Advanced Coding Scenarios: An Expert Review

Audio Seminar/ Webinar
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AHIMA Books by Ms. Kuehn

- Procedural Coding and Reimbursement for Physician Services
- Effective Management of Coding Services
- CCS-P Exam Preparation Guide
- A Practical Approach to Analyzing Healthcare Data

Available at www.ahimastore.org
Presentation Objectives

- Answer your outpatient diagnostic or procedural questions
- Cite sources from currently published coding advice
- Additional question and answer session

Sources for Today’s Questions

- AHA's Coding Clinic for ICD-9-CM
- AHA's Coding Clinic for HCPCS
- AMA's CPT Assistant
- The Official ICD-9-CM Guidelines for Coding and Reporting, Section IV. Diagnostic Coding and Reporting for Outpatient Services
- Medicare Frequently Asked Questions, National Coverage Decisions and other published material
AHA’s Coding Clinic for ICD-9-CM

- “The official publication for ICD-9-CM coding guidelines and advice”


AHA’s Coding Clinic for HCPCS

- “The official publication for Level I HCPCS (CPT-4 codes) for hospital providers and specific Level II HCPCS codes for hospitals, physicians and other health professionals.”
- Same web location
AMA’s CPT® Assistant

- Official source on CPT for physicians and professional fee coders
- AMABookstore.com and search for “CPT Assistant” or

CMS Website

- www.cms.hhs.gov
- Transmittals at
  http://www.cms.hhs.gov/Transmittals/
- Frequently Asked Questions at
  “Questions” on blue menu bar in upper middle, or
Who Do We Believe?

- The official source for CPT (HCPCS Level I) codes for the hospital outpatient coder is Coding Clinic.
- The official source for CPT (HCPCS Level I) codes for the professional fee coder is CPT Assistant.
- The official source for HCPCS Level II codes is Coding Clinic for all coders.

Diagnostic Coding for Ancillary Tests

- “We regularly are questioned regarding the codes we have selected and have become much more conservative as a result. This has caused much delay in our department and with the physicians on our staff. Are we trying to be over-specific?”
- The patient comes for a radiology exam.
- Their facility method is to code the diagnosis from the order for the services, not the report.
Diagnostic Coding for Ancillary Testing

- Q1 – “The diagnosis on the order: COPD, SOB. The exam is a chest x-ray. They are requested to code both the COPD and the shortness of breath.”
- Shortness of breath is the presenting symptom and COPD is the clinical history.

Diagnostic Coding for Ancillary Testing

- The Official ICD-9-CM Guidelines, Section IV, H tells us:
  - List first the ICD-9-CM code for the diagnosis, condition, problem or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.
Diagnostic Coding for Ancillary Testing

- Q2 – “The diagnosis is avascular necrosis right hip, hip pain. The request is for us to code both the necrosis and the hip pain.”
- Merck Manual Online
  http://www.merck.com/mmhe/sec05/ch064/ch064a.html
- Same guideline but different set of circumstances.

Avascular necrosis already diagnosed.
- Pain was the first symptom listed in the Merck Manual.
- Unless they suspect a new disease process, they are monitoring the disease of avascular necrosis.
- Hip pain would not be coded.
Diagnostic Coding for Ancillary Testing

- Another facility sent us a similar question, asking:
- Q3 - “CMS has clarified for physicians that read the reports to bill out the diagnosis of findings (radiologist would use the finding of DJD, a pathologist would use their findings). Would the facility also do the same?”
- Coding Clinic for ICD-9-CM, 1st Qtr, 2002

New to Facility Coding

- Q4 - The coder says “I coded for a physician for 6 years and very recently changed jobs to code hospital outpatient work. I’m having a hard time knowing when things are the same and when they’re different in procedure coding. Do I code drugs the same way I did before? I mean using the HCPCS code amount and rounding up to the next whole unit.”
- This is the same for Pro Fee and Facility.
- Coding Clinic for HCPCS, 1st Qtr, 2005 and 3rd Qtr, 2005 both cover this issue.
**New to Facility Coding**

- Q5 - “My other question is about the surgical global. The GYN did an I&D of a perineal abscess 3 days ago. The patient returned for repeat I&D of the abscess of the perineum. Can I code this? Are the globals the same for the facility?”
- Not the same for Pro Fee and Facility
- Coding Clinic for HCPCS, 4th Qtr, 2004 handles a similar issue.

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**New to Facility Coding**

- Q6 – “Do I code casting supplies like I did in the physician office? No one here knows anything about this and I don’t want to miss the supplies, if I’m supposed to code them.”
- Not the same for Pro Fee and Facility
- Coding Clinic for HCPCS, 2nd qtr 2002
New to Facility Coding

- Q codes are not to be used by the Facility.
- Casting supplies are to be billed separately but with a revenue code 027X
- Physicians code the cast supplies using Q codes.
- Ask if supplies are being coded in the ED, Orthopedics or a cast lab?

Modifiers

- Q7- “We have lots of specialty clinics and our patients see multiple physicians on the same day. Our visits are coded in the clinics and we spend a considerable amount of time checking for this and applying modifiers before claims are submitted. Is modifier 27 really necessary?”
- Medicare FAQ ID #2390, last updated on 11-4-09
Modifiers

- Modifier 27 seems necessary.
- CPT Assistant, May 2003, pgs 7-16.
- It tells us that when more than one E/M service was delivered on the same day, apply modifier 27 to the 2nd and subsequent visits of the day.
- Don’t forget that you need Condition Code G0 when more than one visit occurs in the same revenue code.

Modifiers

- Q8 - “Does the patient have to die to qualify for the use of a CA modifier?”
- Coding Clinic for HCPCS, 1st qtr, 2003 and 4th qtr, 2005
Modifiers

- Q9 - Outpatient coder in a community hospital
- “Our orthopedist does mini-open rotator cuff repairs with arthroscopic labral debridement and subacromial decompression. My codes are 29826, 23412, and 29822. Which ones get the modifier 59?”

Modifiers

- Rotator cuff repair includes the labral debridement
- Codes would be 23412, 29826-59
- Would not report 29822.
Modifiers

Q10 - Discontinued procedure?

The physician documents this about a percutaneous repair of a finger fracture with 3 bone fragments. “Several attempts were made to reduce the fracture. We placed a wire through the distal PIP but x-rays showed less than optimal alignment. Several attempts were made to have the wire align the fracture in all planes, without success. Ultimately a simultaneous, bidirectional wire approach was our only success at proper alignment, confirmed on x-ray.”

Coding Clinic for HCPCS, 3rd qtr, 2007

The unsuccessful attempts are considered a part of the successful procedure.

Different from a discontinued procedure. Procedure was not attempted or partially attempted and, for some reason, was cancelled or not completed.
Modifiers

- Discontinued after administration of anesthesia = modifier 74
- Discontinued after prep but before administration of anesthesia = modifier 73

Q11 - “Our orthopedic department orders pre- and post-reduction x-rays when they set certain fractures. Is this an appropriate situation for the use of modifier 76? It is listed as a hospital outpatient modifier but says it’s a repeat procedure or service by the same physician. Is this OK on a facility claim?”

Coding Clinic for HCPCS, 2nd Qtr, 2009
Modifiers

Q12 - “The OIG workplan lists Medicare Billings with Modifier GY as an area being studied. Why would they care about Modifier GY if it means that we won't get payment? Can you explain this? I must be missing something.”

Transmittal B-02-020, March 27, 2002

Modifiers

- Modifier GA - Waiver of liability statement on file (Used when service is expected to be denied and an ABN IS on file)
- Modifier GZ - Item or service expected to be denied as not reasonable and necessary (Used when an ABN is NOT on file)
- Modifier GY - Item or service statutorily excluded or does not meet the definition of any Medicare benefit
Modifiers

- Very hard to tell what is “statutorily excluded”

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

Choose PFS Relative Value Files
Page down to 2010
Download zipped file
Unzip and open PPRRVU10.xls
Translation file is RVUPUF10.pdf
Procedures

- Q13 – Foreign body removal
  “We go back and forth with the urgent care physicians about whether they have to make an incision to code for a subcutaneous foreign body removal (10120). They constantly charge it on their pro fee claim and we don’t think this is right. We don’t code it. What can we do to make them listen?”

- Coding Clinic for HCPCS, 3rd Qtr, 2002.

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Procedures

- Q14 - “We’ve been told by a compliance reviewer that CPT code 51701 cannot be used to code the collection of urine for urinalysis. Is this true and if so, how do we code this service to get paid? It’s time-consuming and certainly not the same as regular urine collection.”
**Procedures**

- Coding Clinic for HCPCS, 3rd quarter 2007
- HCPCS code P9612, Catheterization for collection of specimen, single patient, all places of service

**Procedures**

- Q15 – “I can’t figure out how to code a knee immobilizer. Did you know that CPT Assistant and Coding Clinic for HCPCS don’t agree on this? CPT Assistant says it’s a splint and Coding Clinic says it’s a strapping.”
- Coding Clinic for HCPCS, 2nd Qtr, 2001, page 7
- CPT Assistant, May 2009, page 8
Procedures

• Q16 – “It’s come to our attention that CPT Assistant and Coding Clinic for HCPCS don’t always agree. We’ve asked for clarification on this from both but don’t have an answer yet.”
• PTA of the left subclavian artery
• CPT Assistant says 35475 (Sept 2008, p 10)
• Coding Clinic says 37799 (4th Qtr 2008, p 8)

Procedures

• Q17 – “I’m really confused about how to code these new H1N1 vaccines that they just started giving. Apparently there are new codes that aren’t in the CPT book. I just heard that there are new HCPCS G codes. What am I supposed to do?”
• Yes, there are new codes
• Vaccines should be billed at $0.00 or $0.01 because they are free from the government
Procedures

- 90663 - Influenza virus vaccine, pandemic formulation, H1N1
- 90470 - H1N1 immunization administration (intramuscular, intranasal), including counseling when performed

Procedures

- G9141 - Influenza A (H1N1) immunization administration (includes the physician counseling the patient/family)
- G9142 - Influenza A (H1N1) vaccine, any route of administration
- 2009 payment for G9141 is $24.89
Procedures

- CPT Guidance
  http://www.ama-assn.org/ama/pub/h1n1/resources/cpt-codes.shtml

- CMS Guidance
  - Page 8

Procedures - Injections and Infusions

- Q18 – “We’re the facility administering the infusions. How do I code IV hydration for 3.5 hours from 8:00 am to 11:30 am and two IV pushes of different medications, one at 9:30 am and the other one at 10:00 am?”

- CPT Assistant, February 2009, page 17 is the best source available

- Coding Clinic for HCPCS, 4th Qtr, 2007

- Read every note in the CPT book section
Procedures - Injections and Infusions

- Hydration cannot be concurrent so subtract out the time used for the pushes.
- 3.5 hrs minus .5 hours (15 min x 2) = 3 hrs
- 96374 - 1st IV push - In hierarchy, the initial code
- 96375 - 2nd IV push - Sequential push of a new substance/drug

Procedures - Injections and Infusions

- 96361 x 3 - Remaining 3 hours of hydration
- Note below 96361 says: (Report 96361 to identify hydration if provided as a secondary or subsequent services after a different initial service (96360, 96374, 96409, 96413) is administered through the same IV access)
Procedures - Injections and Infusions

- Q19 – “We still have challenges getting the end times on IV infusions. Start time doesn’t seem to be as much of a problem. Is there anything we can do to code this work that was obviously done?”

- Coding Clinic for HCPCS, 3rd Qtr, 2007

- IV push

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Procedures - Injections and Infusions

- Q20 – “What are we supposed to use for a start time when the patient arrives with an IV that was started by someone else, usually the paramedics?”

- Medicare Claims Processing Manual (100-04), Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 230.2, D on p 116

Procedures - Injections and Infusions

- Section title: Infusions Started Outside the Hospital
- Assign “HCPCS code(s) that most accurately describe the service(s) they provide”
- Does not state how to determine the time

Audience Questions
Our Apologies

- Our sincere apology if we did not get to your question today
- We received a large variety of questions and tried to group them together by concept
- Please post your question in the Coding CoP if we did not discuss your issue during the program

Thank you!
Audio Seminar Discussion

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Facts of Life in CPT® Development
January 12, 2010

HITECH and Release of Information
January 21, 2010

Facility E-D Coding and Charge Capture
January 28, 2010
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Appendix

Resource/Reference List ................................................................................................ 30
CE Certificate Instructions
Resource/Reference List

American Hospital Association (AHA)

Coding Clinic for ICD-9-CM: The official publication for ICD-9-CM coding guidelines and advice

Coding Clinic for HCPCS: The official publication for Level I HCPCS (CPT-4 codes) for hospital providers and specific Level II HCPCS codes for hospitals, physicians and other health professionals.


American Medical Association (AMA)

CPT® Assistant: Official source on CPT for physicians and professional fee coders

http://www.AMABookstore.com

Search for “CPT Assistant” or go directly to

http://www.ama-assn.org/ama/pub/h1n1/resources/cpt-codes.shtml

Centers for Medicare and Medicaid Services (CMS)

http://www.cms.hhs.gov

Transmittals at http://www.cms.hhs.gov/Transmittals

Transmittal B-02-020, March 27, 2002


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

Frequently Asked Questions at “Questions” on blue menu bar in upper middle, or

Medicare Claims Processing Manual (100-04), Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), Section 230.2, D on p 116

Centers for Disease Control and Prevention (CDC)

The Official ICD-9-CM Guidelines for Coding and Reporting, Section IV. Diagnostic Coding and Reporting for Outpatient Services

http://www.cdc.gov

Search for “ICD-9-CM Guidelines”

Mayo Clinic

http://www.mayoclinic.com/health/copd/DS00916

Merck Manual Online

http://www.merck.com/mmhe/sec05/ch064/ch064a.html
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*Each participant expecting to receive continuing education credit must complete the online evaluation and sign-in information after the seminar, in order to view and print the CE certificate.*