Facing The Change – Outpatient Charge Capture Today & Tomorrow

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• HIM Solutions Product Manager
• Former LYNX Compliance Analyst
• Speaker for the Optum Client Forum, Multiple HFMA State and Individual Chapters, Pennsylvania Coders Association
• AAPC member
Agenda

• Welcome and Introduction
• OPPS Proposed & Final Rules
• CPT 2014 & Changes Coming in 2015
• Evaluation & Management
• ICD-10
• EMR Technology Impacts
• High Impact Treatment Areas

OPPS Proposed and Final Rules
OPPS Final Rule 2014 – Why ED Didn’t Make The Cut

In the CY 2014 OPPS final rule, CMS stated that additional study was needed to fully assess the most suitable payment structure for ED visits, including the particular number of visit levels that would not underrepresent resources required to treat the most complex patients, such as trauma patients and the agency delayed any change in ED visit coding while it reevaluated the most appropriate payment structure for type A and type B ED visits.

CMS continues to believe that additional study is needed to assess the most suitable payment structure for ED visits.

The agency reserves the right to propose changes to the coding and APC assignments for ED visits in future rulemaking.

OPPS Proposed Rule 2015

The Centers for Medicare and Medicaid Services (CMS) published the 2015 proposed rule on changes to the outpatient prospective payment system (OPPS) on July 14, 2014, in the Federal Register.

The proposed OPPS rule and corresponding addenda are currently accessible on the CMS website: [http://www.cms.gov/Medicare/Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html](http://www.cms.gov/Medicare/Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html) Click CMS-1613-P. Proposed changes are to become effective January 1, 2015.

The calendar year (CY) 2015 OPPS proposed rule contains updates and changes to the OPPS and the ambulatory surgery center (ASC) payment systems. Changes to the ASC payment system are addressed in a separate special report posted to this website.
Proposed Rule for 2015 - Comprehensive APC’s

For CY 2015, CMS is proposing to implement, with several modifications, the policy for comprehensive APCs that was finalized in the CY 2014 OPPS final rule. The agency would continue to consider the entire hospital stay, defined as all services reported on the hospital claim reporting the primary service, to be one comprehensive service for the provision of a primary service into which all other services appearing on the claim would be packaged.

This would result in a single Medicare payment and a single beneficiary copayment under OPPS for the comprehensive service based on all included charges on the claim. CMS is proposing a total of 28 comprehensive APCs for CY 2015, including all of the device-dependent APCs remaining after some restructuring and consolidation of these APCs and two comprehensive APCs for other procedures that are either largely device dependent or represent single-session services with multiple components (single-session cranial stereotactic radiosurgery and intraocular telescope implantation).

Comprehensive APC’s and Changes to Add on codes

As in CY 2014, for CY 2015, CMS proposes that services assigned to comprehensive APCs be designated as primary services for comprehensive APCs, using status indicator J1.

All add-on codes will be unconditionally packaged and assigned to SIN. None of these add-on codes will be considered primary services assigned to status indicator J1.

A limited set of add-on codes assigned to the current device-dependent APCs, will be used to signify a potential complexity adjustment under the proposed complexity adjustment criteria.
Proposed Rule 2015 Summary

- No further changes to Clinic E&M Codes
- Continued Evaluation of Emergency Department Codes
- No changes to Critical Care Reporting
- No change to Observation Service Reporting
- Additional Packaging of Services, especially add-on codes
- Continued single payment of multiple “Same Family” Radiology Procedures
CPT Code Changes for 2014

Multiple CPT Code changes were made effective January 01, 2014
- 104 New Codes
- 106 Code Revisions
- ~40 Code Deletions

These code changes included significant updates to Breast Biopsy and Upper GI procedures along with extended Laboratory studies. New code added for Telephonic Physician Consultation services.

** No significant code level changes for Outpatient Evaluation & Management codes or Medication Administration code set in 2014.

What's coming in CPT 2015?

Over #500 changes will become effective in 2015!
E&M Changes in 2014


This code is for hospital use only and represents any and all clinic visits under OPPS. HCPCS

This policy no longer recognizes a distinction between new and established patient clinic visits.

Existing methodology continued to recognize the CPT codes for type A emergency department (ED) visits as well as the five HCPCS codes that apply to type B ED visits.
CMS Proposed Rule - Reporting E/M In 2015

For CY 2015, CMS proposes to continue the current policy, adopted in CY 2014, for clinic and ED visits.

CMS proposes to use CY 2013 claims data to develop the proposed CY 2015 OPPS payment rates for HCPCS Level II code G0463 based on the total geometric mean cost of the levels 1 through 5 CPT E/M codes for clinic visits currently recognized under the OPPS (CPT codes 99201–99205 and 99211–99215).
ICD-9 vs. ICD-10 – By The Numbers

- There are nearly 5 times the number of codes included in the 2014 ICD-10 CM code set than in ICD-9:
  ~68,000 ICD-10 CM (Diagnosis)
- And nearly 19 times the number of codes included in the 2014 ICD-10 PCS code set:
  ~87,000 ICD-10 PCS (Procedural)

<table>
<thead>
<tr>
<th>Code Structure Changes (selected details)</th>
<th>Old</th>
<th>New</th>
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</thead>
<tbody>
<tr>
<td><strong>Diagnosis Structure</strong></td>
<td></td>
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<tr>
<td>ICD-9-CM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-5 characters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First character is numeric or alpha</td>
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<td></td>
</tr>
<tr>
<td>Characters 2-5 are numeric</td>
<td></td>
<td></td>
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<tr>
<td>ICD-10-CM</td>
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<tr>
<td>3-7 characters</td>
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<td></td>
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<tr>
<td>Character 1 is alpha</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Character 2 is numeric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Characters 3 – 7 can be alpha or numeric</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Procedure Structure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICD-9-CM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-4 characters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All characters are numeric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All codes have at least 3 characters</td>
<td></td>
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<tr>
<td>ICD-10-PCS</td>
<td></td>
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<tr>
<td>ICD-10-PCS has 7 characters</td>
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<tr>
<td>Each can be either alpha or numeric</td>
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</tbody>
</table>

Figure 1. Key differences between ICD-9-CM and ICD-10-CM and ICD-10-PCS code sets.

General Differences

In general, when compared to ICD-9, the codes included within ICD-10 CM/PCS:
- Reflect and/or require a greater level of specificity
- Better define laterality
- Better reflect current clinical and technological medical practice
- Contains more extensive vocabulary of clinical concepts
- Includes patient encounter concepts of subsequent and sequela

General Equivalence Mappings (GEMs)

- General Equivalence Mappings are files created specifically to assist users in identifying codes which have a relationship between ICD-9 and ICD-10
- “Forward mapping” – Utilizing ICD-9 codes to assist with locating equivalent ICD-10 codes
- “Backward mapping” – Utilizing ICD-10 codes to check for equivalent ICD-9 codes
- Mappings may contain:
  - 1:1 mapping (Only one code and its equal in the alternate code set)
  - 1:Many mapping (One code may map to multiple codes in the alternate code set)
  - No equivalent (Does not map relationally between code sets)
- CMS has published both 2014 and 2015 GEMs mappings (.zip files)

**Many Optum applications utilize a combination of “native” code identification and GEMs mappings**

Centers For Medicare and Medicaid (CMS)

CMS has published the following resources for general use:
- Latest News
- E-mail updates offerings
- Implementation Timeline Guides (by practice/facility type and size)
- Best Practice Implementation Planning Guides
- Regulations
- Code sets and GEMS mappings by year
- Schedules of CMS sponsored ICD-10 Teleconferences

American College of Emergency Medicine (ACEP)

ACEP has been very active in both ICD-10 regulation/implementation and education over the last several years.

Up to date information may be found within the ACEP Now newsletter at:

Published ICD-10 Emergency Department Clinical Examples:
http://www.acep.org/uploadedFiles/ACEP/practiceResources/issuesByCategory/reimbursement/ICD-10-CM%20ED%20Clinical%20Examples%206%202014.pdf

Information Papers:

ICD-10 Training Webinar Sessions (both historic and ongoing sessions):

EMR Technology Impacts
General EMR Technology Impacts – Charger/Coders

Positive Impacts -
• Clearer Documentation (Handwriting)
• Clarity of Patient Orders
• Reduced “Chart Loss”
• Clearer Encounter Tracking
• Some systems offer Charge Integration and/or Code Assignment

“Other” Impacts -
• Overwhelming amount of documentation
• Not all documentation within the same system
• Concerns with “cloned” documentation

New or Ongoing Audit Target Issues

• Medical Necessity
• Correct Disposition – Admission vs. Observation
• Observation and Admission “Short Stays” with or without a preceding Emergency Department Visit
• Correct Reporting of Injections and Infusions
• Facility Visit Level Calculations
• Physician Signature
• Unbundling of Codes
• Modifier -59
Computer Assisted Coding & NLP

Natural language processing (NLP)
- Software that can “read” clinician documentation, identify key clinical facts, and map those facts to codes
- Clinicians use standard dictation/transcription, speech recognition, or templates with free-text fields
- NLP is the technology behind CAC
- There are multiple technologies used for NLP in the CAC industry, ranging from basic terminology matching to advanced artificial intelligence

High Impact Treatment Areas
Common Emergency Department Charging Issues

- Multiple Systems/Areas of Documentation
- Incomplete or Missing Physician Documentation
- Lack of Clinical Specificity
- Hard vs. Soft Coding of CPT Codes
- Missing or Incomplete Medication Administration

Infusion and Injection Terminology Overview

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Initial Service</td>
<td>Review all documented services according to CPT hierarchy to determine the “1st service to be reported”</td>
</tr>
<tr>
<td>Sequential Infusion</td>
<td>Infusion of a different substance or drug that immediately follows the initial infusion (one after another)</td>
</tr>
<tr>
<td>Concurrent Infusion</td>
<td>Service where multiple infusions are provided through the same IV access simultaneously (at the same time)</td>
</tr>
<tr>
<td>Secondary Services</td>
<td>Codes for additional sequential or concurrent infusions or IV injections used to report additional substances administered within the same patient encounter</td>
</tr>
<tr>
<td>IV Injection/IV Push</td>
<td>An injection in which the healthcare professional is continually present for 15 minutes or less. May also represent an IV infusion of “short duration” or less than or equal to 15 minutes.</td>
</tr>
</tbody>
</table>
General Overview

- Utilizing the Current Procedural Terminology (CPT®) descriptors, the following “hierarchy” concept is generally accepted:
  - Chemotherapy and Complex Medication, including Biologic Response Modifiers (BRM’s) should be reported primary to,
  - Medication Infusions (16 minutes or longer in duration) should be reported primary to,
  - Medication Injections administered IV Push or with an IV Infusion of less than 16 minutes should be reported primary to,
  - Medically Necessary Hydration

- Each Fiscal Intermediary (FI) or Medicare Audit Contractor (MAC) may choose to address documentation and reporting needs specific to their included geographic area.

Intravenous Infusion and Injection Hierarchy

CPT Initial Service Codes
Choose one per IV site using the hierarchy
96365 – TPD intravenous infusion
96374 – TPD intravenous push
96366 – IV hydration

**Note: There is no CPT code assignment for SQ hydration services**
Additional Elements to Consider

**Therapeutic/Prophylactic/Diagnostic Services**
- What are defined included services
- Multiple sites of administration
- CPT Hierarchy
- Multiple Medications
- Facility administration documentation
- Other services provided
- Multiple encounters on the same calendar date

**Hydration Services**
- Multiple sites of administration
- Medical necessity
- Facility administration documentation
- Other services provided
- Multiple encounters on the same calendar date

Other Elements to Consider

**Chemotherapy/Complex Medication Services**
- Multiple sites and routes of administration
- CPT Hierarchy
- Multiple Medications
- Identifying Chemotherapy and Complex Medications
- Facility administration documentation
- Other services provided
- Multiple encounters on the same calendar date

**Non-Hierarchy Services**
- Intramuscular Medication Administration (IM)
- Subcutaneous Medication Administration (SQ)
- Subcutaneous Hydration Administration
- Intraosseous Medication/Hydration Administration
- Intra-Arterial Administration (IA)
- Immunization Administration
- Blood Transfusions
Observation Services - Defined

Observation services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission as an inpatient...

Common Observation Challenges – Documentation of Order

- There must be a provider order for observation
- Observation is a patient status, not a location.
- A patient may be Observed in any available bed in any department of the facility

**Challenge:** Two patients in the same room receiving similar care may be in 2 different statuses.

- Client/Location communication of specific coding/reporting processes through Client Coding Guidelines: Where and who or how this order is documented.
Thank you.

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