

Coding and Documentation 2008 Update

Presented by Healthcare Services Group



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CERTIFIED PUBLIC ACCOUNTANTS
and CONSULTANTS



Overview of Topics

- 2008 Diagnosis Code Changes
- 2008 CPT Code Changes
- 2008 Modifier Changes
- Consultations
- MS-DRG and Present on Admission
- Office of Inspector General (OIG) Work Plan
- Increasing Revenue In Your Practice



2008 Diagnosis Code Changes

168 New Diagnosis Codes

Effective 10/1/07

- Primary Diagnosis Codes
- Additional Digits Required
- Manifestation Codes
 - Not allowed to be reported as a primary diagnosis
 - Describes a manifestation of some other underlying disease, not the disease itself
 - Mandatory multiple coding of etiology & manifestation
- Other Specified Codes
 - "Other" or "Not Elsewhere Classified"
- Unspecified Codes



2008 Diagnosis Code Changes

The Aim for New Codes is More Specificity

- Additional fifth digits
 - Most deleted codes were replaced with codes that have five-digit specificity
 - Corticoadrenal Deficiency – 255.4
 - Must now report the type of steroid deficiency
 - Glucocorticoid Deficiency – 255.41
 - Mineralocorticoid Deficiency – 255.42
- Pay For Performance
- Support CPT code billed for optimum reimbursement



2008 Diagnosis Code Changes

- Examples of New Code Specificity
 - Hearing Impairments
 - More Accurate Descriptions
 - Dysphagia
 - 6 Types
 - Myotonia / Myotonic Disorders
 - Family History of Certain Conditions
 - 6 Codes
 - Ascities
 - Specifying Causes



2008 Diagnosis Code Changes

- Most Misused Unspecified Code
 - Hypertension – 401.9
 - For each hypertension code, there are three selections
 - Malignant – 401.0
 - Severe high arterial blood pressure (BP); results in necrosis in kidney, retina, etc; hemorrhages occur & death commonly due to uremia or rupture of cerebral vessel
 - Benign – 401.1
 - Mildly elevated arterial blood pressure
 - Unspecified – 401.9
 - Elevated BP without dx of hypertension – 796.2
 - Secondary Hypertension (405.0 – 405.99)



2008 Diagnosis Code Changes

- **Infectious & Parasitic Diseases – 16 New**
 - Botulism (Other Specified; Infant; Wound) - 3
 - Roseola infantum - 4
 - Human Herpesvirus – 5
 - Human Herpesvirus Encephalitis – 3
 - Parvovirus B19
- **Neoplasms – 64 New Codes**
 - 60 Lymphoma Codes by Type & Site
 - Marginal Zone - 10
 - Mantle Cell - 10
 - Primary Central Nervous System - 10
 - Anaplastic Large Cell - 10
 - Large Cell - 10
 - Peripheral T-Cell - 10



2007 Diagnosis Code Changes

- **Endocrine, Nutritional and Metabolic, Immunity – 5 New Codes**
 - Glucocorticoid Deficiency
 - Mineralocorticoid Deficiency
 - Multiple Endocrine Neoplasia
 - Type 1
 - Type 11A
 - Type 11B

- **Blood and Blood Forming Organs –3 New**
 - Red cell aplasia (acquired; adult; w/thymoma)
 - Other specified aplastic anemias
 - Bandemia



2008 Diagnosis Code Changes

- **Mental Disorders – 1 New Code**
 - Speech & Language Developmental Delay Due to Hearing Loss
- **Nervous System & Sense Organs – 16 New**
 - Idiopathic Normal Pressure Hydrocephalus - 1
 - Myotonia Disorders - 5
 - Floppy Iris Syndrome – 1
 - Other Disorders of Iris/Ciliary Body – 1
 - Acquired Auditory Processing Disorder - 1
 - Hearing Loss (Conductive; Neural; Sensory; Mixed) – 7
 - Unilateral / Bilateral
 - Unspecified



2008 Diagnosis Code Changes

- **Circulatory System** – 5 New Codes
 - Chronic Total Occlusion of Coronary Artery
 - Septic Pulmonary Embolism
 - Cardiac Tamponade
 - Chronic Total Occlusion of Artery of the Extremities
 - Septic Arterial Embolism
- **Respiratory System** - 1 New Code
 - Influenza Due to Identified Avian Influenza Virus
- **Digestive System** – 6 New Codes
 - Dental Codes – 5
 - Digestive System Code - 1



2008 Diagnosis Code Changes

- **Genitourinary System** – 3 New Codes
 - Vulvar Intraepithelial Neoplasia
 - VIN I & VIN II
- **Complications of Pregnancy, Childbirth and Puerperium** – 4 New Codes
 - Anal Sphincter Tears Complicating Delivery
 - Unspecified As to Episode of Care
 - With or Without Mention of Antepartum Condition
 - Postpartum Condition or Complication
- **Musculoskeletal System & Connective Tissue** – 1 New
 - Aseptic Necrosis of Bone, Jaw



2008 Diagnosis Code Changes

- **Symptoms, Signs, and Ill-Defined Conditions**
 - 8 New Codes
 - Dysphagia – 6
 - Ascities – 2
- **Injury and Poisoning – 2 New Codes**
 - Infection Due to Central Venous Catheter
 - Infection Following Other Infusion, Injection, Transfusion or Vaccination
- **E Codes – 3 New Codes**
 - Environmental Exposure to Harmful Algae and Toxins
 - Oral / Intravenous Bisphosphonates
 - Used in the treatment of osteoporosis, osteitis, bone metastasis, multiple myeloma, etc.



2008 Diagnosis Code Changes

- V Codes – 20 New Codes
 - Personal History Of:
 - Sudden Cardiac Arrest
 - TIA
 - Cervical Dysplasia
 - Family History Of:
 - Malignant Neoplasm, Bladder
 - Sudden Cardiac Death
 - Other Cardiovascular Diseases
 - Multiple Endocrine Neoplasia Syndrome



2008 CPT CODE CHANGES

CPT Changes Effective 1/1/08

135 New Codes

47 Deleted Codes



2008 CPT CODE CHANGES

- Anesthesia – 2 New Codes; 1 Deleted Code
- Musculoskeletal – 25 New Codes; 5 Deleted Codes
 - Computer-assisted surgical navigational procedure for musculoskeletal procedures (20985 – 20987)
 - Manipulation of temporomandibular joint(s), therapeutic, requiring an anesthesia service (21073)
 - Osteotomy of Spine (22207 – 22208)
 - Tenotomy – Elbow (24357 – 24359)
 - Closed / Open Treatments of Fractures
 - Femoral
 - Posterior Malleolus Fracture
 - Arthroscopy – Shoulder (29828)
 - Arthroscopy – Subtalar Joint (29828 – 29907)



2008 CPT CODE CHANGES

- Musculoskeletal – continued
 - Deleted Codes 24350 – 24356 Fasciotomy Codes
- Respiratory – 5 New Codes; 5 Deleted Codes
 - Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent
 - New Code 32421; Deleted Code 32000
 - Thoracentesis with insertion of tube, includes water seal
 - New Code 32422; Deleted Code 32002
 - Insertion of indwelling tunneled pleural catheter with cuff
 - New Code 32550; Deleted Code 32019
 - Tube thoracostomy, includes water seal
 - New Code 32551; Deleted Code 32020
 - Chemical Pleurodesis
 - New Code 32560; Deleted Code 32005



2008 CPT CODE CHANGES

- Cardiovascular – 9 New Codes; 2 Deleted Codes
 - Operative tissue ablation & reconstruction of atria (33257 – 33259)
 - Ascending aorta graft – 33864
 - Bypass graft, with vein; brachial-ulnar or radial – 35523
 - Collection of blood specimen from a completely implantable venous access device
 - New Code 36591; Deleted Code 36540
 - Collection of blood specimen using established central or peripheral catheter, venous, NOS 36592
 - Declotting of thrombolytic agent of implanted vascular access device or catheter
 - New Code 36593; Deleted Code 36550



2008 CPT CODE CHANGES

- Digestive System – 13 New Codes; 4 Deleted
 - Excision or destruction, open, intra-abdominal tumors, cysts or endometriomas (49203 – 49205)
 - Deleted Codes 49200 - 49201
 - Insertions; Conversions; Replacements of:
 - Gastrostomy Tube
 - Duodenostomy or Jejunostomy Tube
 - Cecostomy or Other Colonic Tube
 - Codes 49440 - 49452



2008 CPT CODE CHANGES

- Urinary System – 7 New Codes; 4 Deleted Codes
 - Removal (via snare/capture) & replacement of internally dwelling ureteral stent via transurethral approach, without use of cystoscopy, including radiological supervision & interpretation (S&I) – 50385
 - Same – removal only – 50386
 - Ablation, renal tumor(s); unilateral - 50593
 - Aspiration of bladder; by needle
 - New Code 51100; Deleted Code 51000
 - Aspiration of bladder; by trocar or intracatheter
 - New Code 51101; Deleted Code 51005
 - Aspiration of bladder; with insertion of suprapubic catheter
 - New Code 51102; Deleted Code 51102



2008 CPT CODE CHANGES

- Female Genitourinary System – 7 New Codes
 - Paravaginal defect repair (57285 & 57423)
 - Laparoscopy, surgical with total hysterectomy (58570 – 58573)
- Endocrine System – 1 New Code; 1 Deleted Code
 - Aspiration and/or injection, thyroid cyst
 - New Code 60300; Deleted Code 60001
- Eye & Ocular Adnexa – 6 New Codes; 1 Deleted Code
 - Vitrectomy Codes
 - New 67041 – 67043; Deleted 67038
 - Repair of complex retinal detachment – 67113
 - Treatment of extensive or progressive retinopathy - 67229



2008 CPT CODE CHANGES

- Radiology – 8 New Codes; 7 Deleted Codes
 - Last year – 46 New; 41 Deleted
 - Cardiac magnetic resonance imaging
 - New Codes 75557 - 75564
 - Deleted Codes 75552 - 75556
- Pathology & Lab – 11 New Codes; 1 Deleted Code
 - Basic metabolic panel (calcium ionized) - 80047



2008 CPT CODE CHANGES

- Medicine – 36 New Codes; 5 Deleted
 - Immune globulin, human, for use in subcutaneous infusions, 100 mg each – 90284
 - Immunizations/Vaccines
 - Human Papillomavirus (HPV) – 90650
 - Influenza 90661 – 90663
 - Rotavirus – 90681
 - Diphtheria, tetanus, acellular pertussis vaccine & poliovirus vaccine – ages 4-6 (IM) – 90696
 - Injections & Infusions – (90769 – 90776)
 - Non-Invasive Vascular Diagnostic Studies (93982)
 - Neurology & Neuromuscular Procedures (95980 – 95982)
 - Central Nervous System Assessments/Tests (96125)



2008 CPT CODE CHANGES

- Medicine, continued
 - Special Services, Procedures & Reports
 - Telephone assessment & management service provided by a qualified nonphysician health care professional (98966 – 98968)
 - Online assessment & management service provided by a qualified nonphysician health care professional – 98969
 - Other Services/Procedures
 - Ocular photoscreening with interpretation & report, bilateral – 99174
 - Medical team conference
 - New Codes 99366 – 99368
 - Deleted Codes 99361 - 99362



2008 CPT CODE CHANGES

- Medicine, continued
 - Smoking & tobacco use cessation counseling visit (99406 – 99407)
 - Alcohol and/or substance abuse structured screening (99408 – 99409)
 - Telephone evaluation & management (E&M) service provided by a physician
 - New Codes 99441 – 99433; Deleted 99371 - 99373
 - Online E&M service provided by a physician – 99444
 - Initial hospital care, per day, for the E&M of the neonate, 28 days of age or less, who requires intensive observation, frequent interventions, & other intensive care services – 99477
 - Medication therapy management service(s) – (99605 – 99607)



2008 CPT CODE CHANGES

- Category III Codes – 5 New Codes; 11 Deleted Codes
 - Low-frequency, non-contact, non-thermal ultrasound (wound assessment) – 0183T
 - Excision of rectal tumor, transanal endoscopic microsurgical approach – 0184T
 - Multivariate analysis of patient specific findings with quantifiable computer probability assessment – 0185T
 - Suprachoroidal delivery of pharmacologic agent – 0186T
 - Scanning computerized ophthalmic diagnostic imaging – 0187T
 - All deleted codes from 2007 have become CPT codes in 2008



2008 Modifier Changes

- Modifier Changes Effective 1/1/08
 - Modifier 22
 - Will state for “increased procedural services”
 - Replacing “unusual procedural services”
 - When work required is substantially greater than usually required
 - Also states documentation must show that additional work was done & explain why the extra work was needed



2008 Modifier Changes

- Modifier 59 (Distinct Procedural Service)
 - Description changed to remove any reference to “physician,” replacing it with individual
 - Non-physician providers (NPP’s)
 - Also states that documentation must support the use of this modifier
- Modifier 78 (Return to OR)
 - More detailed description
 - “Unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period



2008 Modifier Changes

- Modifier 92 – New Modifier
 - Alternative Laboratory Platform Testing
 - Should be used when a lab service (such as HIV test codes 86701-86703) is done with a kit containing a single use, disposable chamber



Consultations

- Guidelines

- Request must come from an attending physician or other appropriate source, & the necessity for this service must be documented in the chart
- Consulting physician should provide communication regarding their findings to the requesting physician
- The consultant may initiate diagnostic and/or therapeutic services such as writing orders or prescriptions & initiating treatment plans
- The opinion rendered and services ordered or performed must be documented in the patient's chart



Consultations

- Guidelines

- When the consultant assumes responsibility of any or all of the patient's care subsequent to the consultation encounter, consult codes are no longer appropriate.
- A consultation initiated by the patient or family rather than by a physician is reported with the appropriate office visit code
 - Counseling and Coordination of Care
- A consultation mandated by a third-party payer should be appended with modifier 32



Consultations

- Guidelines

- Inpatient Consultations

- The consultant should only report one consultation code per admission
- Additional visits during the admission should be reported with the appropriate E&M code for subsequent hospital care
 - Includes any services necessary for the consultant to complete their assessment, monitor progress, revise recommendations or examine a new problem



MS-DRG AND PRESENT ON ADMISSION (POA)

- Effective October 1, 2007
- Medicare Severity-Diagnosis Related Groups (MS-DRG's)
 - 745 New Codes
 - Diagnosis Categories
 - Major Complication/Comorbidity (MCC)
 - Complication/Comorbidity (CC)
 - Non-CC
 - Replaces the current 538 CMS-DRG's



MS-DRG AND PRESENT ON ADMISSION (POA)

- May result in increases in payment to urban hospitals
 - Generally treat more severely ill patients
- Prior to 10/1/07 the CC list included 3,326
- Effective 10/1/07, MCC & CC list increased the number of codes to 4,922



MS-DRG AND PRESENT ON ADMISSION (POA)

- Excluded Conditions When a Patient Dies
 - Ventricular fibrillation – 427.41
 - Cardiac Arrest – 427.5
 - Cardiogenic Shock – 785.51
 - Other Shock Without Mention of Trauma – 785.59
 - Respiratory Arrest – 7991



MS-DRG AND PRESENT ON ADMISSION (POA)

- Documentation must be very specific to bill for a MS-DRG
 - Acute Systolic Heart Failure – 428.21 (Major CC)
 - Systolic Heart Failure – 428.20 (CC)
 - Congestive Heart Failure – 428.0 (no longer a CC)
- Chargemaster needs to be reviewed and re-mapped to identify new MS-DRG's
 - DRG 127
 - MS-DRG 291 – Heart Failure & Shock w/MCC
 - MS-DRG 292 – Heart Failure & Shock w/CC
 - MS-DRG 293 – Heart Failure & Shock w/out MCC/CC



MS-DRG AND PRESENT ON ADMISSION (POA)

- Hospital-Acquired Conditions
 - Effective 10/1/08
 - Medicare will not reimburse for a higher-paying DRG for CC's that are hospital-acquired and preventable
 - POA will be the determining factor
 - Hospital-Acquired Injuries
 - Pressure Ulcers
 - Surgical Site Infections
 - Catheter-Associated UTI's
 - Vascular Catheter Associated Infection



MS-DRG AND PRESENT ON ADMISSION (POA)

- Present on Admission (POA)
 - Present at the time the order for inpatient admission occurs
 - Includes conditions present during an outpatient encounter, including the ED
 - Reporting Options
 - Y – Yes
 - N – No
 - Developed during course of stay
 - U – No information in the record
 - Poor documentation
 - W – Clinically undetermined
 - 1 – Unreported/Not Used Exempt from POA Reporting
 - Certain E Codes; V Codes; Maternity



Office of Inspector General (OIG) Physician Work Plan

Physician OIG Work Plan for 2008

- Place of Service (POS) Errors
 - Review physician coding of POS on claims performed in ambulatory surgical centers (ASC) & hospital outpatient departments
 - Medicare pays a physician a higher amount when a service is performed in a non-facility setting (physician's office)
- Evaluation & Management (E&M) Services During Global Surgery Periods



Office of Inspector General (OIG) Physician Work Plan

- “Incident-to” Services
 - Review medical necessity, documentation & quality of care for “incident-to” services
- Assignment Rules by Medicare Providers
 - Review providers that may be billing beneficiaries in excess of amounts allowed by Medicare requirements & assess beneficiary awareness of the potential violations



Office of Inspector General (OIG) Physician Work Plan

- Business Relationships & the Use of MRI Under the Medicare Physician Fee Schedule
 - Review relationships among physicians, billing providers, & others who work together to provide imaging services & determine whether these relationships affect levels of utilization



Office of Inspector General (OIG) Physician Work Plan

- Interventional Pain Management Procedures
 - 2005 – Medicare paid nearly \$2 billion for pain management
 - Will determine the appropriateness of payments for pain management & assess the oversight of these procedures



Office of Inspector General (OIG) Physician Work Plan

- Geographic Areas With a High Density of Independent Diagnostic Testing Facilities (IDTF)
 - IDTF is a facility that performs diagnostic procedures independent of a physician's office or hospital
 - Review service profiles, provider profiles, beneficiary profiles & billing patterns
 - 2006 OIG review found numerous problems
 - Non-compliance with Medicare standards
 - Improper payments



Office of Inspector General (OIG) Physician Work Plan

- High Frequency Chiropractic Treatments
 - Prior OIG work found that 40% of chiropractic services were for maintenance therapy & did not meet Medicare coverage criteria
 - \$186 million in improper payments
 - Review appropriateness of Medicare payments for high frequency chiropractic claims
- Physician Reassignment of Benefits
 - Review the extent to which Medicare physicians reassign their benefits to other entities
 - A large number of reassignments may be indicative of fraudulent or abusive activity



Office of Inspector General (OIG) Hospital Work Plan

Hospital OIG Work Plan for 2008

- Adjustments for Graduate Medical Education (GME) Payments
 - Will review audit adjustments for direct & indirect GME that fiscal intermediaries (FI's) make while settling Medicare cost reports
 - Will determine whether the adjustments were appropriately reflected in the revised Medicare reimbursement



Office of Inspector General (OIG) Hospital Work Plan

- Inpatient Prospective Payment System (IPPS) Wage Indices
 - Will review hospital & Medicare controls over the accuracy of the hospital wage data for CMS to calculate wage indices for IPPS
 - Prior OIG review found hundreds of millions of dollars in misreported wage data
 - Will determine whether hospitals have complied with Medicare requirements for reporting wage data & determine the effect on the Medicare program of incorrect DRG reimbursement caused by inaccurate wage data



Office of Inspector General (OIG) Hospital Work Plan

- Inpatient Hospital Payments for New Technologies
 - Will determine whether hospitals have submitted claims in accordance with the criteria & were appropriately reimbursed for costs associated with the new devices & technologies



Office of Inspector General (OIG) Hospital Work Plan

- Long Term Care Hospital (LTCH) Payments for Interrupted Stays
 - Interrupted stay occurs when a beneficiary is discharged from an LTCH to certain kinds of facilities & then returns to the same LTCH within specified periods of time
 - Will determine if payments for interrupted stays made to LTCH's were correct
- LTCH Short Stay Outliers
 - Review payments for cases discharged from LTCH's with LOS well below the average for their DRG's, which are referred as short stay outliers (SSO)



Office of Inspector General (OIG) Hospital Work Plan

- Provider Bad Debts
 - Review Medicare bad debts claimed by acute care IP hospitals, LTCH's, IP rehab facilities, IP psych facilities & SNF's to determine whether they were reimbursable
- Compliance with Medicare's Transfer Policy
 - Review coding of claims submitted by hospitals for erroneously coded discharges that should have been coded as transfers



Office of Inspector General (OIG) Hospital Work Plan

- Payments for Diagnostic X-Rays in Hospital Emergency Departments (ED)
 - Review a sample of Medicare Part B paid claims & medical records for diagnostic x-rays performed in hospital ED's to determine the appropriateness of payments



Increasing Revenue In Your Practice

- Review and update encounter forms
 - New & Deleted Codes
 - More specificity of codes
- Review insurance reimbursement
 - Track current reimbursement schedules
 - Review EOB's for incorrect reimbursement and/or downcoding
- Review current fee schedule
- Documentation of Services Billed
 - Supports level of CPT code billed



Increasing Revenue In Your Practice

- Review CCI Edits to see what services you can bill together
- Use appropriate modifiers
- Review front desk procedures
 - Obtaining correct demographics and insurance information