion		T	0050	29.1900	1859.23		371.85	
23190	Partial removal of scapula		T	0050	29.1900	1859.23		371.85	
23195	Removal of head of humerus		T	0050	29.1900	1859.23		371.85	
23200	Removal of collar bone		C						
23210	Removal of shoulder blade		C						
23220	Partial removal of humerus		C						
23221	Partial removal of humerus		C						
23222	Partial removal of humerus		C						
23330	Remove shoulder foreign body		T	0020	8.6850	553.18		110.64	
23331	Remove shoulder foreign body		T	0022	21.1098	1344.57	354.45	268.91	
23332	Remove shoulder foreign body		C						
23350	Injection for shoulder x-ray		N						
23395	Muscle transfer,shoulder/arm		T	0051	42.9850	2737.89		547.58	
23397	Muscle transfers		T	0052	79.4244	5058.86		1011.77	
23400	Fixation of shoulder blade		T	0050	29.1900	1859.23		371.85	
23405	Incision of tendon & muscle		T	0050	29.1900	1859.23		371.85	
23406	Incise tendon(s) & muscle(s)		T	0050	29.1900	1859.23		371.85	
23410	Repair rotator cuff, acute		T	0051	42.9850	2737.89		547.58	
23412	Repair rotator cuff, chronic		T	0051	42.9850	2737.89		547.58	

APC 0050 for CPT 23184 Removal Humerus Lesion

APC 0051 for CPT 23410 Repair rotator cuff, chronic

Included in resources

- When a nurse provides care in a hospital outpatient department, the hospital bills for the care services as a facility charge and is reimbursed under APCs. The facility charge does not strictly represent the care/services per se; instead, it constitutes the resources the facility expends in providing the service. These resources could include the following:
  - • Use of the facility equipment/room
  - • Supplies & Dressing
  - • Medications
  - • Nursing staff
  - Discharge Instructions
  - Education
  - • Any other resources used in providing care

Components of the Facility E&M Leveling Criteria

- There are several components that should be assessed to determine which E&M level should be charged for hospital ED/ER.
  - Presenting diagnosis
  - Level of nursing care via resources used (not separately billable)
  - Conditions that are both acute and chronic
  - Patients with multiple symptoms
- Procedures that are separately reimbursed are not included in the criteria matrix ie EKG, X-rays, Lab, surgical procedures, etc.

E&M When a Procedure is Performed – Modifier 25

- In order for a payor to recognize that the procedure was performed on the same date as the evaluation and management (E&M) service and that it was separate and distinct, it is necessary to append modifier 25 to the E&M CPT code in order to be considered for separate payment.
  - So a modifier to the E&M code is assigned

ED/ER E&M with Procedure

- The ED/ER CDM Standard has separate line item charges to charge the E&M code with a modifier 25.
- It is important to consistently apply this modifier.
- Medicare has stated that modifier 25 is required when a procedure with a status indicator of <u>'S' or 'T'</u> (check Addendum B) has been coded and reported with an E&M CPT code.

Know the Different CPTs - Represented Within the Procedure Details

- CPT 23520 Closed treatment of sternoclavicular dislocation; without manipulation
  - The physician treats a dislocation of the joint between the sternum and the clavicle (sternoclavicular) without making incisions and without any manipulation in 23520. The physician applies a splint or brace to hold the joint in place until it has healed. In 23525, manipulation is required. Anesthesia may be necessary. The physician pushes, pulls, or moves the arm and chest to restore the joint to correct position and alignment. After manipulation, the patient is placed in a brace or splint..
- CPT 23530 Open treatment of sternoclavicular dislocation, acute or chronic;
  - The physician treats a chronic or acute dislocation of the sternoclavicular joint. The physician makes an incision overlying the joint between the clavicle and sternum where the dislocation has occurred. The tissues are dissected down to the joint and the dislocation is visualized. The physician may debride the area before realigning the joint back to proper position. In 23532, the physician harvests a fascial graft from the patient through a separate incision. The physician repairs the surgically created graft donor site. The fascial graft is attached to the bones in the sternoclavicular joint, preventing recurrent dislocation. Fixation may be applied. The joint is irrigated and the incision is closed in layers. A splint or brace may be applied to the outside of the body.

Specific and detailed physician documentation is critical

Clinical Documentation of the procedure

- Documentation of any procedure performed in the ED/ER must be present in the medical record
  - Written or dictated report
  - Timely
  - Legible – if it can't be read it may not get coded
- Critical for the correct CPT code assignment and payment

Charge/Encounter Form to the ED/ER

Enter quantity of each nursing procedure performed. Note: Use E/M Level w/procedure if any (*) items are checked.

CDM #	QTY	CDM DESCRIPTION	CDM #	QTY	CDM DESCRIPTION
		ER TRIAGE			*ANOSCOPY/LARYNGOSCOPY DIAG
		ER LEVEL 1			*APPLICATION OF CAST
		ER LEVEL 2			*APPLICATION OF SPLINT
		ER LEVEL 3			*ARTERIAL PUNC/CATH/CANN
		ER LEVEL 4			*AVULSION NAIL PLATE EACH ADD
		ER LEVEL 5			*CHANGE CYSTOSTOMY TUBE COMPLEX
		*ER LEVEL1 W/PROCEDURE			*CHANGE TUBE SIMPLE
		*ER LEVEL 2 W/PROCEDURE			*CLOSE WOUND LATE COMPLEX
		*ER LEVEL 3 W/PROCEDURE			*CLOSE/PACK WND DEHISCEN SMPL
		*ER LEVEL 4 W/PROCEDURE			*COLPOCENTESIS
		*ER LEVEL 5 W/PROCEDURE			*CONTRL NOSEBLED/CHEM CAUTERY
		ER CRITICAL CARE 30-74MIN			*DEBR SKIN EA ADD 10%
		**ER CRITICAL CARE W/PROCEDURE			*DEBRID/AVULSION NAIL,EVAC HEMA
		ER EMTALA MED SCRN EXAM			*DEBRIDE OPEN FX W/FB REMOV
		ER EVIDENTIARY EXAM			*DEBRIDEMENT SKIN/SUBQ/MUS/BONE
		LEFT WO BEING SEEN STAT			*DRESS/DEBRIDE BURN
		OBSERVATION STATISTIC			*EPIDURAL BLOOD PATCH
		ER BED STATISTIC			*EPISIOTOMY VAGINAL REPAIR
		INPT BED HOLD PER HOUR			*EXC NAIL MATRIX REM PHALANX
		ER OBSERVATION PER HOUR			*EXCISE/REPR NAIL; INGROWN
		ER WORKERS COMP 1ST HOUR			*FETAL NON-STRESS TEST
		ER WORKERS COMP EA ADD HOUR			*HEMORRHOID EXC/INC SIMPLE
		TAXI FARE			*INCISION/DRAINAGE/ASP COMPLEX
		ER PROCEDURES (not HIM coded)			*INCISION/DRAINAGE/ASP SIMPLE
		ADMIN OTHER IMMUN VACCINE ONE			*INJ NERVE/OTHR ASP/INJ JOINT
		ADMIN OTHER IMMUN VAC EA ADD			*INSERT CATH BLADDER
		IV INFUSION THERAPY 1ST HR			*INSERT OR REPL NONTUN/PICC WO
		IV INFUSION THER ADD MAX 8			*INSERT PERITONL CATH/CANN TEMP
		INJECT TX/DX SUBQ/IM			*INS/REM TUN CV CATH/PERIP CVAD
		INJECT TX/DX INTRA-ARTERIAL			*INSERT TUNNEL CVAD
		INJECT TX/DX INTRAVENOUS			*INS/REPL TEMP PACER ELECTRODE
		INJECT ANTIBIOTIC IM			*INTUBATION ENDOTRACHEAL
		INJECT ANTIBIOTIC IM ADDL			*IRRIG/LAVG/INSTL BLADDER
		ADMIN HEP B VACCINE			*LACERATION REPAIR COMPLEX
		ADMIN INFLUENZA VACCINE			*LACERATION REPAIR CPLX ADD<5CM
		ADMIN PNEUMO VACCINE			*LACERATION REPAIR INTERMEDATE
		CONSCIOUS SEDATION IV/IM/INH			*LACERATION REPAIR SIMPLE
		CONSC SEDATION ORAL/RECTL/NASL			*LUMBAR PUNCTURE
		*EMERG ROOM CPR			*PERICARDIOCENTESIS INITIAL
		*CARDIOVERSION			*PLACE NEEDLE INTRAOSSEO INFUS
		THROMBOLYSIS, CORONARY IV			*PLACE/LAV NASO/OROGAS TUBE
		PACING TRANSCUTANEOUS			*REMOVE CERUMEN IMPACTED

Other Services to Charge/code for . . .

1. **Finger Sticks –** Need to report all finger sticks with CPT 82962 ($ pd lab fee). Need MD order and documentation of the results in the medical record. Verify if your facility has a CLIA certificate. If yes, must use –QW modifier.
2. **Urine Dip –** Use CPT 81000 ($pd lab fee) to report urine dip, non-automated with microscopy. Use CPT 81002 to report urine dip, non-automated without microscopy. Need MD order and documentation of the results in the medical record. Verify if your facility has a CLIA certificate. If yes, must use –QW modifier.
3. **Blood Draws –** Use CPT 36415 venipuncture ($ pd) when performed by Nursing in the ED
4. **Pulse Oximetry –** Assign CPT 94760 for pulse oximetry. It is a packaged service under OPPS, but should still be charged

Documentation must be present in the medical record

Other Services to Charge/code for . . .

- **Irrigation & Foley Catheter Insertion, other than for a urine sample:**
- **Foley Catheter:** There are 3 CPT codes (51701, 51702, & 51703) available and should be assigned accordingly. *Effective 1/1/06, Medicare will reimburse for these procedures.*
  - **MD Order and documentation in the medical record**

51700	Irrigation of bladder		T	0164	2.0077	127.88		25.58
51701	Insert bladder catheter		X	0340	0.6310	40.19		8.04
51702	Insert temp bladder cath		X	0340	0.6310	40.19		8.04
51703	Insert bladder cath, complex		T	0126	1.0356	65.96	16.21	13.19
51705	Change of bladder tube	CH	T	0164	2.0077	127.88		25.58
51710	Change of bladder tube	CH	T	0427	15.3545	977.99		195.60

P Code - Change

- Urinary Catheterization:
  - **P9612 Catheterize for urine specimen…. now has a status indicator A meaning paid on Lab fee schedule ($3.00).**
  - P9615 Urine specimen collect mult…. Paid on lab fee schedule ($3.00)
  - Do not assign 51701, 51702, & 51703 for a catheterization for the purpose of a urine specimen or for just a urine specimen collection
- CDM driven
  - Update your charge form, educate your staff
- Important for OPPS

Injections/Infusion in the ED/ER

- This service was covered in detail in a prior session.
- **Injections –** Injection Administration should be charged based on the number of syringes used ($pd); not the number of drugs administered. Review Nursing documentation.
- Review for an MD order. Charge in addition for the actual drug/medication J/C codes (Pharmacy)
- **Infusions –** Non-Chemo Infusion charges MUST be based upon the documented start and stop time of each substance infused.

- Rules change… so auditors and staff must keep up to date!

Injection/Infusion is complex – audit this area!!

Infusion / Hydration (single)

Piggyback (IVPB) (Concurrent if two in the same line, same time)

Push Injection

Audit Infusions Services in the ED/ER, in Chemotherapy or in Infusion Unit/Dept.

Is there an MD order?

90760	Hydration iv infusion, init		S	0440	1.7998	114.64		22.93
90761	Hydrate iv infusion, add-on		S	0437	0.3945	25.13		5.03
90765	Ther/proph/diag iv inf, init		S	0440	1.7998	114.64		22.93
90766	Ther/proph/dg iv inf, add-on		S	0437	0.3945	25.13		5.03
90767	Tx/proph/dg addl seq iv inf		S	0437	0.3945	25.13		5.03
90768	Ther/diag concurrent inf		N					
90769	Sc ther infusion, up to 1 hr	NI	S	0440	1.7998	114.64		22.93
90770	Sc ther infusion, addl hr	NI	S	0437	0.3945	25.13		5.03
90771	Sc ther infusion, reset pump	NI	S	0438	0.8041	51.22		10.24
90772	Ther/proph/diag inj, sc/im		S	0437	0.3945	25.13		5.03
90773	Ther/proph/diag inj, ia		S	0438	0.8041	51.22		10.24
90774	Ther/proph/diag inj, iv push		S	0438	0.8041	51.22		10.24
90775	Tx/pro/dx inj new drug addon		S	0438	0.8041	51.22		10.24
90776	Tx/pro/dx inj same drug adon	NI	N					
90779	Ther/prop/diag inj/inf proc		S	0436	0.2545	16.21		3.24

Is there documentation that the service was provided?

Start and stop times for infusion (check with FI requirements)

Chemotherapy APCs

96401	Chemo, anti-neopl, sq/im		S	0438	0.8041	51.22		10.24
96402	Chemo hormon antineopl sq/im		S	0438	0.8041	51.22		10.24
96405	Chemo intralesional, up to 7		S	0438	0.8041	51.22		10.24
96406	Chemo intralesional over 7		S	0438	0.8041	51.22		10.24
96409	Chemo, iv push, sngl drug		S	0439	1.6544	105.38		21.08
96411	Chemo, iv push, addl drug		S	0439	1.6544	105.38		21.08
96413	Chemo, iv infusion, 1 hr		S	0441	2.3446	149.34		29.87
96415	Chemo, iv infusion, addl hr		S	0438	0.8041	51.22		10.24
96416	Chemo prolong infuse w/pump		S	0441	2.3446	149.34		29.87
96417	Chemo iv infus each addl seq		S	0438	0.8041	51.22		10.24
96420	Chemo, ia, push tecnique		S	0439	1.6544	105.38		21.08
96422	Chemo ia infusion up to 1 hr		S	0441	2.3446	149.34		29.87
96423	Chemo ia infuse each addl hr		S	0438	0.8041	51.22		10.24
96425	Chemotherapy,infusion method		S	0441	2.3446	149.34		29.87
96440	Chemotherapy, intracavitary		S	0441	2.3446	149.34		29.87
96445	Chemotherapy, intracavitary		S	0441	2.3446	149.34		29.87
96450	Chemotherapy, into CNS		S	0441	2.3446	149.34		29.87
96521	Refill/maint, portable pump		S	0440	1.7998	114.64		22.93
96522	Refill/maint pump/resvr syst		S	0440	1.7998	114.64		22.93
96523	Irrig drug delivery device		Q	0624	0.5689	36.24	12.65	7.25
96542	Chemotherapy injection		S	0438	0.8041	51.22		10.24
96549	Chemotherapy, unspecified		S	0436	0.2545	16.21		3.24
96567	Photodynamic tx, skin	CH	T	0013	0.7930	50.51		10.10
96570	Photodynamic tx, 30 min		T	0015	1.4595	92.96		18.59
96571	Photodynamic tx, addl 15 min		T	0015	1.4595	92.96		18.59
96900	Ultraviolet light therapy		S	0001	0.4806	30.61	7.00	6.12
96902	Trichogram		N					
96904	Whole body photography		N					
96910	Photochemotherapy with UV-B		S	0001	0.4806	30.61	7.00	6.12
96912	Photochemotherapy with UV-A		S	0001	0.4806	30.61	7.00	6.12
96913	Photochemotherapy, UV-A or B		S	0683	2.6045	165.89		33.18

Infusion Key Questions to Ask When Auditing…

- Why is the patient here?
- What did the patient receive?
- How was it given?
- How long did it take?

Audit Other Services Charged/coded . . .

- **Tetanus (Td) Injection** – Requires two CPT code 90471 & 90718. Caution the codes are "age" specific. Review for MD orders and nursing documentation. Caution that the toxoid isn't charged via Pharmacy as a J code. *Effective 1/1/06, Medicare will reimburse for CPT 90471.*

Don't also charge/code the injection code 90772 for tetanus admin

Audit Drugs - Pharmacy

Drugs – Use J and C HCPCS codes when appropriate. Need to report all codes with appropriate units, follow Medicare guidelines regarding waste. Need to report even if packaged. Make certain administration codes have been charged.

Audit the “units” – dosage versus what was charged and given

Review CMS guidance regarding “waste”

Other Services to Charge/code for . . .

- **Blood Transfusion** – CPT 36430 must be assigned for the transfusion and the blood bank should charge for the blood product with appropriate P code (PRBC = P9021).
  - Units for the blood product
  - Administration – once per encounter 36430

Audit - Charging for Blood and Blood Products

- Always use the "P" code for blood and blood products
  - The revenue code, units, and charge alone are not sufficient for payment
- When you have a blood or blood product code, you should also report the blood administration CPT code 36430
- Also report a blood draw code and associated labs
- Audit your internal practices by running a report

Review the Encounter/Charge Form

- Ask to see the Charge form
- The outpatient department must/should have a encounter/charge form as a mechanism to capture all related charges for **each** encounter/visit for **each** patient. (ED/ER, Chemo, Wound Care, etc.)
- The encounter/charge form should accurately reflect current and appropriate CDM charge codes for services/tests or treatment/procedures provided.
- The encounter/charge form should be reviewed & revised annually.

Encounter/Charge Form (con't)

- The encounter/charge form has been changed to uniformly capture ED/ER facility levels and associate procedures performed.
- It is the responsibility of the nursing staff to document (TIMELY and ACCURATELY) all ED/ER facility services provided for each patient encounter/visit.
- It is also the physicians' responsibility to document timely, thoroughly and accurately.

Example Encounter/Charge Form

Make sure the ED/ER Charge form is correct.

Enter quantity of each nursing procedure performed.

QTY	CDM #	CDM DESCRIPTION	CPT	MOD
		ER E/M LEVELS, CRIT CARE		
		LEFT W/O BEING SEEN STATISTICAL		
		ER LEVEL 1	99281	
		ER LEVEL 2	99282	
		ER LEVEL 3	99283	
		ER LEVEL 4	99284	
		ER LEVEL 5	99285	
		ER LEVEL1 W/PROCEDURE	99281	25
		ER LEVEL 2 W/PROCEDURE	99282	25
		ER LEVEL 3 W/PROCEDURE	99283	25
		ER LEVEL 4 W/PROCEDURE	99284	25
		ER LEVEL 5 W/PROCEDURE	99285	25
		ER EMTALA MED SCRN EXAM	99281	
		ER CRITICAL CARE 30-74MIN	99291	
		ER CRITICAL CARE W/PROCEDURE	99291	25
		ER PROCEDURES		
		INJ ANTIBIOTIC IM	90788	
		INJECT TX/DX INTRAVENOUS	90784	
		INJ TX/DX SUB-Q/IM	90782	
		IV INFUSION THERPY 1ST HR	90780	
		IV INFUS THER ADD HR MAX8	90781	
		INJ TX/DX INTRA-ARTERIAL	90783	
		ADMIN OTHER IMMUN VAC INITIAL	90471	
		ADMIN OTHER IMMUN VAC ADDITL	90472	
		ADMIN INFLUENZA VACCINE	G0008	
		ADMIN HEP B VACCINE	G0010	
		ADMIN PNEUMO VACCINE	G0009	

QTY	CDM #	CDM DESCRIPTION	CPT
		MUSC/SKEL/SKIN/WD/LACERAT	
		APPLICATION OF CAST	
		APPLICATION OF SPLINT	
		STRAPPING	
		WINDOWING/WEDGING OF CAST	
		REMOV/BIVALV CAST ARM/LEG	29705
		LACERATION REPAIR SIMPLE	
		LAC RPR INTERMEDATE	
		LACERATION REPAIR COMPLEX	
		LAC REPAIR CPLX ADD<5CM	
		REMOVE FOREIGN BODY SIMPLE	
		REMOVE FB INTERMEDIATE	
		REMOVE FB COMPLEX	
		REPR HAND/FINGER EXTENSOR	
		INCIS/DRAIN/ASPIR SIMPLE	
		INCIS/DRAIN/ASPIR COMPLEX	
		TX BURN 1ST DEGREE INITIAL	16000
		DRESS/DEBRIDE BURN	
		DEBRIDE SKIN/SUBQ/MUS/BONE	
		DEBRIDE SKIN EA ADD 10%	
		DEBRIDE OPEN FX W/FB REMOV	
		DEBRID/AVUL NAIL,EVAC HEMAT	
		AVULSION NAIL PLATE EA ADD	
		EXC NAIL MATRIX REM PHALANX	
		EXCISE/REPR NAIL; INGROWN	

Audit Hospital-Based Clinics

- If being based under OPPS
- ICD-9-CM diagnosis codes
- MD Orders
- Documentation
- CPT procedures
- CPT E&M
- Modifiers

Hospital Based Clinic – Visits (E&M)

99201	Office/outpatient visit, new		V	0604	0.8388	53.43		10.69
99202	Office/outpatient visit, new		V	0605	0.9964	63.46		12.69
99203	Office/outpatient visit, new		V	0606	1.3226	84.24		16.85
99204	Office/outpatient visit, new		V	0607	1.6604	105.76		21.15
99205	Office/outpatient visit, new	CH	Q	0608	2.1740	138.47		27.69
99211	Office/outpatient visit, est		V	0604	0.8388	53.43		10.69
99212	Office/outpatient visit, est		V	0605	0.9964	63.46		12.69
99213	Office/outpatient visit, est		V	0605	0.9964	63.46		12.69
99214	Office/outpatient visit, est		V	0606	1.3226	84.24		16.85
99215	Office/outpatient visit, est	CH	Q	0607	1.6604	105.76		21.15

Audit Wound Care

- OIG area of interest
  - 2 published report in 2007
- Documentation of surgical debridements
- Medical Necessity of surgical debridements
- Surgical debridements in addition to E&M visit on the same day

OPPS – Wound Care

97597	Active wound care/20 cm or <	CH	T	0015	1.4595	92.96		18.59
97598	Active wound care > 20 cm	CH	T	0015	1.4595	92.96		18.59
97602	Wound(s) care non-selective	CH	T	0015	1.4595	92.96		18.59
97605	Neg press wound tx, < 50 cm	CH	T	0013	0.7930	50.51		10.10
97606	Neg press wound tx, > 50 cm	CH	T	0015	1.4595	92.96		18.59

Audit HBO

- Review CMS coverage guidance
- MD order
- Frequency of HBO treatments
- C code versus CPT code
- Documentation of services by staff
- Documentation of improvement and benefits of HBO treatment

The Role of HIM/Coding

- Health Information Management/Coding staff will review the medical record documentation and assign the specific ICD-9-CM diagnosis code or codes.
- ? HIM/Coding will review the medical record documentation and assign the surgical range CPT code(s).
  - This will link to the “charge/fee $ code” and crosswalk to the bill/claim. Check the UB as there may be crosswalk issues (IT).

Physician Order

- A MD order is required for all services administered/provided to the patient.
- The MD order should contain a diagnosis to support medical necessity.
  - Verify that the medical record has an MD order(s)
- It should also contain details regarding method of administration, drug, dosage and frequency.
- Every MD order should be signed and dated.

Work Flow? . . . Walk through the departmental process

- Review the work flow
  - Paper process and trail
- Triage in ED/ER
- Admitting/Registration
- Patient is received at the department
- Nursing takes a history and vitals (triage)
- Clinician takes history and documents information.
  - Review MD orders
- Treatment/services are given to the patient.
  - Documentation in the medical record
- Patient is discharged.
- Charge for service on the encounter/charge form.

Case Example #1

- 3 year old male child comes to the ED/ER with parents complaining of ear pain. Triaged (vitals taken) and Registration completed.
- Taken to Room by nursing.
- History taken from the parents and family members and the Physician examines the patient. HEENT examined.
- Diagnosed with Otitis Media and Upper Respiratory Infection
  - Instructed to p/u medication at Pharmacy
  - Drink fluids and see pediatrician in 2 days

- What level E&M CPT code does this represent? ____________

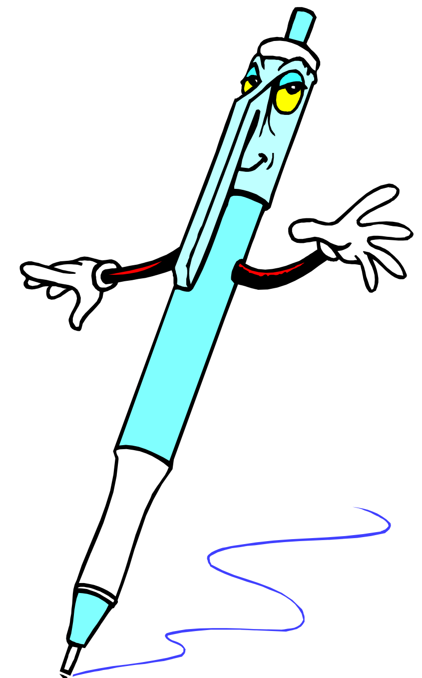
Case Example #2

- 65 year old male was involved in a fall from a ladder at his daughter's home while putting up Christmas lights. Patient fell 10 feet landing on his left arm and left hip. An ambulance was called and the patient was transported to the trauma unit.
- In the ED/ER, the patient was examined. The patient has a history of a CVA in the past without any residual. Patient is taking levaquin for a recent bronchitis. Examination including extremities, cardiac, neuro, and respiratory systems was performed. An x-ray of the left arm, hip and chest were performed as well as an EKG. He was placed on a cardiac monitor and noted to have some Atrial Fib.
- X-ray confirmed a Colles' fracture of the left wrist and a intertrochanteric fracture of the hip. Admission was advised but since the patient was now stable he wanted to be hospitalized at a hospital near his home, so transfer was arranged via ambulance.
- What level E&M CPT code would be assigned? __________

Again, Let's Talk About Documentation

- The documentation, in your office record ***MUST BE***:
  - TIMELY
  - THOROUGH & CONCISE
  - LEGIBLE
  - DETAILED & SPECIFIC

  Every entry should be ***SIGNED, DATED and TIMED***.



Summary - ED/ER APC Specific Documentation Risks

- Lack of Documentation to Support the procedures charged, lack of orders
- Lack of Documentation to Support E/M Assignment
- Lack of Documentation to Support Modifier Use

Summary – Auditing

- Reimbursement covers overhead, such as costs for electricity, square footage, supplies, packaged drugs, and equipment.
- Claim Line item detail via codes for payment
- Outpatient department directors/managers need to be attentive to charging processes
- Up to date CDM – outpatient directors/mgrs must know its contents

Summary – Auditing

- Complete and accurate Charge/encounter form
- Auditors determine if coders should have the ability and tools to add charges to the accounts so that the coding and charges are appropriate

Summary and Auditing Next Steps

- Is there a written policy to support the E&M leveling criteria?
- Written policy to support the charge/encounter form process and usage?
- Daily charge reconciliation is imperative for proper OPPS payment
- Clinical Documentation it a must!
- Self-audit off and on
- Are the key departments working as a “team”?
- Compliance is your role…

Questions

- Are there any questions?

Resources/References

- OPPS Final Rule 2000
- OPPS Final Rule 2007 and 2008
- Coder's Desk Reference 2008
- AHA Outpatient Services CPT 2005 & 2006, 2007 and 2008
- AHA CPT Book 2007 and 2008
- Addendum B 2007 and 2008

Thank you

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