Net Revenue Matters

March 2011

Welcome to the March edition of Net Revenue Matters, a publication of Integrated Revenue Management, Inc. We hope that in this issue you'll find several topics of interest.

IRM's Revenue Mangement Education introduces coding education. For more information, please see, "Affordable Quality Coding Education."

Also, we hope that you'll appreciate the information presented in "New Initial Access Guideline from AMA for CPT Drug Administration Services," "Tools that Work," "Q&A on Use of Flouroscopy CPT Code 76000," and "Got PEPPER?"

Finally, please note our Best Practice information and upcoming events. We don't want you to miss anything!

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Affordable Quality Coding Education

Because ICD-9-CM and CPT-4 code assignment is so closely tied to hospital reimbursement, it is vitally important that coding staff understand the complexities of both classification systems. Revenue Management Education (RME), a division of IRM, presents, "A Comprehensive Guide to ICD-9-CM Coding" and "A Comprehensive Guide to Surgical CPT-4 Coding," two in-depth and easy-to-understand education programs designed for inpatient and outpatient coders alike. Our online offerings maximize the flexibility and versatility of the e-learning experience by enabling you to take courses anytime and anywhere and offering a Help Desk to answer any questions pertinent to your educational needs. Both coding programs together, as well as the Help Desk service, are competitively priced and available for custom packaging.

The highlight of the ICD-9-CM education program is the extensive overview of anatomical structures, disease processes, and medical terminology, a feature that will also serve as excellent preparation for the greater granularity of ICD-10-CM in these areas. Each of the 19 courses incorporates logic from the Official Guidelines for Coding and Reporting and Coding Clinic in a simplified and structured format. Coding tips, documentation tips, MS-DRG tidbits, and quick references make the education an easily adaptable reference tool for day-to-day coding. Our ICD-9-CM courses have been approved for continuing education credit by the American Health Information Management Association (AHIMA).

"RME presents, "A Comprehensive Guide to ICD-9-CM Coding" and "A Comprehensive Guide to Surgical CPT-4 Coding..."

Applying codes from the CPT coding system to the hospital setting is a challenging and complex process. Because the coding system was developed by physicians for physician use, interpreting the guidelines for application in the hospital can be very confusing. Complete with guidelines set forth by the American Medical Association (AMA)

and other regulatory agencies such as the Centers for Medicare and Medicaid Services (CMS), our CPT education program is ideally suited for all levels of coders who are involved in both the hard-coding and soft-coding process. It includes 17 courses covering all aspects of surgical CPT coding and interventional radiology.

Both programs include review exercises to enhance and reinforce the learning experience. ▲

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New Initial Access Guideline from AMA for CPT Drug Administration Services

Effective 1/1/2011, The American Medical Association (AMA) has implemented a new initial access guideline for discontinuous drug administration services that span more than one calendar day, that guideline being that any disruption between the two administration services (hydration, infusion, or push) spanning two different calendar dates would make the second service performed on the second calendar date a new initial service. This revised guideline appears on page xii of the introduction to the CPT Manual. The relevant passage from the introduction is copied below:

> *Some services measured in units other than days extend across calendar dates. When this occurs a continuous service does not reset and create a first hour. However, any disruption in the service does create a new initial service. For example, if intravenous hydration (96360, 96361) is given from 11 PM to 2 AM 96300 would be reported once and 96361 twice. However if, instead of a continuous infusion, a medication was given by intravenous push at 10 PM and 2 AM, as the service was not continuous, both administrations would be reported as initial (96374). For continuous services that last beyond midnight, use the date in which the service began and report the total units of time provided continuously.*

The advice stated in the CPT Manual introduction is consistent with that offered by Dr. Peter Hollmann in his presentation on time-based code changes for CY 2011 given at the November 2010 CPT Symposium. It should be noted that Dr. Hollmann is vice chairperson of the CPT Editorial Panel, the body responsible for reviewing and approving all proposed changes to the CPT Manual. See the link below:

http://www.ama-assn.org/ama1/pub/upload/mm/362/e-m-vaccines-time-based-codes.pdf
(see slides 22 & 37)

This revised guideline represents a special exception to the prevailing general rule, still mentioned in the drug administration section of the CPT Manual, that only one initial service code is to be reported for administrations involving the same access site during the same encounter. The general rule would still apply to drug administration services for a single encounter within the same calendar day or to a continuous service that spans two calendar days (i.e., a drug administration service that starts on one calendar day and continues uninterrupted into the next calendar day).

"However, it is important to point out that the CMS does not accept the AMA's new advice..."

However, it is important to point out that the Centers for Medicare and Medicare Services (CMS) does not accept the AMA's new advice on page xii of the CPT Manual's introductory pages. The January 2011 update to Chapter 4 Section 230.2 of the Medicare Claims Processing Manual contains the following passages:

> *Drug administration services are to be reported with a line item date of service on the day they are provided. In addition, only one initial drug administration service is to be reported per vascular access site per encounter, including during an encounter where observation services span more than 1 calendar day.*
>
> *Beginning in CY 2007, hospitals should report only one initial drug administration service, including infusion services, per encounter for each distinct vas-*

cular access site, with other services through the same vascular access site being reported via the sequential, concurrent or additional hour codes. Although new CPT guidance has been issued for reporting initial drug administration services, Medicare contractors shall continue to follow the guidance given in this manual.

This same information is summarized in CMS Transmittal 2141 Change Request 7271. See below:

http://www.cms.gov/transmittals/downloads/R2141CP.pdf
(see item 10 on page 23)

This creates the need to have different advice for Medicare vs. nonmedicare accounts. For Medicare payers, coders should follow the advice in the Medicare Claims Processing Manual and report one initial service per access site for an encounter regardless of whether or not that encounter spans more than one calendar date. For nonmedicare payers, coders should follow the instructions in the CPT book and the Symposium slides stating that when the service spans more than one calendar date and there is a disruption in the service, this would result in a new initial service for code assignment.

Coders should continue to carefully monitor CPT Assistant and other sources of official CPT coding advice for any future clarifications or changes concerning this matter. ▲

Tools that Work

Comments jog our memory and allow us to recall what is important without redoing a particular task in its entirety. The charge audit database comment field is a free-text field large enough to add as much detail as necessary to explain the charge audit findings, or lack thereof.

Comments can be categorized to reflect the most important details.

- A focused audit for implants should trigger the comment reflecting what was on the original bill and what was found as an under- or overcharge during the audit.
- High-dollar overcharge findings should be discussed with the clinical area expecting that revenue. This discussion and its conclusion should be noted in the comments. An RMD/RID should identify the dollar threshold required for this type of comment with agreement from the clinical areas. As a clinical department manager, would you want to know a $100.00 overcharge is being removed from an account, or you would not need to be notified until the overcharge was $1000.00?
- Stop loss audit comments would include the dollar amount for the stop loss, the original itemized statement total dollars, and the amount found. Additional comments addressing the findings is also helpful when determining revenue leakage in the charge capture process.
- Should an account not be audited fully, a comment stating this and the reason for the partial audit is good practice. Should this account be re-audited in the future, additional findings in other areas not originally audited will not reflect negatively on the original auditor.
- Other reasons to use comments include auditing for certain revenue codes such as 636 and 274-279 and carve outs identified in the contract matrix. Identifying a particular physician, nurse, or other clinician responsible for documentation errors can be noted in this field.

"The more that you as an auditor explain your findings in the comment section, the more information that can be shared..."

The more that you as an auditor explain your findings in the comment section, the more information that can be shared with your RMD/RID director, fellow auditors, and clinical department directors. This information is the basis for observation log entries which lead to process improvement initiatives. Please reach out to IRM for assistance in utilizing comments to the fullest potential. ▲

Happy Auditing!
Dawn

Q & A on Use of Fluoroscopy CPT Code 76000

Q: Can you confirm that CPT code 76000 is specifically for billing the physician time? If a facility does not bill for the physician, it should not use this code, correct?

A: Although CPT 76000 has a time-based restriction to it, the code does more than capture the amount of time the physician spent on the service. This code is meant to capture the fluoroscopy service itself when fluoroscopy is the only imaging service rendered and when there is no more specific fluoroscopic code available and the fluoroscopic guidance is not considered inherent to the code for the main procedure performed. If this fluoroscopic service took up to one hour, then 76000 would be reported; if it took more than one hour, then 76001 would be reported instead. If this service is performed at a facility and the facility owns the equipment used to perform the fluoroscopy, the facility can usually bill for the technical component of 76000 by appending the TC modifier to this code.

CPT Assistant June 2008 pages 9-10 provides some examples and additional guidance in regard to using this code. This article is copied below:

> *Code 76000 may be reported when fluoroscopy is the only imaging performed. For example, a patient presents to the radiology department with a prior joint x-ray series demonstrating a calcified body near the joint. The physician uses fluoroscopy with the joint flexed, extended, and rotated to determine whether the calcification is indeed loose within the joint. Because fluoroscopy is the only imaging procedure performed at that patient encounter, code 76000 is reported once (not for each joint position examined).*
>
> *Another example is when there is no other fluoroscopy code that more accurately describes the imaging performed (ie, code 77001, 77002, or 77003). For example, a patient steps on a needle and fluoroscopy (C-arm) is used to assist the physician to locate and remove this foreign body from the skin wound. In this instance, if C-arm fluoroscopic imaging is being provided without a diagnostic radiologic examination (i.e., no hard copy record of the images is produced), then code 76000 should be used to identify the imaging procedure provided. Because code 76000 is designated as a separate procedure, modifier 59, Distinct Procedural Service, should be appended and reported in addition to the appropriate codes from the Integumentary System section.*

Coding Tip

The Centers for Medicare and Medicaid Services (CMS) reinstated the use of the HCPCS Level II TC modifier (Technical component) for code 76000 (transmittal AB-01-167) retroactive to January 1, 2001.

Fluoroscopy (code 76000) may not be reported if it is performed in conjunction with another radiologic procedure wherein fluoroscopy is considered to be an inclusive component. Some examples follow.

74320 Cholangiography, percutaneous, transhepatic, radiological supervision and interpretation

7435 Percutaneous placement of enteroclysis tube, radiological supervision and interpretation

74445 Corpora cavernosography, radiological supervision and interpretation

74470 Radiological examination, renal cyst study, translumbar, contrast visualization, radiological supervision and interpretation

74475 Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation

75809 Shuntogram for investigation of previously placed indwelling nonvascular shunt (eg, LeVeen shunt, ventriculoperitoneal shunt, indwelling infusion pump), radiological supervision and interpretation

75810 Splenoportography, radiological supervision and interpretation

75885 Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation

Continued on page 6

Got PEPPER?

The Program for Evaluating Payment Patterns Electronic Report is a valuable resource which is free and facility-specific. The TMF Health Quality Institute in Austin, TX is contracted by The Centers for Medicare and Medicaid (CMS) to release PEPPER data.

What is PEPPER?

The Office of Inspector General encourages hospitals to develop and implement a compliance program to protect their operations from fraud and abuse. Part of the hospital compliance program should include regular audits to ensure that charges for Medicare services are properly documented and billed. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) can assist with the hospital's auditing and monitoring activities.

"PEPPER is an electronic data report..."

PEPPER is an electronic data report that contains a single hospital's claims data statistics for Medicare Severity Diagnosis Related Groups (MS-DRGs) and discharges which are at high risk for improper payment due to coding, billing, and/or medical necessity issues.

Each report contains statistics for the most recent twelve federal fiscal quarters for target areas. The data is presented both in graphs and tabular format, depicting the hospital's target area percentages over time. PEPPER also includes reports on the hospital's top medical and top surgical MS-DRGs for one-day stays.

All of the data tables, graphs, and reports in PEPPER were designed to assist the hospital in identifying potential overpayments, as well as potential underpayments.

In ST PEPPER, a hospital is compared to other short-term acute care hospitals in three comparison groups: state, Medicare Administrative Contractor/ Fiscal Intermediary jurisdiction, and nation. These comparisons enable a hospital to determine if it is an outlier, differing from other short-term acute care hospitals.

Specifications for claims included in ST PEPPER are shown in the table below.

Inclusion/Exclusion Criteria	Data Specifications
Acute care providers only	Third position of the CMS Certification Number = "0"
Claim facility type of "Hospital"	UB04 Form Locator (FL) 4 Type of Bill, second digit (Type of Facility) = 1 (Hospital) or 4 (Religious Non-medical (Hospital))
Include claim service classification type of "Inpatient"	UB04 FL 04 Type of Bill, third digit (Bill Classification) = 1 (Inpatient Part A)
Claim with valid medical record number	UB04 FL 03a or 03b is not null (blank)
Medicare claim payment amount greater than zero	The hospital received a payment amount greater than zero on the claim (*note that Medicare Secondary Payer claims are included*)
Final action claim	The patient was discharged; exclude claim status code "still a patient" (30) in UB04 FL 17
Exclude Health Maintenance Organization claims	Exclude claims submitted to a Medicare Health Maintenance Organization
Exclude cancelled claims	Exclude claims cancelled by the Fiscal Intermediary or Medicare Administrative Contractor

CMS has approved the ST PEPPER target areas because they have been identified as being prone to improper Medicare payments. A problematic area is the coding of complications and comorbidities (CCs) and more recently major complications and comorbidities (MCCs). Oversight agencies have identified coding errors related to the addition of a CC or MCC that wasn't supported by documentation in the medical record.

How can hospitals use PEPPER data?

Jurisdiction, state, and national percentile values for each target area with reportable data for the most recent fiscal year quarter are included in PEPPER. Hospitals can use comparative data for several consecutive quarters to help identify whether the hospital's target area percents changed significantly in either direction from one quarter to the next. This could be an indication of a procedural change in admitting, coding or billing practices, facility staff turnover, or a change in medical staff.

The PEPPER national data reports for the fourth quarter 2010 were released March 2. A few of the top target areas for 4QFY2010 are:

- Septicemia, Simple Pneumonia, and Stroke Intracranial Hemorrhage
- 30-day readmit to same hospital, 1-day stays excluding transfers, and 3-day SNF-qualifying admissions.

The complete report can be found at the following:
http://pepperresources.org/Data.aspx

There are also tools at this link to assist you with auditing and help to prevent improper payments:
http://pepperresources.org/Tools.aspx

What types of facilities is PEPPER for?

In 2011, PEPPER will continue to be distributed to short-term and some long-term acute care hospitals and will be provided and distributed for the first time to critical access hospitals via My QualityNet. PEPPER will also be provided and distributed for the first time to inpatient psychiatric and rehabilitation facilities as paper copies, mailed to the hospital administrator.

My QualityNet is the only method CMS has approved for the electronic transmission of confidential data. PEPPER is distributed to hospital QualityNet administrators and hospital staff who have a QualityNet basic user account with the PEPPER Recipient role.

For more information, please visit:
http://pepperresources.org/Home.aspx

If you are not already using PEPPER, you are missing a great resource for compliance, coding, and clinical documentation improvement. Use of the tools and information from the reports can assist with preventing RAC issues in your hospital. ▲

Cont. from page 4 "Q&A on Use of Flouroscopy CPT Code 76000"

75887 Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation

75980 Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation

75982 Percutaneous placement of drainage catheter for combined internal and external biliary drainage or of a drainage stent for internal biliary drainage in patients with an inoperable mechanical biliary obstruction, radiological supervision and interpretation

75989 Radiological guidance (ie, fluoroscopy, ultrasound, or computed tomography), for percutaneous drainage (eg, abscess, specimen collection), with placement of catheter, radiological supervision and interpretation

Code 76000 would be used for up to an hour, and code 76001 would be used for greater than an hour of physician time in the event the physician uses fluoroscopy to monitor/confirm the placement of brachytherapy needles and seeds during prostate brachytherapy (55875). ▲

Client Corner

Have you registered?

Best Practice Forum 2011
May 17-19
The Driskill, Austin, TX

Please visit our website to submit your registration, if you haven't yet done so. We don't want you to miss our informative, fun-filled event.

http://www.irminconline.com/news/news_bestpractice.htm

Master of Ceremonies: Jack Duffy, IRM Exec VP

Tuesday Presentations

- IRM: *"Is It Time to Reassess Your Clinical Documentation Program?"*
- Guest: Velocette, Denial Management Experts
- IRM: *"Process Improvement and Bill Presentation"*
- IRM: *"Vascular IR and Cardiac Cath Highlights"*
- Guest: Integris Health

Tuesday afternoon will allow time for your personal exploration of beautiful, downtown Austin and the evening will offer a reception, dinner, and live music. Don't forget your dancing shoes!

Wednesday Presentations

- Guest: HFMA, *"Reform and the Revenue Cycle"*
- IRM: *"Bundled Payments"*
- Guest: EpsteinBeckerGreen, "*Accountable Care Organizations"*
- Panel Q&A: "*Accountable Care Organizations"*
- Clients: *Process Improvement Initiatives*

Thursday Presentations

- Guest: Our Lady of the Lake Regional Medical Center, *"OPPS Quality Measures"*
- Guest: Floyd Medical Center, *"Cost Saving and Revenue Leakage"*
- Clients: *Process Improvement Initiatives*

Thursday sessions will conclude about noon with an award ceremony that recognizes your favorite client process improvement presentations. Have you planned yours? ▲

Don't Forget!

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, IRM recommends 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

Apr 5 RAC Forum: RAC & CMS Updates
27 Charge Audit/CCDR Forum: Blood

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

Observation and One-Day Stays

Device Dependent APCs

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 Integrated Revenue Management, Inc. (IRM), 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, IRM does not warrant or guarantee the information contained will be applicable or appropriate in all situations. Each facility will have 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 an IRM professional.

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