Spring Training for Outpatient Hospital Coding Compliance

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While this month's first "Coding Notes" article covers the bases of coding compliance across the continuum of care, this article offers some hard-hitting rules for playing the compliance game in outpatient hospital coding and reporting.

Staying abreast of all of the regulatory requirements and coding guidelines for hospital-based outpatient services is challenging. The 2001 workplan from the Office of Inspector General includes several areas of focus, so we know it is important to follow existing guidelines for coding and billing outpatient services, including those that involve Ambulatory Payment Classification (APC) grouping.[1]

The targeted areas for review in 2001 related to outpatient services include:

- one-day hospital stays
- DRG payment window, which involves hospital unbundling of outpatient services that should have been included in the associated DRG covered stay
- outpatient prospective payment system (OPPS)
- outpatient pharmacy services at acute care hospitals
- outpatient medical supplies at acute care hospitals

The planned OIG review will examine internal controls that ensure that services are adequately documented, properly coded, and medically necessary. Coding professionals have a significant role to play in this process. However, it can be difficult to avoid information overload as we read and apply the information contained in the landslide of new HCFA Program Memoranda already issued in 2001. Further, confusion abounds about modifier assignments and coding technicalities. Following are the coding issues to keep in mind for each area.

One-day Hospital Stays

If a Medicare patient is admitted to the hospital for a procedure or for medical treatment, only ICD-9-CM codes would be reported on the insurance claim. Care must be taken that these admissions are not inappropriately changed to outpatient services after the fact and then require CPT coding, an issue that is sometimes identified at the time of coding. There are several surgical procedures that if performed on an outpatient basis will not be reimbursed by Medicare with an APC payment. The *Federal Register* indicates that the "inpatient list" would be revised quarterly beginning April 1, 2001.[2] When covered and medically necessary, these services will be paid under a DRG.

Outpatient observation services are not required by HCFA to be reported with CPT codes (they must still be reported by revenue code) but hospitals may use the range 99234-99236, as appropriate with a revenue code from the 760 series. Currently, there is no separate payment for observation services in the APC reimbursement system, because observation is considered incidental to the associated medical or surgical service. For services of observation not associated with another medical service, HCFA has indicated that a low level evaluation and management (E/M) facility code may be reported, but medical necessity would be closely scrutinized for these services.

72-hour Window Requirements

Medicare reporting hospitals are not allowed to separately bill for outpatient services that are related to an inpatient hospital stay within a three-day period. The coding professional needs to identify diagnostic visits that are associated with a hospital stay, such as pre-operative laboratory or radiology services, so a separate claim will not be submitted.

OPPS

Learning and managing the complexities of the APC game has been a challenge for coding professionals. Because numerous pass-through items have been added, we now have approximately 1,075 APCs to monitor. More than 600 new HCPCS Level II codes developed during 2000 are vendor-specific and have dedicated revenue code assignments. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 modifies the procedures and standards for categorizing and eligibility requirements for medical devices. The development of special categories for new medical devices is now under consideration, and it is likely that payment will evolve into a category basis, then be incorporated into the associated service at the end of the transitional period for APCs (currently January 1, 2004).

The pass-through lists will be updated each quarter, so it is important that eligible codes be incorporated into the chargemaster and appropriately linked to the correct revenue code. Currently, coders must ensure that when one of these services is provided, the appropriate code makes it to the claim form. Even those services that are considered incidental to other services should receive a code when possible and generate a line item on the UB-92. Then the services can be considered in the outlier process and Medicare or other interested third-party payers will have charge data available for future decision making.

Modifier assignment and the outpatient code edits applied to outpatient services continue to create controversy in the coding community. There may be subtle differences in reporting requirements for each fiscal intermediary. It is important to follow appropriate CPT and Medicare reporting guidelines. Medicare information can be obtained from the HCFA Web site.[3]

It is especially important to avoid indiscriminate use of modifier -59 and modifier -25 for Medicare reporting, because both can trigger inappropriate APC assignment and result in overpayment for the hospital. We don't want too many "foul balls" associated with assigning -59 to CPT procedures designated as separate procedures.

Outpatient Pharmacy Services at Acute Care Hospitals

This area may not be a major concern for most coders, because pharmaceuticals are generally processed via the chargemaster. However, one of the basic rules has always been that Medicare Part B does not cover self-administered drugs, so there should not be any process in the hospital that disguises this practice by using other codes to get them reimbursed. The OIG will focus on periods before the implementation of APCs, but it still important to be aware of the rules so we are not hit unexpectedly by the stray ball of a full-blown audit because of a chargemaster code-mapping problem.

Outpatient Medical Supplies at Acute Care Hospitals

Before the implementation of APCs, coding professionals were not particularly interested in medical supplies. In the APC environment, many medical supplies are incidental to the associated service and are not separately reimbursed. Supplies that have a HCPCS Level II code will be listed in the APC regulations with the following status indicators that show the expected reimbursement result for each code:[4]

- A for durable medical equipment, prosthetics, and orthotics
- N for incidental services packaged into the APC rate
- E for noncovered services
- F for acquisition of corneal tissue
- G for current drug/biological pass-through
- H for device pass-through
- J for new drug/biological pass through
- K for non-pass-through drug/biological

Even those supplies that do not result in additional APC reimbursement should be reported so that they are included in the outlier calculations. It is also beneficial to have the detailed data collection that specific code assignment may offer for future decision support involving outpatient services.

A Coder's Game Plan

It may be helpful to adopt this abbreviated set of guidelines for coding professionals responsible for outpatient record processing. These guidelines can be posted at coding workstations and displayed in other areas of the hospital where outpatient services are provided or the resulting paperwork is processed. This is not an exhaustive list, but includes some of the most important points for achieving data quality and consistency in outpatient reporting.

1. Coding guidelines for inconclusive diagnoses (often expressed as probable, suspected, rule-out, etc) were developed for inpatient reporting and do not apply to outpatient services. Diagnosis data should be taken from physician documentation and often will be signs, symptoms, or abnormal test results rather than definitive diagnoses.[5]
2. When a diagnosis is confirmed at a higher degree of specificity during the outpatient encounter, it is appropriate to report the code for a condition confirmed by a physician's interpretation rather than the sign or symptom that may have prompted the test or diagnostic service.[6]
3. If the diagnostic information is absent or not complete enough for an assignment of the correct reason for visit on a hospital outpatient, it should be returned to the physician. Assumption coding based on the service rendered is inappropriate and unethical.[7]
4. Medicare's Local Medical Review Policies (LMRP) may be used as a guide for determining which diagnosis codes may result in a paid claim, but should not be the source of which code is reported. Ethical coding practices demand that codes be assigned based on medical record documentation provided by a physician, and not be influenced by insurance coverage alone.
5. The APC system allows reporting of services, such as injections by nursing staff, that may not have been previously reported when outpatient services were based on cost and were included in the facility overhead. Each facility should follow specific coding compliance protocols that delineate which services are eligible for reporting when documentation supports them.
6. Follow CPT coding guidelines for reporting procedures on a UB-92. Note when payer-specific requirements require a HCPCS level II code rather than a CPT code for selected services.
7. Do not attempt to report CPT codes for any case that does not have key elements of the record present at the time of code selection. Essential elements for an outpatient surgical case include a history and physical, the completed operative or procedure report from the physician, and any associated diagnostic services associated with the operative report, including a completed pathology report.
8. If a CPT procedure has component parts, report the code that represents the service provided rather than reporting a CPT code for each component. For example, it is incorrect to report services such as venous access (36000), injections (90780-90784), or non-invasive oximetry (94760 and 94761) with a diagnostic or therapeutic endoscopy because they are routine components of the endoscopy. The diagnostic portion of a therapeutic endoscopy is not reported separately for the same reason.
9. Use the appropriate set of National Correct Coding Initiative (NCCI) code edits for the type of coding performed. Outpatient hospitals use version 2.1 of the outpatient code editor, while physicians or coder reporting physician services would rely on NCCI version 7.0.[8] You may want to confirm that any software vendor is using the correct set of edits for any of your applications involving the reporting of outpatient services.
10. Understand that the guidelines for reporting E/M services provided for Medicare patients for physicians and for facilities are not the same and the level of service is not expected to always match because the measurement of levels for facilities is provided from a different criteria set. Physician services use the HCFA/American Medical Association criteria, while hospitals are free to develop their own system, as long as it is consistently applied and supported appropriately with clinical documentation.[9]
11. When the information in an outpatient record is confusing or ambiguous after analysis, coders are obligated to communicate with the physician or other clinician to ensure correct reporting of services. Physicians should not be approached with questions that may be readily answered by a medical dictionary or looking up the appropriate coding guideline. A pattern of poor documentation from the same person should be referred to the appropriate authority for follow up, per the policies and procedures in place for the facility compliance program.
12. The central role of today's coding professional is to read and interpret clinical information and apply the appropriate coding principles and guidelines to translate the text information into the numeric codes used for claims processing or data management. It is critical that these codes reflect the actual services provided to the patient.

These 12 compliance guidelines should get coding professionals in great shape for accurate coding and no compliance worries. Play ball!

Notes

1. The OIG Workplan for 2001 is available at the Department of Health and Human Services Office of Inspector General Web site at http://www.dhhs.gov/progorg/oig/wrkpln/index.htm.
2. *Federal Register* 65, no. 219, November 13, 2000; p. 67827. Available at http://www.access.gpo.gov/su_docs/fedreg/a001113c.html.

3. Medicare Learning Network Quick Reference Guides offer a training manual for the outpatient prospective payment system with instructions concerning modifiers. Available at http://www.hcfa.gov/medlearn/refguide.htm. The HCFA site for Program Transmittals and Memoranda is http://www.hcfa.gov/pubforms/transmit/memos/comm_date_dsc.htm.
4. *Federal Register* 65, No. 219, November 13, 2000, p. 68005.
5. Official coding guidelines for ICD-9-CM may be obtained from http://www.cdc.gov/nchs/data/icdguide.pdf.
6. American Hospital Association. Coding Clinic for ICD-9-CM 17, no. 1. Chicago, IL: American Hospital Association, 2000.
7. The Standards of Ethical Coding are available on AHIMA's Web site at http://www.ahima.org/.
8. The Outpatient Code Editor with Ambulatory Payment Classification (OCE/APC) for Medicare Billing and The National Correct Coding Initiative Reference Tools Including the National Correct Coding Policy Manual for Part B Medicare Carriers are available for purchase from the National Technical Information Service at http://www.ntis.gov/.
9. Documentation guidelines are available at http://www.hcfa.gov/medicare/mcarpti.htm.

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Article citation:
Scichilone, Rita A. "Spring Training for Outpatient Hospital Coding Compliance." *Journal of AHIMA* 72, no.5 (2001): 76-78.