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CODING & BILLING FOR PROSPECTIVE PAYMENT SYSTEMS

Inside This Issue:

Are You Ready to Report POA Indicators?

All hospitals are aware now that as of October 1, 2007, present on admission (POA) indicators will need to be reported with electronic claim filing. While CMS continues to implement ways to improve its data capture, hospitals scramble to educate their staff and physicians to meet these reporting deadlines. This leaves the provider community looking for means and resources to be used to ensure that coding staff, billing staff, and physicians have a good understanding of the changes in their roles and responsibilities. Although, hospitals constantly address improving lines of communication with the physician community, now more than ever, that has to have added emphasis. So what should the hospital be doing?

Inform everyone of CMS reporting deadlines. Present on Admission (POA) Implementation timeline:

- October 1, 2007 – begin reporting all secondary diagnosis POA and corresponding indicators
- January 1, 2008 – claims processed without correct POA indicators will continue to process; however, remark codes will be present on remittance advices
- April 1, 2008 – claims that do not contain valid POA indicators will be returned to the hospital for corrections

Next, provide the physicians and hospital staff with copies of or access to the information being published by CMS. Overview the material with physicians and hospital staff and discuss what steps will need to be taken to implement the requirements in the hospital.

> Excerpts from CMS transmittal: *"General Reporting – POA is defined at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as POA. The POA indicator is assigned to principal and secondary diagnosis and the external cause of injury codes (E codes)."*

Hospitals should be providing education to physicians on the requirements for reporting POA indicators. Utilize medical directors and physician liaisons to gain the support of the physician and mid-level practitioner community. Consider all their input and ideas in redefining health information management query, UR/ case management review, concurrent coding, and documentation improvement processes.

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Are You Ready to Report POA Indicators? *(cont'd)*

Although hospitals will want to encourage participation at all levels, the leaders in the key departments (e.g., HIM, PFS, UR/CM) should be submitting their plans for implementing the POA reporting requirements. Hospitals should enlist the leaders' knowledge and expertise to redefine processes where necessary and educate the departmental staff.

A hospital plan and timeline should look a little like this:

- ✓ August 1, 2007 – all input and ideas for POA reporting should be addressed
- ✓ September 1, 2007 – finalize and roll-out education to pertinent staff and physicians regarding any changes in process
- ✓ October 1, 2007 – begin transition period for reporting POA indicators
- ✓ November 1, 2007 – monitor processing issues, review remittance remarks codes, audit implementation, report any deficiencies in the process, and a develop a plan to provide re-education
- ✓ December 1, 2007 – re-audit implementation and report any deficiencies with a plan to provide further education
- ✓ January 1, 2008 – full implementation for reporting POA indicators

There are many sources of information and educational opportunities being made available everyday to the provider community. It is necessary to obtain as much guidance as possible from CMS, FI or A/B MAC (Medicare Administrative Contractor), and professional associations to ensure successful implementation.

The following is a sample of guidance and tools that are currently available on the internet:

http://www.cms.hhs.gov/transmittals/downloads/R1240CP.pdf
http://www.cms.hhs.gov/transmittals/downloads/R1240CP.pdf
http://www.cdc.gov/nchs/data/icd9/POAguideSep06.pdf
http://www.delmarvafoundation.org/providers/medicare/hpmp/docs/AppE_Audit_Tool_Coding.pdf

Reporting the Present on Admission Diagnosis Code Indicator

As we know, UB04 has expanded the number of diagnosis and procedure code fields, as well as added a new diagnosis code flag to indicate whether the condition was present on admission or developed during the episode of care. What may not be fully understood, however, is that the UB04 is the paper claim submission, which is used by only a few providers. Most facilities submit their claims electronically, using the 834 format. This format does not support the new POA indicator, therefore until some kind of workaround is provided; this reporting is not required.

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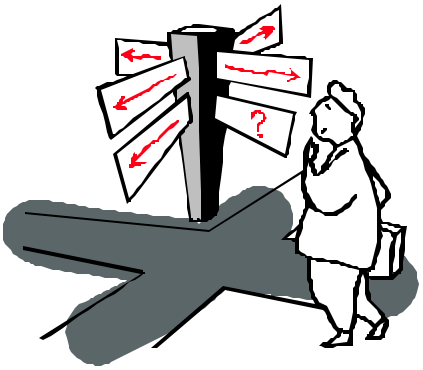
You may be wondering why all the hullabaloo about Present on Admission when facilities cannot even report it electronically right now. You should be aware that some states have already started requiring the indicator and, as usually happens, once one state agency requires something eventually they all will. Therefore, it would behoove facilities to contact their state hospital association or data collection agency for their plan since each state has different reporting requirements. For example, some have not limited this flag to inpatient acute care, but have expanded the requirement to include both outpatient and rehab services. Currently, there is no national reporting requirement, and as there is no speculation about what that could entail, the state requirements take priority.



For calendar year 2007, ICD-9-CM in conjunction with several other professional groups developed the POA reporting guidelines, which are included as Appendix I in the ICD-9-CM Official Guidelines for Coding and Reporting. It is important to note that these guidelines are not intended to *replace* any guidelines contained in the main body of the Guidelines, nor are they intended to provide guidance on when on a condition should be coded. They are strictly to be utilized as a resource for assigning the POA indicator to the diagnosis codes being reported.

Documentation from any provider involved in the patient's care may be used to determine whether or not a condition was present on admission. The provider does not need to specifically document whether each condition was present on admission. However, it is essential that any missing or unclear documentation be clarified before making the present on admission determination, as is the usual course of action before assigning any diagnosis code. In many instances, it is a matter of the coder using common sense to determine whether the condition was present on admission. The assigning of this indicator should not become a hardship for facilities, and there should be no need for to develop additional forms to accommodate the collection of this data.

Flag	Option	Definition
Y	Yes	Present at the time of inpatient admission
N	No	Not present at the time of inpatient admission
U	Unknown	Documentation is insufficient to determine if condition is present on admission
W	Clinically Undetermined	Provider is unable to clinically determine whether condition was present on admission or not
Blank		Exempt from POA reporting

All reported diagnoses, principal and secondary, including external cause of injury codes (E-codes) should have a POA indicator applied. A list of codes that has been determined as exempt from POA reporting may be found in Appendix I of the ICD-9-CM Official Guidelines for Coding and Reporting.

For the complete guidelines, please go to:
www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide06.pdf.

July 2007 OPPS – Policy Changes

On June 1, 2007, CMS released Change Request 5623 to notify hospitals of the OPPS policy changes. A summary of these changes is listed below:

- New procedure to device edits for AV fistula or graft (HCPCS codes G0392 and G0393) and change of ureter tube (HCPCS code 50688).
- New HCPCS code C9728, Place device/marker, non prostate.
- Five new Category III codes (0178T, 0179T, 0180T, 0181T, and 0182T).
- Updates to brachytherapy sources and addition of HCPCS codes to report stranded and non-stranded sources. Three codes (C1718, C1720, and C2633) are being deleted and replaced with the added codes. Two of the new codes (C2698 and C2699) are to be used to report sources that have been approved by the FDA, but have not yet been assigned a separate source code.
- Payment rates are being updated for approximately 9 drugs and biologicals
- Nelarabine has been designated eligible for pass-through status. Seven HCPCS Q codes are being added to report Immune Globulin and Reclast. Zometa is to be reported using J3487 and Reclast is to be reported using Q4095. HCPCS code J1567 will no longer be reported under OPPS and the new HCPCS Q codes will be reported instead.
- CMS has issued another reminder to report the correct number of units for drugs.

The CMS transmittal for the July 2007 OPPS changes can be viewed in its entirety by clicking on link provided:
http://www.cms.hhs.gov/transmittals/downloads/R1259CP.pdf

Go to the following transmittal for further instructions on the changes for immune globulin:
http://www.cms.hhs.gov/transmittals/downloads/R1261CP.pdf

Go to the following transmittal for further instructions on the changes for albuterol and reclast:
http://www.cms.hhs.gov/transmittals/downloads/R1260CP.pdf

CMS Issues Clarification on Use of Modifier 59

In MLN article SE0175, CMS clarifies existing policy on the proper use of modifier 59. They remind us that modifier 59 should not be used simply to bypass an edit. The proper criteria for use of modifier 59 must be met and documentation in the medical record must satisfy that criteria. Many hospitals want to place modifier 59 in their chargemasters with an associated service to facilitate billing. The primary problem faced by hospitals in doing so is that this opens up an opportunity for inappropriate billing. It is very easy for a busy clinician to select an incorrect service item and therefore create an audit concern. Assigning modifier 59 should be the responsibility of either HIM coding professionals and/or clinicians/ individuals with training and good understanding of applying this modifier.

The clarification should be shared with staff and clinicians that are responsible for assigning modifier 59. It would also be appropriate to share this information with the hospital medical staff.

The MLN Matters article can be viewed at:
http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0715.pdf

HCPCS Code Update for Hemophilia Clotting Factors

Providers should be made aware the implementation date for the HCPCS code updates has been changed to October 2, 2007. During the period between January 1, 2007 and FISS implementation of hemophilia edit changes in the October 2007 release, the following procedures should be followed:

- Providers shall submit claims for hospital inpatient care omitting HCPCS code J7187 (or J7188). Claims from inpatient psychiatric facilities (IPFs) paid under IPF PPS will also need to omit HCPCS code J7187. Even though IPFs receive a comorbidity adjustment under IPF PPS based on the presence of a hemophilia diagnosis, claims containing the new HCPCS code J7187 will error out.
- Claims from inpatient psychiatric facilities (IPFs) paid under IPF PPS; IPFs receive a comorbidity adjustment under IPF PPS based on the presence of a hemophilia diagnosis.
- Once the provider has received PPS payment for the inpatient claim, the provider is to immediately submit an adjustment request (TOB = 117), this time including HCPCS code J7187.
- Contractors are to hook any provider initiated adjustment requests containing HCPCS J7187 with discharge dates between January 1, 2007 and September 30, 2007.
- FISS will replace HCPCS code J7188 with HCPCS code J7187 in all inpatient editing for hemophilia clotting factors with dates of service on and after January 1, 2007.
- FISS will include this coding update in its October 2007 release.
- Once FISS has been updated for this new clotting factor code, J7187, contractors are to release all held adjustment requests.

The link to the transmittal has been provided, go to:
http://www.cms.hhs.gov/transmittals/downloads/R1234CP.pdf

Payment Guidelines for DSMT

CMS issued Transmittal 1255 on May 25, 2007 to inform the provider community of revisions to payment for diabetes self-management training (DSMT). Effective July 1, 2007 DSMT provided to hospital outpatients will be paid under the Medicare Physician Fee Schedule (MPFS). The frequency editing in the CWF will also be updated to reject only at the line level when the total hours for the year have been exceeded. Currently, the CWF is rejecting at the claim level.

CMS has also provided a few examples for tracking the training of a beneficiary during the calendar year. These examples will be added to the Medicare Claims Processing Manual, Chapter 18, Section 120.2.1.

The revised payment and billing guidelines can be viewed at:
http://www.cms.hhs.gov/transmittals/downloads/R1255CP.pdf

Bone Mass Measurement Policy Revisions

CMS recently added HCPCS code G0130 to the bone mass measurement (BMM) payment policy. The policy revision is being implemented July 2, 2007. The following is an excerpt from the MLN Matters article:

> BMM is not covered when a procedure other than dual-energy x-ray absorptiometry is used to monitor osteoporosis drug therapy. Therefore, Medicare will not pay for procedure codes 76977, 77078, 77079, 77081, 77083 and G0130 when billed with the following ICD-9-CM diagnosis codes:

733.00	733.01	733.02	733.03	733.09	733.90	255.0

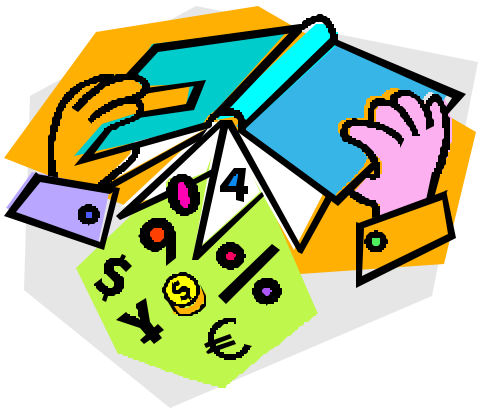
CMS encourages providers to issue Advance Beneficiary Notices (ABN) when it is known that a service/item will not be paid when the diagnosis code does not support medical necessity. Hospitals should inform staff responsible for scheduling these services as well as the provider community so they understand the coverage changes and can properly inform Medicare beneficiaries.

CMS Transmittal 1236 and the MLN article 5521 can be read in their entirety, go to:
http://www.cms.hhs.gov/transmittals/downloads/R1236CP.pdf
http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5521.pdf

CMS Releases 2008 IPPS Proposed Rule

The highlighted contents included in the 2008 IPPS proposed rule are summarized below:

- DRG reclassification to Medicare Severity DRG (MS-DRG) to better recognize severity of illness.
- Refine relative weight classifications taking into account the severity-adjusted DRG system.
- Prepared a proposed listing of hospital-acquired conditions and are considering these to be subject to statutorily required quality adjustments.
- Providing clarification of “custody” for services provided to beneficiaries in custody of penal authorities.
- Policy changes relating to disclosure of patients of physician ownership of hospitals and patient safety measures.



Link to the 2008 Proposed Rule of the IPPS:
http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/CMS-1533-P.pdf

To view the data files for the proposed rule, go to CMS page and refine the view for 2008 files only:
http://www.cms.hhs.gov/AcuteInpatientPPS/FFD/list.asp#TopOfPage

PQRI's Effect on Emergency Department Documentation

CMS is replacing the Physician Voluntary Reporting Program (PVRP) with the Physician Quality Reporting Initiative (PQRI). PQRI will involve all emergency care providers, including physician assistants and nurse practitioners. The program is voluntary for 2007; but in 2008, financial penalties may be imposed on providers who either do not participate or do not meet the reporting thresholds. However, incentives are expected to be increased for those providers who do comply with the new program. CMS strongly encourages providers to begin participating in PQRI while the program is still voluntary in order to gain experience with reporting clinical quality data to CMS.

Currently, PQRI includes 74 quality measures into the program. Ten of these measures directly relate to emergency medicine and were developed in conjunction with ACEP and other professional medical organizations. These 10 measures are:

- Aspirin on arrival for AMI
- Beta blocker on arrival for AMI
- ECG performed for non-traumatic chest pain
- ECG performed for syncope
- Vital signs for CAP
- Assessment of oxygen saturation for CAP
- Assessment of mental status for CAP
- Empiric antibiotic for CAP
- t-PA considered in ischemic stroke
- Dysphagia screening in acute stroke

Both PQRI and PVRP are provider-focused programs established by CMS to further the ideal of practicing quality, evidence-based medicine with the goal of improved patient outcomes. The PQRI program will most likely expand over the next several years, adding new measures as they are identified and approved by various quality care organizations. The program may also impose financial penalties on providers who are found to deliver sub-optimal care. The purpose of the PQRI program is to positively affect efforts in achieving high-quality, safe, efficient and cost-effective patient care, which are the goals of all who practice emergency medicine.

For detailed information about the PQRI program and its measures, please visit the CMS website at **www.cms.hhs.gov/PQRI/.**

The American College of Emergency Physicians (ACEP) have been working diligently to educate their colleagues on the PQRI standards. See the link for a document prepared by ACEP:
http://www.aqaalliance.org/files/EmergencyMedMeasuresWorksheetsFinal.doc.

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HMI would like to wish everyone a Happy Independence Day and express our gratitude to those serving our country here and abroad. Thank you!

The information contained herein is solely for the purpose of informing you the health care professional of current changes. Every effort has been made to ensure the accuracy of the contents. However, this newsletter does not replace policies or guidelines set by your Medicare FI or replace the ICD-9-CM or CPT/ HCPCS coding manuals. It serves only as a resource.

Since 1989 HMI Corporation, a Healthcare Management Company, has been assisting acute care, teaching, critical access, long term care, nursing home, home health, and skilled nursing facilities, as well as physician groups, with clinical reimbursement through accurate coding and billing for all financial classes as well as maintaining compliance with Federal payers.

HMI's consultant specialists perform compliance reviews, billing and coding medical reviews, as well as other revenue improvement services, utilizing the provider's chargemaster. HMI also provides physician education to strengthen the medical staff's E/M coding for compliance and to improve reimbursement.

HMI offers a full-service program to assist providers in positioning themselves to meet federal compliance guidelines, with an emphasis on PPS reimbursement. This process also includes inpatient and outpatient record review, on-going chargemaster maintenance, and on-site education/training of clinical staff and physicians. Our fifteen-year success has been primarily founded on facilitating quality consulting service, on-going accountability through management plan objectives and guaranteed service based on our ability to deliver results.

Do you have a specific coding question or topic that you would like to see addressed in our next newsletter? You may fax your question to (615) 661-5147 or go to "contact us" on our website at www.hmi-corp.com. We would like to hear from you.

Q & A Corner

Q. If our cytology technician prepares multiple slides from the same block and there are multiple blocks for a single patient, can we charge for each immunostain?

A. The stains are separately billable within each specific "group of stains" – these classify to CPT codes 88312, 88313, and 88314. The key to billing for these stains separately is that the testing performed on each slide must classify to a specific Group stain or staining methodology as indicated by the CPT description for the above mentioned codes.

For example, in the scenario above – the slides would be separately billable as long as each slide is stained for something different. However, if 4 slides are prepared from one block and two of those slides are stained for Group I microorganism, histochemical staining is performed on one, and Group II staining is performed on the fourth slide, the CPT codes would be as follows:

88312 X 1
88313 X 1
88314 X 1

(Question submitted by a North Carolina hospital)