**OIG UPDATE**

**Observation Services**
The results of several audits completed by the OIG just this year have resulted in identification of hundreds of thousands of dollars in overpayment to hospitals in several states that went under review.

The commonalities for the audit findings are as follows:

- No complications (medical necessity) indicated in the record
- Medical records contained standing orders
- No physician orders
- Inappropriate number of observation hours reported

Each hospital should have in place a policy and procedure for outpatient observation status that describes the key components required to appropriately bill for observation services. This policy and procedure should be approved for use by the hospital’s administration and the medical director. All admitting physicians, nurses, case management, utilization management, HIM staff, business office staff should then receive the proper education/training for obtaining all the required information in the patient’s medical record.

It may be necessary to bring in-house an outside vendor to accomplish the education/training of the hospital staff. Additionally, on-going audits by an outside vendor may be necessary to assist the hospital in monitoring the billing activities for observation services.

**DRG Upcoding**

With much of the audit emphasis focused towards outpatient services, it’s easy for hospitals to lose sight of the OIG’s upcoding project listed in the 2002 Work Plan. Example of the focused DRG’s are 079, 127, 416, 088, 296, etc. Although there have been no published reports so far this year about overpayments due to upcoding, many hospitals should continue to monitor their coding for DRG’s as well. It is particularly important to review cases periodically as the results of coding practices have a great impact on a hospital’s case mix index (CMI).

For further information about OIG audit results see: [www.oig.hhs.gov](http://www.oig.hhs.gov/).

**Emergency Department Visits**

In January 2002, the Advisory Panel on Ambulatory Payment Classification Groups (APC) met. The Advisory Panel included in their discussion the comments on guidelines for facility coding of E/M visits in the Emergency Department (ED) and Clinics. This discussion was facilitated by CMS’ August 24, 2001 proposed rule that solicited comments from the provider community.

The meeting included discussion on different charging options that are currently in place by various institutions. Sample E/M charging methodologies are as follows:

- Point System – points assigned to ED staff interventions
- Levels of Care – based on staff interventions
- Levels of Care – based on time measurement

Regardless of the current methodology your facility is utilizing, periodic monitoring on the use of the charging mechanism is recommended. Also, review claims to ensure that the ED is capturing billable procedures above the services included in the E/M level, which are being performed in their department.

However, if your facility is currently assigning E/M levels based on guidelines for physician coding, CMS recognizes that this system does not directly correlate with the resources of the facility. Your facility may want to adopt one of the methodologies listed above until further information becomes available.

CMS has issued a proposed rule and is available for viewing at [www.access.gpo.gov](http://www.access.gpo.gov) access government information, then go to Federal Register (8/09/02).

**Diabetic Peripheral Neuropathy**

Effective for services beginning July 1, 2002, CMS released new HCPCS codes (G0245 – G0247) under OPPS for reporting evaluation and management and foot care by a physician for diabetic patients. The initial PM AB-02-042, and a clarification PM AB-02-096 address the coding and billing requirements.

A summary of coding and billing information for HCPCS codes G0245 – G0247 is as follows:

1. Required diagnosis codes – 250.60, 250.61, 250.62, 250.63, and 357.2.
2. APC status – G0245 and G0246 are grouped to APC
600, and a status indicator of “V” (Visit to Clinic or Emergency Department). G0247 is grouped to APC 009, and a status indicator of “T” (Significant Procedure, Multiple Procedure Reduction Applies).

3. Code G0247 should be billed with G0245 or G0246 and modifier 25, when applicable.

4. These HCPCS codes are billable when a licensed practitioner provides the services.

For further information, the above referenced program memorandums can be viewed at [www.hcfa.gov](http://www.hcfa.gov/).

**Pass-through Devices**

PM A-02-050 provides an update to 100 HCPCS codes representing medical devices that will expire December 31, 2002.

Essentially, this means that CMS will no longer recognize the current HCPCS code assignment for additional reimbursement, as the payment for these devices will be included in the APC reimbursement for its associated procedure.

However, it is important to maintain applicable revenue code assignment for these devices as hospitals will still need to report the associated device and its charge, along with the CPT/HCPCS code representing the procedure.

Additionally, the PM addresses coding and billing instructions pertaining to kits. The excerpt reads as follows:

“**Kits**

Manufacturers frequently package a number of individual items used in a particular procedure in a kit. Generally, to avoid complicating the category list unnecessarily and to avoid the possibility of double coding, we have not established codes for such kits. However, hospitals are free to purchase and use such kits. If the kits contain individual items that separately qualify for transitional pass-through payments, these items may be separately billed using applicable codes. Hospitals may not bill for transitional pass-through payments for supplies that may be contained in kits.”

Hospitals should monitor closely the items contained within kits that are purchased, and code and bill separately for eligible pass-through devices where applicable.

For further information on this PM, see [www.hcfa.gov](http://www.hcfa.gov/).

**Self-administerable Drugs**

Inpatient claims: These should be billed as covered charges under revenue code 250.

Outpatient claims: These should be billed as non-covered charges under the required revenue code as directed by your FI. Note: Because outpatient self-administerable drugs are statutorily non-covered by Medicare, hospitals are not required to obtain an ABN from the patient. (PM AB-02-072)

**ICD-9-CM Code Updates**

Hospitals can check out the changes to become effective October 1, 2002 at [www.cms.hhs.gov/medleam/icd9code.asp](http://www.cms.hhs.gov/medleam/icd9code.asp).

**Sodium Hyaluronate**

Hospitals should verify that their CDM contains HCPCS code Q3030 effective July 1, 2002. Code J7316 has been discontinued. Additionally ensure that your FI is accepting the new code assignment. (PM AB-02-082)

**ESRD Claims**

Attention ESRD providers. The outpatient code editor (OCE) will be updated to reflect that HCPCS code J1955 will be updated to service indicator B, payable in an ESRD setting. This change became effective with the July 2002 version of the OCE. (PM A-02-056)

Do you have a specific coding question or topic that you would like to see addressed in our next newsletter? Please fax (615) 661-5147 or go to feedback on HMI’s website: [www.hmi-corp.com](http://www.hmi-corp.com). We would like to hear from you.

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Newsletter Prepared by:

HMI Corporation
155 Franklin Road, Suite 190
Brentwood, TN 37027
(615) 661-5145

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