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Dual Coding: A Tool for Coder Practice

FAQS
Frequently Asked Questions for July
**FEATURED ARTICLE**

**What CPT® Codes Are You Using for Autism Spectrum Disorder Diagnoses Services?**  
By Shelley Nave, RHIA, CPC-H

“Autism spectrum disorder (ASD) is a developmental disability that can cause significant social, communication and behavioral challenges,” reports Shelley Nave in this month’s CCFN. “The term 'spectrum' refers to the wide range of symptoms as well as levels of impairment or disabilities. The range may be high functioning (often called Asperger’s Syndrome) to severe mental retardation along with specific characteristics of deficits in social communication and interaction, repetitive pattern behavior and developmental delays that are characteristic of autism.” Although there is no cure for ASD, however, there are a few different methodologies for treating ASD, reports Nave.

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**RAC UPDATES**

**Recovery Auditor Update for August**  
By Renee Goetsch, RHIT, CCS

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**TALKING POINTS**

**To Exclude (1) or To Exclude (2), That is the Question in ICD-10-CM**  
By John D. Hope, CPC

ICD-10-CM has two different excludes notes — Excludes1 and Excludes2. The inclusion of these two notes should help to end the confusion of exclusionary guidelines and coding conventions.

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**TALKING POINTS**

**Supply Packaging – Moving from a Fee Schedule System of Payments to a Prospective Payment System**  
By Lynda Millican, RN, BSN

You may have been able to separately bill certain supplies. With packaging of items and services, supplies that you previously reported separately, you may no longer be able to do so.

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**ICD-10 TALK**

**Dual Coding: A Tool for Coder Practice**  
By Darnacea Harris, MHA, RHIT, CCS

Now that the implementation date for ICD-10 has been reestablished, organizations will need to find ways to resume and improve coder skills. Two methods for providing coder practice are to implement dual coding, and to code case studies.
The apparent suicide of actor and comedian Robin Williams in mid-August has focused the nation’s attention on mental health. And so do we in the August edition of Coding and Compliance Focus News. MedAssets Shelley Nave writes about coding disorders associated with autism spectrum disorder (ASD) diagnoses. Coincidentally, the Centers for Disease Control and Prevention (CDC) study found that 1 in 68 children have been identified with ASD.

News of a more positive nature came this month with the publication of the ICD-10 final rule in the Federal Register. Darnacea Harris reports on what coders can do to practice coding in anticipation of the implementation of I-10 come October 2015. Renee Goetsch reports on the latest activities by the recovery auditors (RAs). John Hope answers his own rhetorical question: “To Exclude1 or Exclude2, That is the Question” in his article about excludes notes in ICD-10. Finally, Lynda Millican reports on supply packaging this now moving from a Fee Schedule System of Payments to a Prospective Payment System.

For more on this story plus other timely articles, we welcome you to the August edition of CCFN.
What CPT® Codes Are You Using for Autism Spectrum Disorder Diagnoses Services?

In 2010, the Center for Disease Control and Prevention (CDC) reported that 1 in every 68 children in the United States was diagnosed with Autism spectrum disorder (ASD).

By Shelley Nave, RHIA, CPC-H

Autism spectrum disorder (ASD) is a developmental disability that can cause significant social, communication and behavioral challenges. The term “spectrum” refers to the wide range of symptoms as well as levels of impairment or disabilities. The range may be high functioning (often called Asperger’s Syndrome) to severe mental retardation along with specific characteristics of deficits in social communication and interaction, repetitive pattern behavior and developmental delays that are characteristic of autism.

In 2010, the Center for Disease Control and Prevention (CDC) reported that 1 in every 68 children in the United States was diagnosed with ASD. Currently, there is no cure for ASD, however, there are a few different methodologies for treating ASD. A widely acceptable treatment among healthcare professionals is applied behavior analysis (ABA). ABA services encourage positive behaviors while discouraging negative ones through motivational techniques designed to modify aberrant behavior.

Legislation has passed in most states to implement coverage for the treatment of autism, including ABA. However, there has been no uniformity among state and commercial payers for billing ABA services. Most states and some payers have accepted Level II HCPCS codes (e.g., H2001–H2020), although these codes were not reportable on a Medicare claims.

Other payers, including Medicare, have accepted Category I (CPT) codes (e.g., 90834, 90853, 92508, 96101, 96110-96118, 96152-96155, 97003-97004). Although physical and occupational therapists, speech language pathologists, clinical social workers, psychiatrists, psychologists and clinical neurologists may report these codes in treating patients with ASD, their professional services are separate and distinct from ABA. According to the American Medical Association (AMA) CPT® Editorial Panel ABA workgroup, these HCPCS/CPT codes do not accurately describe ABA services and should not be used to report ABA services.
NEW CATEGORY III CODES

The AMA CPT® Editorial Panel workgroup developed 16 new CPT category III codes that describe the work involved in ABA services for patients diagnosed with ASD. These codes were effective July 1, 2014, however, they will not be published in the CPT Manual until 2015. Adaptive behavior assessments and treatments category III codes 0359T–0374T may be reported for treating patients of any age with ASD or other diagnoses and conditions associated with deficient adaptive or maladaptive behaviors. The adaptive behavior assessments and treatment codes are reportable on a Medicare outpatient claim and are reportable when ABA services are performed by physicians or other qualified healthcare professionals working within the scope of their respective state licensure or professional credentials. Licensed psychologists, assistant behavior analysts and technicians are also qualified to perform such services. The following information provides a more detailed analysis of the new category III codes.

ASSESSMENTS

0359T – Behavior Identification Assessment by the physician or other qualified healthcare professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report

0360T – Observational behavioral follow-up assessment, includes physician or other qualified healthcare professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient

TREATMENTS

0361T – Observational behavioral follow-up assessment, includes physician or other qualified healthcare professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)

0362T – Exposure behavioral follow-up assessment, includes physician or other qualified healthcare professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient

0363T – Exposure behavioral follow-up assessment, includes physician or other qualified healthcare professional direction with interpretation and report, administered by physician or other qualified healthcare professional with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)

0364T – Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time

0365T – Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)

0366T – Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time

0367T – Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)

0368T – Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time

0369T – Adaptive behavior treatment with protocol modification administered by physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)

0370T – Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)

0371T – Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present)
0372T – Adaptive behavior treatment social skills group, administered by physician or other qualified health care professional face-to-face with multiple patients

0373T – Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians’ time, face-to-face with patient

0374T – Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); each additional 30 minutes of technicians’ time face-to-face with patient (List separately in addition to code for primary procedure

**CPT CODING GUIDANCE**

The new adaptive behavior codes are categorized as assessments and treatments. Although, the codes’ descriptors clearly describe the services that are inclusive of the adaptive behavior assessment and behavior treatment codes, several of the coding guidelines, listed below, should help you bill these new codes appropriately. The following are assessment codes.

**BEHAVIORAL ASSESSMENTS (0359T-0363T)**

Assessments are useful in developing behavior treatment plans that reduce identified problem behavior. Behavioral assessment involves observing patient behavior, administering tests, conducting interviews, reviewing previous assessment records, and reassessing patients to revise treatment plans or provide to add new treatment goals.

CPT code 0359T reflects behavior identification assessment and includes face to face observation, current and past behavior history, a care of plan, interviews with family and guardian(s); administering standardize and non-standardize test, interpreting test(s), reports and discussing findings. This assessment is performed by the physician or other qualified healthcare professional. This code is generally reported once within a defined time-frame (e.g. six months to a one-year interval). Reassessments may also be reported with 0359T. Reassessments may be necessary for a new or revised treatment goal due to failure and/or success of the current treatment plan. This code may be reported for the assessment required for early intensive behavioral intervention (EIBI).

There are two different types of follow-up assessments which are categorized as observational behavioral and exposure behavioral. The follow-up assessments codes (0360T – 0363T) may be reported when a physician or other qualified healthcare professional needs to finalize or amend the baseline results and the plan of care that was initially created during the behavior identification assessment session.

CPT codes 0360T and 0361T are observational behavioral follow-up assessments. This type of assessment is provided for patients who have specific destructive behavior(s); or behavior problems secondary to repetitive behaviors or deficits in communication and social relatedness. Observational behavioral follow-up assessment requires patient observation that may be performed by a qualified technician under the direction of a physician or other qualified healthcare professional. Also included in this service are the physician’s interpretation of results, preparation of a report and discussion of findings and recommendations. These assessments are provided by technicians and directed by the physician or qualified healthcare professional. The physician or qualified healthcare professional, however, is not required to be onsite. The assessments are generally completed over several days but less than one month after the behavior identification assessment (CPT 0359T).

Exposure behavioral follow-up assessment is less frequently performed and is reported using CPT codes 0362T and 0363T. This type of assessment involves patients with one or more specific severe destructive behavior(s) (e.g., self-injury, aggression, property destruction). The method utilized in this assessment is exposing the patient to a series of social and environmental conditions associated with the patient’s behavior(s). This service is also provided by technicians, however, the service does require the physician or other qualified healthcare professional to provide on-site direction to a team of technicians (typically two or three are required). Exposure behavior follow-up assessments generally require the use of protective gear and a padded room to avoid injuries to patients. Also included in this service are the physician’s interpretation of results, preparation of a report and discussion of findings and recommendations. Codes 0360T-0363T are based on a single technician's face-to-face time with the patient even though more than one technician was present with the patient. Do not combine time of the multiple technicians.

**ADAPTIVE BEHAVIOR TREATMENTS (0364T–0374T)**

ABA includes the use of adaptive behavior treatments. The treatments include individual and family or group treatment, social skills training, and exposure
treatment. Adaptive behavior treatments are focused on providing behavior treatment for patients diagnosed with ASD or other diagnosis or conditions (e.g., development disabilities, head trauma) associated with deficient adaptive or maladaptive behavior. Most of the adaptive behavior treatments are provided by technicians under the direction of a behavior analyst.

Specifically, codes 0370T and 0371T are reportable when family members or guardians are taught treatment protocols. Adaptive behavior treatments address the patient’s specific behavior problems that were observed during the behavior identification assessment (0359T); or in one of the behavior follow-up assessments (0360T–0363T). Treatment may take place in multiple sites and social settings, including individual sessions or group sessions at home or other environments. The treatments include analysis and alteration of relative events and motivating factors, stimulus-consequence strategies and replacement behavior and monitoring of outcomes.

Adaptive behavior treatment by protocol may be performed by a single technician under the direction of a physician or other qualified healthcare professional. Treatments are delivered to patients in an individual session (0364T, 0365T); or in a group session of two or more patients (0366T, 0367T). For patients in groups larger than eight patients, do not report codes 0366T and 0367T, To report 0366T and 0367T, patients must participate in the interaction of the group adaptive behavior treatment by protocol to meet their own individual treatment goals,

Adaptive behavior treatment by protocol modification (0368T, 0369T) cannot be performed by technicians. These treatments may only be reported when performed by physicians or other qualified healthcare professionals. During the session the physician resolves one or more problems with the protocol and may instruct the new or modified protocols to a technician, caregiver(s), and/or guardian(s). Please note that if the patient is not present, it would not be appropriate to report this service.

Family and multiple family group adaptive behavior treatment guidance is a service provided for patients diagnosed with ASD, so that families can learn to apply treatment protocols. These sessions are administered by physicians and other qualified healthcare professionals face-to-face with the patients caregiver(s), or guardian(s), without the present of the patient. Code 0370T is reportable when the guidance session involves one patient’s family. Code 0371T is reportable when the guidance session involves many individuals within the patient’s family. Do not report codes 0370T or 0371T if the group includes family (caregivers/guardians) of more than eight patients.

Treatment for social skills and problems are reportable using CPT code 0372T. This treatment is provided in a group setting where a physician or other qualified healthcare professional monitors the needs of the individual patients and adjusts the treatment technique methods in real time to address target social deficits and behavior problems. This CPT code should not be reported if the group session includes more than eight patients. Additionally, 0372T should only be reported if the patients are participating in the interaction of the group session to meet their individual treatment goals.

Exposure adaptive behavior treatments (0373T, 0374T) are provided in staged environments in order to train appropriate alternative responses under the environmental context that typically evoke problem behavior. Exposure adaptive behavior treatment addresses one or more types of destructive behavior. The treatments may be performed by technician(s) under the direction of a physician, or another qualified healthcare professionals in a structured, safe environment; and protective gear. Codes 0373T and 0374T are reported based on a single technician’s face-to-face time with the patient and time should not be combined if multiple technicians are involved during the treatment session.

**CPT TIME RULE**

The behavior assessment and behavior treatment codes are time based services reportable on a single date of service. It is important when reporting time base codes that they are reported according to the CPT Time rule.

The rule states, “A unit of time is attained when the mid-point is passed.” Therefore, if at least 16 minutes of face-to-face is not attained it would be inappropriate to report a behavior follow-up assessment or behavior treatment code that describes first 30 minutes time, face to face with the patient. The table below provides an example of the CPT Time rule:

The follow-up assessments (0360T-0369T) and the behavior treatment (0364T-0369T, 0374T) codes are timed in 30 minute increments. When 16 minutes of assessment or treatment is not attained it would not be appropriate to report the assessment or treatment.

This “time” rule also applies to exposure adaptive behavior treatment code 0374T, which is a 60-minute time based code. To appropriately report this code at least 31 minutes of treatment must be provided and supported by medical record documentation. If additional time is warranted, then report add-on code
0374T. Based on the time rule, at least 75 minutes of treatment must be provided to appropriately report the code pair (0373T and 0374T). The following table provides the behavior assessment and treatment codes with the associated time rule.

**TIME RULE**

<table>
<thead>
<tr>
<th>Time</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 16 minutes</td>
<td>Not reportable</td>
</tr>
<tr>
<td>16–45 minutes</td>
<td>0360T, 0362T, 0364T, 0366T; OR 0368T</td>
</tr>
<tr>
<td>46–75 minutes</td>
<td>0360T AND 0361T; OR 0362T AND 0363T; OR 0364T AND 0365T; OR 0366T AND 0367T; OR 0368T AND 0369T</td>
</tr>
<tr>
<td>31–75 minutes</td>
<td>0373T</td>
</tr>
<tr>
<td>76–105 minutes</td>
<td>0374T</td>
</tr>
<tr>
<td>Each additional increment up to 30 minutes</td>
<td>ADDITIONAL 0361T, 0363T, 0365T, 0367T, 0369T, 0374T</td>
</tr>
</tbody>
</table>

Coding and sequencing for adaptive assessment and treatment codes are dependent on the physician or other qualified healthcare professionals’ documentation in the medical record. Under Medicare, physicians, other qualified healthcare professionals should report the appropriate CPT adaptive assessment and treatment code that describes the procedure performed, and should be reported only if all services described by the code descriptor are performed.

A summary of some of the information included in this article has been provided in the following chart.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Timed-Code (YES OR NO)</th>
<th>Physician Direction (YES OR NO)</th>
<th>Physician or Other qualified Health care Professional Only (YES OR NO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0359T</td>
<td>N</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>0360T</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>0361T</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>0362T</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>0363T</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>0364T</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>0365T</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>0366T</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>0367T</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
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<tr>
<td>0368T</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
</tr>
<tr>
<td>0369T</td>
<td>Y</td>
<td>N</td>
<td>Y</td>
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<td>0370T</td>
<td>N</td>
<td>N</td>
<td>Y</td>
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<td>0371T</td>
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<td>0372T</td>
<td>N</td>
<td>N</td>
<td>Y</td>
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<tr>
<td>0373T</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>0374T</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

MedAssets recommends that you review the new adaptive assessment and treatment codes to gain an understanding of the codes and services that are represented and are inclusive of the codes.

Remember, prior to July 1, 2014, the code set for reporting ABA services varies from payer to payer, and from state to state. It is important to verify with third party payers if the new adaptive assessment and treatment codes are acceptable to report for ABA services. Revisit third party policies to determine if new coverage criteria must be met. Also, check for new or revised limitations criteria for reporting ABA services using the new adaptive assessment and treatment codes for ABA.

**ABOUT THE AUTHOR**

Shelley Nave, RHIA, CPC-H, is a senior coding and CDM analyst with MedAssets. In this role she provides coding and reimbursement guidance and maintains the CPT/HCPCS content for MedAssets products. Prior to joining MedAssets, Shelley was director of health information management (HIM) for five years in an acute care hospital in Georgia. Shelley graduated from the Medical College of Georgia with a B.S. degree in Health Information Management.

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U.S. Department of Health & Human Services – Our Commitment to Supporting Individuals on Autism Spectrum and their Families – HHS.gov
Recovery Auditor Update for August

By Renee Goetsch, RHIT, CCS

New recovery auditor (RA) contracts remain on hold due to litigation against the Centers for Medicare & Medicaid Services (CMS). In the meantime, there are no complex reviews under current RA contracts. And last month, in a hearing conducted by the United States Senate's Special Committee on Aging Roundtable, CMS auditing services came under fire. Meanwhile, it appears to be business as usual for the Office of Inspector General for the Department of Health and Human Services (OIG). Here are the details on these stories.

Aug. 4, 2014 – Due to the continued delay in awarding new Recovery Auditor contracts, the CMS is initiating contract modifications to the current Recovery Auditor contracts to allow the Recovery Auditors to restart some reviews. Most reviews will be done on an automated basis, but a limited number will be complex reviews of topics selected by CMS.

Work continues on the procurement process for the four Part A / Part B Regions and the national DMEPOS/HH&H Region. The CMS remains hopeful that the new round of Recovery Auditor contracts will be awarded this year.

Last month, the US Senate's Special Committee on Aging Roundtable conducted a hearing on auditing practices. "The Medicare claims review process is unfairly burdening healthcare providers and failing to improve program integrity, due in part to the payment system for certain auditors", Senate leaders said during a roundtable hearing Wednesday, July 9, 2014. Lawmakers also slammed anti-fraud efforts being conducted by CMS. For entire report, see the committee staff report “Improving Audits: How We Can Strengthen the Medicare Program for Future Generations.”

AS A REMINDER FROM THE CMS RAC WEBSITE
“Last day that Recovery Auditors may send claim adjustment files to the Medicare Administrative Contractors (MAC) is June 1, 2014. As of June 2, 2014, only claim closure files may be sent to the MACs, by the Recovery Auditor.

Because no additional reviews will occur under the current contracts, current Recovery Auditors will not be required to update the “New Issue” (“Approved Issue”) portion of their websites, as of June 2, 2014. However, Recovery Auditors shall continue to update the “Claims Status” portion of their provider portal, in a timely manner, until further notice.

Recovery Auditors shall complete all Discussion Periods that are underway as of June 1, 2014. Recovery Auditors shall continue to accept new Discussion Period requests until June 30, 2014. All Discussion Periods initiated during June shall be completed. Recovery Auditors shall not accept new Discussion Period requests on or after July 1, 2014.

Recovery Auditors shall continue to maintain their customer service areas (telephone lines and appropriately training staff) and process for escalating concerns, until further notice.

Recovery Auditors shall continue to support the appeal process.

Note: Medicare Administrative Contractor (MAC) processes will continue. Therefore, claims sent for adjustment, by a Recovery Auditor, on or before June 1, 2014 may complete the adjustment process on, or after, June 2, 2014. The Medicare Appeals process will also continue. Therefore, recoupments can occur, if a provider does not file a timely appeal (to the 1st or 2nd level of appeal), or receives an “unfavorable” decision at the 2nd level (QIC) of the appeals process.”

RAC REGIONAL UPDATES
Region A (Performant); Region B (CGI); Region C (Connelly); and Region D (HDI)

Because no additional reviews will occur under the current contracts, current Recovery Auditors will not be required to update the “New Issue” (Approved Issue) portion of their websites as of June 2, 2014. Therefore at this time no new issue updates have been posted to any region contractor websites. Meanwhile, CMS has extended its contracts with current vendors until Dec. 15, 2015, for “administrative and transition activities,”

OTHER UPDATES
While auditing activity by the RAs appears to be in a holding pattern, the Office of Inspector General (OIG) continues its normal audit activities of provider billing practices via the agency’s Office of Audit Services under the Recovery Act Oversight.

As outlined in the OIG Work Plan for 2014, areas of audit focus for hospital billing and payments continue to include:

- Inpatient claims for mechanical ventilation
- Selected inpatient and outpatient billing requirements for compliance**
- Duplicate graduate medical education payments
- Outpatient dental claims
- Nationwide review of cardiac catheterization and heart biopsies
- Outpatient evaluation and management services billed at the new-patient rate
- Payments for patients diagnosed with Kwashiorkor
- Bone marrow or stem cell transplants
- Indirect medical education payments

OIG audits of providers for both inpatient and outpatient hospital services focus on the following compliance issues:

- Incorrectly Billed as Inpatient
- Incorrectly Billed Diagnosis-Related Group Codes
- Manufacturer Credits for Replaced Medical Devices Not Obtained
- Incorrect Discharge Status
- Incorrect Source-of-Admission Code
- Incorrect Charges Resulting in an Incorrect Outlier Payment
- Insufficiently Documented Services
- Manufacturer Credit for a Replaced Medical Device Not Reported
- Incorrectly Billed Evaluation and Management Services
- Incorrectly Billed Healthcare Common Procedure Coding System Codes
- Incorrectly Billed Number of Units

ABOUT THE AUTHOR
Renee Goetsch, RHIT, CCS is a charge and revenue integrity analyst for the charge capture audit product of MedAssets. She has more than 20 years of practice in the healthcare industry, including consulting services; charge master maintenance and compliance; charge capture and billing; coding classifications; and software systems maintenance and analysis.

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CMS Recovery Audit Program

OIG reports and publications (audits)
By John D. Hope, CPC

Up until the publication of the ICD-10 final rule in the Federal Register last month, the delay, which began on April 1 of this year, had given healthcare professionals that were not up to speed more time to study the new code set. In addition, those who had invested in ICD-10 education and certification would now have more time to examine the details of the new coding conventions.

Similar to the ICD-9 coding convention within the ICD-10 code set, there is a variety of notes that appear in the Tabular List. These notes include the following:

- Exclude notes
- Code first notes
- Use additional code notes
- Cross reference notes

When comparing excludes notes between ICD-9-CM and ICD-10-CM, major changes will be noticed. In ICD-9-CM, there is one type of exclude note that can mean two different things: An excludes note under a code indicates that the terms excluded from the code are to be coded elsewhere or, in other cases, the excluded terms may be used together with an excluded code. This has led to many questions from coding professionals and required coders to determine how to apply the rationale.

ICD-10-CM has two different excludes notes — Excludes1 and Excludes2. The inclusion of these two notes should help to end the confusion of exclusionary guidelines and coding conventions. Even though the two ICD-10-CM excludes notes encompass the single ICD-9-CM Exclude, the additional distinction provided by ICD-10-CM removes the uncertainty from the coding analysis.

**EXCLUDES1**
An Excludes1 note indicates that the Exclude1 code should never be used along with code above the Excludes1 note. This note is used when two conditions cannot be reported together. Conditions listed in an Excludes1 note are mutually exclusive. Another way to look at the Exclude1 note is that it means “NOT CODED HERE!”

**For example, R05 Cough**
The ICD-10-CM manual lists two codes with Excludes1 notes: Cough with hemorrhage (R04.2) and Smoker’s cough (J41.0). The Excludes1 note in this case simply indicates that the coder cannot report R05 with R04.2 or J41.0.

**EXCLUDES2**
An Excludes2 note, representing “Not Included Here,” indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when both conditions are present.

For example, L04.3 Acute lymphadenitis of the lower limb lists an Excludes2 note—Acute lymphadenitis of the groin (L04.1).

This note instructs the user that L04.1 is not part of the condition L04.3 but that they are not mutually exclusive and can be used together if applicable.

**COINCIDING EXCLUDES1 & 2 NOTES**
It is also possible that a code may have both Excludes1 and Excludes2 notes.

The Acute Bronchitis J20 category contains Excludes1 notes for Bronchitis NOS (J40) and Tracheobronchitis NOS (J40). Again, this notifies the user that these two conditions would never be reported with the Acute Bronchitis J20 code.

In addition, Acute Bronchitis J20 contains Excludes2 notes for Acute Bronchitis with bronchiectasis (J47.0) along with ten other conditions allowing use of the codes in conjunction with J20, if appropriate.

**CONCLUSION**
Although excludes notes may be well-known concepts in ICD-9-CM, they were often vague and inconsistent. The ability to offer greater detail will enable coders to meet the demands of today’s healthcare data needs. ICD-10-CM has the ability to differentiate between the existing conditions to make it easier for the coder to apply the correct codes.

**ABOUT THE AUTHOR**
John Hope, CPC, is the lead data integrity analyst for MedAssets Integrity Services. John has 10 years in the healthcare industry as a coder, biller and educator.

**REFERENCES**
The world of healthcare is ever changing. So, it should come as no surprise that the Centers for Medicare & Medicaid Services (CMS) is continuing to consider further packaging of items and services. In past years, you may have been able to separately bill certain supplies. With the continuation of packaging of items and services, however, those supplies that you previously reported separately, you may no longer be able to do so.

Beginning in CY (Calendar Year) 2014, CMS implemented additional changes to further package items and services. Using a prospective payment system (PPS), a national payment rate was established utilizing standardized geographic differences (taking into account the region of the country hospitals are located) and including operating and capital related costs that are integral supportive, ancillary, dependent or linked to performing an outpatient procedure or service. Outpatient Prospective Payment System (OPPS) is relying on the concept of averaging to establish the payments for services. CMS believes that by continuing to package items, this will encourage hospitals and clinics to negotiate better pricing with manufacturers and vendors to achieve the most economical healthcare costs. Packaging will also encourage the hospitals to take a closer look at the services they are providing and review the actual cost of each procedure and the supplies packaged into the procedures. In addition, CMS believes that packaging will create opportunities for optimal resources used by hospitals.

To assist in the transition to packaging supplies and services, CMS established in the CY2008 OPPS/APC final rule seven categories with the primary diagnostic or therapeutic modalities. These are items and services that are typically ancillary and supportive as well as being an integral part of a primary service to which they support. The seven categories are the following: (1) Guidance services; (2) image processing services; (3) intraoperative services; (4) imaging supervision and interpretation services; (5) diagnostic radiopharmaceuticals; (6) contrast media; and (7) observation services. These categories were chosen because — as noted above — these are typically ancillary, supportive to a diagnostic or therapeutic modality and are integral to the primary service they support.

In CY 2009, implantable biologics were packaged. In CY 2014, the OPPS started transitioning from a fee schedule system to a more consistent prospective payment system where the payment is packaged into the primary service for certain packaged services.

To package items and services further, CMS created and established seven new package categories for 2014. These include the following:
1. Drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure
2. Drugs and biologicals that function as supplies when used in a surgical procedure (3) Certain clinical diagnostic laboratory tests
3. Procedures described by add-on codes
4. Ancillary services (status indicator “X”)
5. Diagnostic tests on the bypass list
6. Device removal procedures

To clarify the intent of packaging of supplies and explain what is considered “supplies,” CMS stated in the OPPS 2014 Final Rule, “Under the regulations at § 419.2(b)(4), medical and surgical supplies and equipment are unconditionally packaged in the OPPS and have been since the beginning of the payment system. Supplies is a large category of items that typically are either for single patient use or have a shorter life span in use than equipment. Packaged supplies can include certain drugs, biologicals, and radiopharmaceuticals. The only supplies that are sometimes paid separately in the hospital outpatient setting are prosthetic supplies under § 419.22(j), and if paid separately, they are paid according to the DMEPOS fee schedule” (OPPS Final Rule Vol. 78, No 237)."
or other payment methodology) were updated to SI "N" (unconditionally packaged). The exception is made for prosthetic supplies. They remained SI "A." This change is intended to promote clarity regarding the OPPS packaging policy.

The following is a listing of the supplies in which the status indicator changed from a SI "A" (paid by a fee schedule) to a SI "N" packaged.

### SUPPLIES CHANGED FROM SI "A" TO SI "N" IN CY 2014

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<td>Compress burngarment glove-wrist</td>
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TALKING POINTS
Supply Packaging – Moving from a Fee Schedule System of Payments to a Prospective Payment System — continued

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<td>A7509</td>
<td>Heat &amp; moisture exchange sys</td>
<td>A</td>
<td>N</td>
<td>Q4126</td>
<td>Memoderm/derma/tranz/integup</td>
<td>A</td>
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<td>A7520</td>
<td>Trach/laryn tube non-cuffed</td>
<td>A</td>
<td>N</td>
<td>Q4128</td>
<td>Flexhd/Allopatchhd/matrixhd</td>
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<td>A7521</td>
<td>Trach/laryn tube cuffed</td>
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<td>Q4129</td>
<td>Unite biomatrix</td>
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<td>A7522</td>
<td>Trach/laryn tube stainless</td>
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<td>Q4131</td>
<td>Epifix</td>
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<td>A7523</td>
<td>Tracheostomy shower protect</td>
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<td>N</td>
<td>Q4134</td>
<td>hMatrix</td>
<td>A</td>
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<td>A7524</td>
<td>Tracheostoma stent/stud/bttn</td>
<td>A</td>
<td>N</td>
<td>Q4135</td>
<td>Mediskin</td>
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<td>A7525</td>
<td>Tracheostomy mask</td>
<td>A</td>
<td>N</td>
<td>Q4136</td>
<td>EZderm</td>
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<td>A7526</td>
<td>Tracheostomy tube collar</td>
<td>A</td>
<td>N</td>
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<td>A7527</td>
<td>Trach/laryn tube plug/stop</td>
<td>A</td>
<td>N</td>
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<td>C1830</td>
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<td>C1840</td>
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<td>C1886</td>
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<td>C9248</td>
<td>Inj, clevidipine butyrate</td>
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<td>C9358</td>
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<td>C9360</td>
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<tr>
<td>C9363</td>
<td>Integra Meshed Bil Wound Mat</td>
<td>A</td>
<td>N</td>
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<td>Q4101</td>
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<td>Q4102</td>
<td>Oasis wound matrix</td>
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</table>

In addition, CMS would like to review their current structure to make changes and consolidate device dependent APCs which have similar costs. Should these changes be implemented, it will create 28 Comprehensive APCs for CY 2015.

Packaging of items and services will continue to grow based on the CMS initiatives we have seen thus far to further incorporate items and services to a more Comprehensive APC. Through these changes, certain packaged supplies will be incorporated into the base cost of the procedure rather than being separately payable. Although many supplies are no longer separately payable and are now packaged, CMS still asks that the HCPCS code for items be reported. This allows CMS to make sure the appropriate cost of the item is included in the packaged procedure or APC.

ABOUT THE AUTHOR
Lynda Millican, RN, BSN is a senior coding and CDM analyst for MedAssets. She is a Registered Nurse with more than 35 years of experience, including more than 15 years of operating room experience. Lynda served as the manager of sterile supply and central distribution at a teaching hospital in Atlanta.

REFERENCES
Addendum B: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html


Dual Coding: A Tool for Coder Practice

By Darnacea Harris, MHA, RHIT, CCS

Up until the Centers for Medicare & Medicaid Services published the ICD-10 final rule establishing October 2015 as the new compliance date last month, the delay, which began on April 1 of this year, had derailed transition plans. Facilities slowed implementation activities including coder training. Some organizations spent thousands of dollars ensuring coders had sufficient ICD-10 training. Now that the implementation date has been reestablished, organizations will need to find ways to resume and improve coder skills.

And all along, reports have circulated that coder productivity is expected to significantly decline in the first six months after implementation (Carmichael, 2011). Factors contributing to loss of coder productivity include the following:

• The longer ICD-10 code
  Codes require more characters and coders will need to become familiar with sixth and seventh digits

• New Guidelines
  Some coding guidelines have been changed, or expanded.

• New terminology
  The ICD-10-PCS coding system changes the meaning of terminology to which coders are accustomed. The term “excision,” for example, means ‘removal of’ in ICD-9-CM procedural classification. ICD-10-PCS defines the term as ‘cutting out or off a portion of a body part without replacement’. The term encompasses procedures that would have had other descriptors entirely in ICD-9. A biopsy would be coded to excision in ICD-10-PCS. Coders will also need to learn new terminology, like “extirpation” (taking or cutting out solid matter from a body part), which did not exist in ICD-9-CM.

• New indexing process
  The new terminology will require coders to have a good understanding of anatomy and clinical specifics to locate codes faster. ICD-10-PCS uses a table structure in place of the tabular section of ICD-9. This table structure will require time to become comfortable with its use.

• Increase in the volume of codes
  The sheer number of available codes can cause confusion for coding staff.

While these factors can cause a decrease in productivity, one should practice applying these codes in order to minimize this loss. Two methods for providing coder practice are to implement dual coding, and to code case studies.

Dual coding is the practice of coding medical records using both ICD-9 and ICD-10 coding conventions. Each record is coded once using ICD-9, then coded a second time using ICD-10 conventions. Dual coding benefits the hospital in many ways. Coder productivity can be predicted when dual coding is implemented. Organizations will also come to understand the impact on ancillary processes. And ICD-10 data can be collected for future reporting and for use in data analytics. Dual coding now provides greater flexibility in scheduling and resource utilization.

The new terminology will require coders to have a good understanding of anatomy and clinical specifics to locate codes faster.

Coders can also spend some time coding case studies. Organizations such as the American Health Information Management Association (AHIMA) have workbooks available that include case studies for coding practice. Coders may code these case studies and then compare
In the first case study, both coders correctly coded the principal diagnosis and two of the secondary diagnoses. When coding the atrial fibrillation, both coders chose I48.91 (unspecified atrial fibrillation and flutter) rather than the correct choice of I48.0 (Paroxysmal atrial fibrillation). The principal procedure and one of the secondary procedures were correct. However, there was a slight discrepancy in one of the secondary codes. The bilateral coronary angiography should be coded to B2061ZZ (Angiography, combined right and left heart). Both coders applied code B2161ZZ (fluoroscopic angiography of the right and left heart, using low osmolar contrast dye). The correct code was B2111ZZ (fluoroscopic angiography of multiple coronary arteries using low osmolar contrast dye).

Once the coders practiced and made errors on the first case study, the responses improved. In the second case study, both coders applied the correct diagnosis codes, although one was sequenced incorrectly. The principal procedure code proved a little more difficult as both coders chose the incorrect device. The secondary procedure code was coded correctly.

This experiment demonstrated that practice improves results. The need for coders to maintain current knowledge of coding guidelines, anatomy, devices and other clinically oriented processes, in addition to having practical experience with applying ICD-10 codes is evident in these results.

Applying newly learned skills in an organized and repetitive fashion minimizes costs and resources that will be needed for re-training as ICD-10 is implemented.

ABOUT THE AUTHOR
Darnacea Harris, MHA, RHIT, CCS, is an AHIMA approved ICD-10-CM/PCS Trainer and Ambassador with more than 25 years experience in the coding, compliance and reimbursement industry. Darnacea has previously held such positions CCA rules manager, assistant director of HIM, HIM manager, coding manager, and consultant. She has also held teaching positions at several colleges and universities where she has taught coding, billing, HIM, and supporting courses.

REFERENCES
www.aacca.net

FAQs

In this section, MedAssets has reviewed and analyzed the questions that are received via our compliance help desk. We offer some of the most frequently asked questions and the MedAssets response for your convenience.

Frequently Asked Questions for August

Q: WHO PICKS THE HCPCS CODE WHEN A NEW ITEM NEEDS TO BE SET UP IN THE PHARMACY CDM, THE PHARMACY DIRECTOR OR THE CDM COORDINATOR?

A: This is actually dependent on the clinical knowledge of the CDM coordinator, as well as the type of IT system being utilized. Because more and more pharmacy formularies are driving the billing, we are seeing greater involvement by pharmacists. Identifying the drug is key: the usage of that drug may specifically drive the appropriate assignment of the HCPCS. MedAssets stresses the collaboration with the pharmacy department.

Q: PLEASE CLARIFY THE FOLLOWING: WHEN A BILATERAL PROCEDURE IS PERFORMED, SHOULD 19083 AND 19084 BE USED, OR SHOULD 19083 BE USED TWICE WITH THE APPROPRIATE MODIFIER (AND WHICH MODIFIER IS APPROPRIATE)?

A: The Medicare Claims Processing manual, chapter 4, section 20.6 states “As indicated in §20.6.2, modifier 50, while it may be used with diagnostic and radiology procedures as well as with surgical procedures, should be used to report bilateral procedures that are performed at the same operative session as a single line item. Modifiers RT and LT are not used when modifier 50 applies.

A bilateral procedure is reported on one line using modifier -50. Modifier 50 applies to any bilateral procedure performed on both sides at the same session.” This reference is available in KnowledgeBase.

Generally, breast procedure codes describe a unilateral procedure. Only one unit of service (UOS) is reportable with code 19083, and appending modifier RT or LT may be appropriate to indicate the breast biopsied.

Below is an excerpt from the CPT® Assistant May 2014 (available in KnowledgeBase), which provides guidance on the reporting of codes 19083 and 19084, and states: “Codes 19082, 19084, and 19086 are add-on codes used to report more than one image-guided biopsy using the same type of imaging guidance in the same breast; however, if additional biopsies are performed using different imaging modalities or if an image-guided biopsy using the same guidance modality of the opposite breast is performed, the primary codes from this code range (19081, 19083, 19085) are used for the first incidence of each different imaging modality.

Based on the guidance provided above it may be appropriate to report 19083 with modifier 50 appended to indicate the first lesion was biopsied on the RT breast and the first lesion on the left breast was also biopsied, during the same encounter. When additional lesions (beyond the first lesion) are biopsied, it may be appropriate to report 19084, appending modifier LT and/or modifier RT to indicate each additional lesion biopsied.

For example, the first breast lesion was biopsied on the right breast and an additional lesion was biopsied on the same right breast. In this scenario it may be appropriate to report codes 19083-RT and 19084-RT.

If the first breast lesion was biopsied on the left breast, and a first lesion was biopsied on right breast during the same patient encounter, it may be appropriate to report 19083-50, since only one unit of service may be reported on a Medicare claim for code 19083. Using this same scenario, if an additional lesion were biopsied on the left breast it may be appropriate to report codes 19083-50 and 19084-LT. If an additional lesion was biopsied on the right breast, using the same scenario, it may be appropriate to report 19083-50 and 19084-50.

Medicare instruct providers that when reporting a bilateral procedure where the code’s descriptor does not include the term “bilateral” then you should report the bilateral procedure using a single unit of service with modifier 50. This guidance, MLN Matters SE1422, is available in KnowledgeBase.
What CPT® Codes Are You Using for ASD?

□ ADAPTIVE
□ ANALYST
□ AUTISM
□ CHARACTERISTIC
□ CODES
□ COMMUNICATION
□ DEVELOPMENTAL
□ DISABILITY
□ DISORDER
□ EXPOSURE
□ FAMILY
□ GOALS
□ GROUP
□ IMPAIRMENT
□ PATIENT
□ PROTOCOL
□ PSYCHOLOGIST
□ SPECTRUM

(answers on following page)
What CPT® Codes Are You Using for ASD?

(Over, Down, Direction)
ADAPTIVE (3,10,SE)
ANALYST (17,18,W)
AUTISM (11,6,N)
CHARACTERISTIC (1,4,SE)
CODES (1,3,E)
COMMUNICATION (15,7,SW)
DEVELOPMENTAL (17,1,S)
DISABILITY (18,17,NW)
DISORDER (12,20,E)
EXPOSURE (18,4,S)
FAMILY (1,15,NE)
GOALS (19,9,S)
GROUP (6,3,SE)
IMPAIRMENT (16,11,N)
PATIENT (7,12,NW)
PROTOCOL (15,9,SW)
PSYCHOLOGIST (12,2,W)
SPECTRUM (2,16,NE)
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