Principles of Healthcare Reimbursement

Instructor's Manual

Chapter 2

Clinical Coding and Coding Compliance

Lesson Plan

Background and Instructional Delivery

Chapter 2 describes the different code sets approved by the Health Insurance Portability and Accountability Act of 1996, including ICD-10-CM/PCS, ICD-9-CM, CPT, and HCPCS. The code structure, maintenance of the coding system, and coding guidelines for each code set are discussed. This chapter also examines coding issues that affect compliance, with an emphasis on ethics in coding.

Chapter Outline

Objectives
Key Terms
The Clinical Coding-Reimbursement Connection
- The *International Classification of Diseases*
  - ICD-10-CM/PCS
    - Structure of ICD-10-CM
    - Structure of ICD-10-PCS
    - Maintenance of ICD-10-CM/PCS
    - ICD-10-CM/PCS Coding Guidelines
- Healthcare Common Procedure Coding System
  - CPT (HCPCS Level I)
    - Structure of CPT
    - Maintenance of CPT
    - Requesting a Code Modification for CPT
    - CPT Coding Guidelines
  - HCPCS Level II
    - HCPCS Level II Permanent Codes
    - HCPCS Level II Temporary Codes
    - HCPCS Level II Modifiers
    - Maintenance of HCPCS Level II Coding System
    - Requesting a Code Modification for HCPCS Level II
    - HCPCS Level II Coding Guidelines
- Coding Systems as Communication Facilitators

Coding Compliance and Reimbursement
- Fraud and Abuse
  - Legislative Background
  - False Claims Act
  - Office of Inspector General (OIG) Compliance Program Guidance
  - Operation Restore Trust
  - Health Insurance Portability and Accountability Act of 1996
  - Balanced Budget Act of 1997
  - Improper Payments Legislation
- Oversight of Medicare Claims Payment
  - Comprehensive Error Rate Testing Program
  - Office of Inspector General Reports
  - National Recovery Audit Program
    - RAC Program
- Other Third-Party Payer Reviews
- Coding Compliance Plan

Policies and Procedures
Education and Training
Auditing and Monitoring

References and Bibliography

Appendix 2A

American Health Information Management Association Standards of Ethical Coding

Activities with Keys

Theory into Practice

This chapter discusses coding and billing compliance. The first half of the chapter discusses the code sets that are utilized by providers to communicate their services and supplies to the payer. The second half of the chapter discusses how payers identify claims that were improperly submitted for payment. In the Recovery Auditing in Medicare for Fiscal Year 2013 report, the National Recovery Audit Program reports that the RACs collected 3.75 billion in improper payments. This figure has drastically increased since 2010, where the monies recovered by RACs totaled 92.3 million.

Review the RAC 2013 Report to Congress located at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program. Why are facilities and providers unable to prevent the improper claims that the RACs have identified in their reviews? What can providers and facilities learn from this report? What key points can be identified and then implemented at the coder, physician, and clinician level to improve reporting processes?

Instructor can assign students to review the most recent RAC report instead of the 2013 report as they become available on the CMS website.

Each student will have a different take away from the report. The point of this exercise is to get students thinking about how difficult the revenue cycle process is at a facility; for them to contemplate the vast number of rules and regulations that govern the Medicare system in America. It is also important for students to be able to read Medicare and other government documents and then translate the information into action plans for the provider setting.

Lecture

Microsoft PowerPoint (.pptx) slides are available on the ahimapress.org website. These slides may be used as lecture guides.

Class Discussion

The Theory into Practice section, Application Exercises, and questions in the Check Your Understanding sections located throughout the chapter can be used to stimulate class discussions or online chats.

Application Exercises

1. Locate the current *Office of Inspector General Work Plan* on the Health and Human Services Office of Inspector General website. Write a memo to your Compliance Officer outlining the key areas for your inpatient facility. Identify which areas would be appropriate for the auditing schedule, which areas would be appropriate for the education schedule, and which areas would be appropriate for both schedules.
   Memos will vary each year based on the current OIG Work Plan. Reviewing the work plan familiarizes students with the document layout, as well as, current terminology for compliance issues.

2. Visit the Medicare CERT homepage. Locate the most recent CERT annual report. Use Appendix B: Projected Improper Payments and Type of Error by Type of Service for each Claim Type to identify the top issue for the following claim types: Part B, DMEPOS, Part A excluding Inpatient Hospital PPS and Part A Inpatient Hospital PPS. For each claim type identify the top issue (for Part A Inpatient Hospital PPS identify the top clinical area). For each top issue identify the payment implication, the error rate, and the most significant error type.

   After reviewing the statistics discuss what providers and facilities should do to improve their performance.

   The CERT homepage can be found at:
   https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/index.html?redirect=/cert

   As of the summer of 2015, the most recent CERT report is for 2014. The following data for the Appendix B of the 2014 report.

   Part B Services
   Hospital visit – subsequent (CPT code reported by physician)
   Payment: $2,092,821,992
   Error rate: 6.6%
   Error type: insufficient documentation

   DMEPOS
   Oxygen supplies/equipment
   Payment: $951,886,364
   Error rate: 62.1%
   Error type: insufficient documentation

   Part A – Non-IPPS
   Home Health
   Payment: $9,395,609,515
   Error rate: 51.4%
   Error type: insufficient documentation

   Part A – IPPS
   Heart failure and shock
   Payment: $541,351,523

Error rate: 15.8%
Error type: medical necessity

Discussion will be different for each student. However, the student should mention insufficient documentation and offer ways to improve physician documentation.

Questions from Text with Keys

Check Your Understanding Questions

Check Your Understanding 2.1

1. The code sets to be used for healthcare services reporting by both public and private insurers were designated by what legislation?
   The Health Insurance Portability and Accountability Act of 1996 (HIPPA)

2. The first three characters in an ICD-10-CM diagnosis code represent its:
   a. Subclassification
   b. Subcategory
   c. Category
   d. Modifier

3. What organizations maintain the ICD-10-CM/PCS code set?
   National Center for Health Statistics (NCHS) and the Centers for Medicare and Medicaid Services (CMS), which together comprise the ICD-10-CM/PCS Coordination and Maintenance Committee

4. Where are the ICD-10-CM coding guidelines published?
   ***The Official Coding Guidelines* can be found on the NCHS and CMS websites; available for download. Additional guidance and advice can be found in the *Coding Clinic for ICD-10-CM and ICD-10-PCS*.**

5. What code set was incorporated into the Healthcare Common Procedure Coding System as HCPCS Level I?
   CPT

Check Your Understanding 2.2

1. The new coding assistant at the Glen Ellyn Medical Group office coded and submitted a claim to Blue Cross for an initial evaluation and management office visit when in fact the patient was established with the practice and was seen strictly for a follow-up medical check. The resulting error was an example of:
   Abuse, the submission of unintentionally inaccurate charges on a claim for reimbursement

2. All of the following are efforts to fight healthcare fraud and abuse **except**:
   a. Operation Restore Trust
   b. Medicare Integrity Program
   c. Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)
   d. Medicare and Medicaid Patient and Program Protection Act of 1987

3. What legislation supports the CERT program?
   IPERA and IPERIA

4. What differentiates recovery auditors from other entities performing improper payment reviews?
   RACs are paid on a contingency basis instead of a contract basis

5. What are the core areas of the coding compliance plan?
   Policies and procedures, education and training, and auditing and monitoring

Review Quiz

Match each coding system on the left with its description of uses on the right.

1. ICD	a. Medical and surgical supplies
2. HCPCS Level II	b. Physician inpatient or outpatient procedures
3. CPT	c. Diagnoses and inpatient procedures

1 = c, 2 = a, 3 = b

4. Common forms of fraud and abuse include all of the following **except**:
   a. Upcoding
   b. Unbundling
   c. Refiling claims after denials
   d. Billing for services not furnished to patients

5. Name and describe three of the seven OIG elements of an effective compliance plan.
   The seven elements are: written policies and procedures, designation of a compliance officer, education and training, communication, auditing and monitoring, disciplinary action, and corrective action.

6. The CERT program was established to correct improper payments. True or false?
   False, the purpose of CERT is to measure improper payments

7. Describe the importance of the RAC prepayment review demonstration project.
   The RAC prepayment review demonstration project is important because it allows CMS to identify error claims prior to paying for such claims. In the first year 58% of the claims were improperly billed. Clearly there is work to be completed in the revenue cycle arena for healthcare providers and facilities.

8. What resource can managers use to discover current hot areas of compliance?
   The OIG Workplan, revised annually

9. What two forms of benchmarking can be used to determine a staff's level of compliance?
   Internal and external

10. The International Classification of Diseases (ICD) is maintained by the American Medical Association. True or false?
    False; WHO maintains ICD

Test Bank with Key

Instructions: For each item, complete the statement correctly or choose the most appropriate answer.

1. The coding system that is used primarily for reporting diagnoses for hospital inpatients is known as:
   a. ICD-10-CM
   b. CPT
   c. ICD-10-PCS
   d. HCPCS Level II

2. Which of the following coding systems was created for reporting procedures and services performed by physicians in clinical practice?
   a. ICD-9-CM
   b. CPT
   c. ICD-10-PCS
   d. HCPCS Level II

3. Which of the following is an example of fraud?
   a. Billing for a service not furnished as represented on the claim
   b. Misinterpreting *Coding Clinic* advice
   c. Transposition of digits that results in an inaccurate code to be reported
   d. Duplicate bills submitted due to a systems issue

4. Which of the following entities does not perform improper payment reviews for CMS?
   a. QIO
   b. CERT
   c. RACs
   d. MACs
   e. None of the above

5. Which type of RAC review combines data analysis and submission of medical records to the RAC?
   a. Automated
   b. Semi-automated
   c. Complex
   d. Onsite

6. Which of the following is the correct format for HCPCS Level II codes?
   a. 1234A
   b. 123A4
   c. 12A34
   d. 1A234
   e. A1234

7. The RAC appeals process has ____ levels.
   a. 2
   b. 3
   c. 4
   d. 5

8. The policies and procedures section of a Coding Compliance Plan should include:
   a. Upcoding
   b. Coding medical records without complete documentation
   c. Correct use of encoding software
   d. All of the above

9. Which of the following is **not** a common cause of improper payments?
   a. Physician orders not present in the medical record
   b. Implementation of a documentation improvement program
   c. Medical necessity is not supported in the medical record
   d. Incorrect coding

10. Recovery Audit Contractors are *different* from other improper payment review contractors because:
    a. RACs are reimbursed on a contingency-based system
    b. RACs are charged with finding overpayment and underpayments
    c. RACs audit inpatient and outpatient claims
    d. All of the above