



Welcome to the January edition of Net Revenue Matters, a publication of CentraMed.

We have a new look! It goes right along with our new name. But you can count on the fact that the high quality of our content is unchanged.

We hope that you'll appreciate the information presented in this month's issue: "New Modifier PD," "CDI: Not Just for Improved Inpatient Coding," and "Modifier 59 & 91 Usage Pitfalls."

Also, please be sure to note our client corner and upcoming events. We don't want you to miss anything.

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## New Modifier PD

The Centers for Medicare and Medicaid Services (CMS) introduced the new modifier PD in the Medicare Physician Fee Schedule (MPFS) final rule. Modifier PD's full description is as follows: "diagnostic or related non-diagnostic item or service provided in wholly owned or wholly operated entity to a patient who is admitted as an inpatient within three days or one day." CMS began accepting the new modifier on January 1, 2012; however it will be required beginning July 2, 2012.

This means that a freestanding clinic wholly owned or operated by a hospital must append the new modifier PD to Part B claim line items, where appropriate, to identify them as meeting the three-day payment window requirement. The technical component (TC) of the services provided at the clinic is then bundled into the inpatient claim. The three-day payment window applies to diagnostic and non-diagnostic services that are clinically related to the reason for the patient's inpatient admission regardless of whether the inpatient

and outpatient diagnoses are the same. The TC portion of all non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital or wholly owned or operated clinic on the date of the inpatient admission are deemed related to the admission and must be included on the bill for the inpatient stay.

***"So how do hospitals with wholly owned or operated freestanding clinics prepare for this new modifier?"***

If the non-diagnostic services are clinically unrelated to the inpatient admission, the wholly owned or operated clinic should include the TC portion of the services in their billing. CMS further clarifies by stating, "If the non-diagnostic services are clinically distinct or independent from the reason for the beneficiary's inpatient admission, these services are covered by Medicare Part B." Hospitals and physicians must document the reason the services are not clinically related.

So how do hospitals with wholly owned or operated freestanding clinics prepare for this new modifier? First and foremost, it is critical to create and maintain a high level of coordination and communication between the hospital and clinic(s). The two must create an efficient process by which the hospital and clinic are made aware of clinic patients admitted within the three-day window. CMS states, "The hospital is responsible for notifying the entity of an inpatient admission for a patient who received services in a wholly owned or operated entity within the three-day payment window prior to the inpatient stay." Therefore, hospitals must put in place a process to notify their clinics of related inpatient admissions.

***"The wholly owned or operated clinic must manage their billing process to ensure that they bill for their physician services appropriately when a related inpatient admission has occurred."***

The wholly owned or operated clinic must manage their billing process to ensure that they bill for their physician services appropriately when a related inpatient admission has occurred. All claims for these clinics will have to be held for at least three days before submission to ensure any related inpatient admissions are reported to them and billed correctly.

Hospitals and clinics will have to determine how to separate the costs/charges of the TC portion from the professional component (PC) and include them on the hospital's inpatient claim. When the modifier PD is present on clinic claims, CMS will pay only the PC for CPT/HCPCS codes with a TC/PC split. For codes without a TC/PC split, CMS will pay the facility rate. However, in both cases the TC portion must also be moved to the inpatient claim. CMS did not offer guidance on how to determine the amount to split out for the TC portion on those codes without a TC/PC split. It will be up to the hospitals and clinics to determine a process or calculation to determine the amounts to bill.

It will be crucial for hospitals and their clinics to work together in order to create and implement an effective process for billing the new modifier PD by July 2012.

For more information on the New PD modifier, please see CMS' Transmittal 2373 regarding the new PD modifier located at the following link.

<https://www.cms.gov/transmittals/downloads/R2373CP.pdf>

More information can also be found in the CMS Claims Processing Manual, Chapter 3, Section 40.3.

<http://www.cms.gov/manuals/downloads/clm104c03.pdf>

## **Clinical Documentation Improvement: Not Just for Improved Inpatient Coding**

When we hear the term Clinical Documentation Improvement, or CDI, the first thing that comes to mind is obtaining more complete and compliant physician documentation in order to assist with accurate coding. However, CDI can have a much larger impact/footprint on your facility.

***"CDI can have a much larger impact/ footprint on your facility."***

Below are some examples of expanded scope roles related to CDI programs and staff.

### **Other Roles**

Present on Admission (POA)

- Impact both quality indicators and payment
- Ensure diagnoses which were present on admission are documented as such
- Medical Necessity
  - Correct documentation of medical necessity can impact all levels of care – Observation, Short-term Acute Inpatient, Long-term Acute Inpatient, and Rehabilitation.

- Core Measures
  - Customer service to the physicians - combining the roles of CDI and Core Measures abstraction mean less queries and less aggravation to the physicians.

## Outpatient CDI

- Emergency Department
  - CDI specialist can impact the quality of patient care, ensuring all pertinent diagnoses are documented.
  - CDI specialist can verbally query the physician as he/she is treating the patient and provide education at the same time.
  - Concurrent review of documentation can assist with verifying medical necessity.
  - Can help to identify which conditions are present on admission.
  - Can make sure core measures are appropriately documented and captured.
- Observation
  - Review for correct orders.
  - Verify medical necessity for both observation and subsequent admission to inpatient status.
  - Ensure the physician documents all diagnoses completely and accurately to support the level of care.
- Surgery
  - Review procedures with a high rate of payment denials for correct diagnoses and procedures in the operative report.
  - Identify trends.
  - Provide education to physicians to assist them with documentation.

## ICD-10 Preparation

- ICD-10 is definitely coming.
- There are nearly twice as many categories in ICD-10 than there were in ICD-9.
- There are about five times as many diagnoses codes.

- Many of the default, unspecified codes which coders now have to use will not be available. Documentation must be complete and specific.
- Now is the time to educate physicians and query for more specificity.

## Modifier 59 & 91 Usage Pitfalls

Correct modifier usage is imperative in order to attain a desirable outcome for both reimbursement and compliance reasons. Coding professionals agree that one of the most commonly misused modifiers is modifier 59. It is only appropriate to append modifier 59 when two procedures are performed at a separate site or during a separate patient encounter on the same day of service and cannot be used in connection with Evaluation and Management services or with radiation treatments. It is recommended that modifier 59 be audited annually to ensure that coders keep up with CCI edits and know when it is appropriate to assign modifier 59. It is recognized that some facilities use modifier 59 regardless of the instruction “if appropriate.” It may not always be appropriate.

***“Correct modifier usage is imperative in order to attain a desirable outcome for both reimbursement and compliance reasons.”***

Modifier 91 is commonly misused, also. Repeated lab procedures performed on the same day can prove to be problematic if the coders are not trained properly on the use of the modifier. Modifier 91 is not intended to be used when labs are repeated for the following reasons: confirming initial results, problems with the lab equipment or with the specimens, or for any other reason when a normal, one-time lab test would be required, typically.

As always, it is recommended that coding staff responsible for resolving CCI edits review the documentation prior to assigning either of these modifiers in order to ensure that the modifier is truly appropriate.

# CLIENT CORNER

## FTP Calendar

Below is the FTP calendar for 2012. You will receive reminder emails to submit the databases, as well as verification emails of received databases.

2012 Calendar to FTP Databases	
January 3	January 10
February 1	February 10
March 1	March 12
April 2	April 10
May 1	May 10
June 1	June 11
July 2	July 10
August 1	August 10
September 4	September 10
October 1	October 10
November 1	November 12
December 3	December 10

## More CEUs!

We are pleased to announce that our library of CEU certified classes has expanded. Our online Observation course (CC-3013) has been approved by the AAPC for two CEUs. You can find all of CentraMed's educational offerings by navigating to [www.irminconline.com](http://www.irminconline.com) and visiting Revenue Management Education.

Stay tuned for more updates regarding our online education.

## Please Note



All CBR (Code-Based Reimbursement)/CCDR (Compliant Coding and Documentation Review) activity for the month must be entered into the CBR/CCDR Software applications, including DRG Catalyst, prior to the 10th of the following month.

Be sure to follow the steps below so that results from retrospective CBR/CCDR audits translate onto the Executive Summary:

### Inpatient (DRG Catalyst)

- The rebill checkbox must be checked. (Please make sure that you send the checked accounts to PFS for rebilling!)

### Outpatient (CBR Database)

- The completion date must be entered under the CBR/CCDR Utilities tab, and
- The rebill checkbox must be checked. (Please make sure that you send the rebill accounts to PFS for rebilling!)
- Before the database closes each month, we recommend that you complete the following checklist:
  - Confirm that all completed retrospective audits for the month have an end date entered into the CBR/CCDR database.
  - Check the rebill box in the CBR/CCDR database or DRG Catalyst for each retrospective claim that has been approved for rebilling.
  - Complete a Summary of Audit Findings form for any projects you closed this month and submit it to the coding Subject Matter Expert (SME).
  - Ensure that data is entered for all accounts audited for the current month.

# UPCOMING WEBINARS

## Client RMD/RID Webinars

*Feb 7: RAC Forum: RAC Updates*

### Potential Topics

*Consumer-Driven Healthcare/Pay for Performance*

*Medicare Managed Care*

*Auditing ICU Accounts*

*How to Handle Adversity*

*Silent PPOs*

*How to Interact with Internal Customers*

*Write-Off Analysis*

*Software Reporting*

*Injections and Infusions*

*Introduction to Inpatient Audits*

*Inpatient Mechanical Ventilation*

*POA and HAC*

*Device Dependent APCs*

*Observation and One-Day Stays*

*Pain Management*

*Outpatient Orders*

*Spine Surgery*

*Chemotherapy*

*Pathology*

*Brachytherapy*

*Moderate Sedation*

*Radiology Imaging*

*Erythropoiesis Stimulating Agents*

*Discharge Dispositions*

*Emergency Department*

*Vascular Access Devices*

*Neurostimulators*

*GI Endoscopy*

*Tracking and Trending CCI Edits*

Please watch for your e-mail invitation approximately three weeks prior to the scheduled event.

Thank You

*Net Revenue Matters is a monthly publication of CentraMed and is offered as an informational service. Due to the nature of this publication, examples cited and advice given must often be general in nature and may not apply to a particular facility or situation. Thus, CentraMed does not warrant or guarantee that the information contained within will be applicable or appropriate in all situations. Each facility will need to evaluate its specific opportunities and take such action as to best meet its business needs. To find out more about a given subject or for information tailored to your specific circumstances, contact a CentraMed professional.*

*If you have questions or would like to submit information for a future newsletter, please contact:*

*Cynthia Hufferd ☎ 760-448-1034 ✉ [chufferd@centramed.co](mailto:chufferd@centramed.co)*