A stress test evaluates a patient’s heart during physical or pharmacological stress and is generally performed on a bicycle or treadmill. During a stress test a patient will usually exercise until symptoms occur or patient reaches a maximum heart rate (85% of predicted heart rate based on age). If the patient is physically unable to exercise or is taking medications that depress heart rate, pharmacological stress can be substituted for exercise. Pharmacologic stress agents can be billed separately by the entity that provides them. Common stress agents are Adenosine, Dobutamine, Dipyridamole and Arbutamine.

To report both exercise and pharmacologic stress:

- 93015 – Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
- 93016 – physician supervision only, without interpretation and report
- 93017 – tracing only, without interpretation and report
- 93018 – interpretation and report only

Under CCI edits, codes for electrocardiogram (93000-93010), rhythm strip (93040-93042), pulse oximetry (94760-64761) and Injection or Infusion (90774) are all included in the stress test and should not be reported separately.

**Echocardiograms**

Echocardiography uses high frequency sound waves to record the structure of the heart and blood flow within the heart. Transthoracic echocardiograms (TTE) are the most common type of echo performed. During TTE a transducer is moved on the surface of a patient’s chest to obtain images that are captured for analysis. EKG monitoring is also performed to assist in evaluating the heart in different stages of cardiac cycle. Heart chamber size, contraction, wall motion, wall thickness and valve structure can all be evaluated using echocardiography. Doppler echocardiography is often used to detect acute complications following a myocardial infarction.

Doppler color flow imaging evaluates the blood flow through the heart and displays flow data on 2-D echocardiographic image. Doppler wave form imaging provides directional information about flow, velocity and characteristics. Wave form is obtained when a transducer transmits a series of pulses to detect motion.

*Continued on following page...*
Basic Cardiology Coding Continued...

To report TTE:

93303- Transthoracic Echocardiography for congenital anomalies; complete
93304 – follow-up or limited study

*Please note codes 93303-93304 are to be used for patients with congenital anomalies only*

93306- Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler and color flow Doppler echocardiography (93320 and 93325 are now bundled with this code and should not be reported separately)

93307–Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral Doppler or color flow Doppler echocardiography

93308-follow-up or limited study
+ 93320 - Doppler echocardiography, pulsed wave and/or continuous wave with spectral display.
+ 93321 - follow-up or limited study
+ 93325 - Doppler echocardiography color flow velocity mapping

Sometimes a physician will order a Stress Echocardiogram to evaluate the motion of the heart's walls and pumping action when the heart is stressed. This will help him/her to better determine a lack of blood flow that isn't always apparent on other heart tests. During a stress echo images are recorded before, after and sometimes during stress. Patient’s EKG, heart rate and blood pressure are also monitored before, during and after test. The goal is to evaluate hemodynamic, electrocardiographic and echocardiographic responses to stress.

To report stress echo:

93350 - Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle and/or pharmacologically induced stress with interpretation and report

+ 93352 Use of contrast agent during stress echocardiography

For more on cardiology coding visit our website www.rmcinc.org and sign up to attend our upcoming June audio conference titled Cardiology Coding for the Physician Office.

Monique Vanderhoof, CPC, joined RMC in September 2011 as Manager of HCC Services, focusing on HCC coding reviews and client education. With over 15 years’ experience as a clinic manager, Monique has extensive experience working in both outpatient and inpatient physician billing with an emphasis on cardiology. Her skills also include EHR implementation, HIPAA, eRx, and Meaningful Use readiness and attestation.

NEW TO RMC EDUCATION?

2012 Audio Conference: Series 1 is now available on CD!
Cost is $50 per CD.

Past topics include: ICD-10 Intro; OIG Workplan & OPPS Highlights; Perinatal Conditions; Podiatry; Cardiology.
Contact Kristin@rmcinc.org for more information!
See page 5 for upcoming audio conferences!
ICD-10 has been coming for years. If other coding professionals are anything like me, they have largely ignored it as CMS kept pushing back the deadline. I made the decision 6 months ago to begin taking the transition seriously so that I would not be left behind. My coding career has been good to me for a number of reasons; primarily it has kept me learning. Learning ICD-10 has proved to be a challenging but important endeavor as the differences between it and its predecessor (ICD-9) are significant. Coders need to be the experts and to do that they must start now!

Start by doing research. As a coding consultant doing research has become second nature. Through reading articles on my favorite websites and participating in several AHIMA calls, I familiarized myself with some of the new terms like “root operations”; “characters vs. digits”; “qualifiers” etc. Unlike ICD-10-CM codes that are different but easy to grasp, ICD-10-PCS codes present more of a challenge. At first exposure, just looking at them confused me! Being a hands-on learner, they did not start to become clear until I began applying them. (Ten digits? Alphanumeric? What means what? No decimal—how will I keep this all straight? These codes look ridiculous and messy!)

Knowledge of anatomy and physiology is more important than ever in ICD-10 due to greater specificity in the new codes. For instance, one code no longer covers the same procedure done in different anatomical locations, so it is important that you begin increasing your knowledge now. When you code a procedure and don’t fully understand the anatomy and physiology of it, take the time to go to a resource and learn it as you go. Increasing your knowledge can only help you with ICD-10.

Approach the ICD-10-CM codes chapter-by-chapter, noting the major changes and documentation opportunities. Information on changes that effect reimbursement is still being discovered, so we can expect more information to become available to us as we progress in ICD-10. We know that if done correctly, the same DRG assignment will result from both coding systems in most cases. There are a few sequencing changes (such as those used for coding neoplasm and skin ulcers) that will change reimbursement. Coders need to learn these changes now and CDI programs need to begin working with physicians for the documentation that will be necessary to get the appropriate code and DRG assignments for ICD-10-CM.

ICD-10-PCS may be approached by learning the definitions of the 31 root operations. Some are terms you are probably not familiar with, and it will prove useful to commit them to memory. The surgeon does not have to state the root operation but the coder must read the operative report to determine assignment. Unlike ICD-9-CM, after the coder learns to use the ICD-10-PCS tables they are not required to use the alphabetic index. In addition, the old, familiar eponyms we coders love are gone (this will be a big change for surgeons as well). Next, learn the terms used to describe approaches in ICD-10-PCS. There are only a few of these in ICD-10-PCS, but the terminology used will require review by the coders who currently use ICD-9.

After introducing yourself to the ICD-CM and ICD-10-PCS coding guidelines, code practice will make all the difference in the world. A certain comfort level has to be reached before you begin assigning codes to a patient record with a bill going out the door. The only way to assign ICD-10 codes confidently is through practice and receiving immediate feedback. The AHIMA website has some very practical resources to assist you with coding scenarios that allow you to compare your code assignments to the codes assigned by an ICD-10 expert.

Coder confidence needs to be built progressively so that we are ready for ICD-10 implementation. I don’t know about you but I can envision that day being filled with knowledge and confidence or filled with regret and anxiety—I know which way I want it to be.

Laura Legg is a coding consultant with 30 years experience in the HIM arena. She has been a Director of HIM for acute care and critical access hospitals and major health systems; provided education for physician, coding and CDI staff; developed educational presentations in the areas of physician queries, sepsis coding and ICD-10 planning and implementation and much more. Laura lives in Renton, WA with her husband, two cats and her Jack Russell terrier. Hobbies include spending time with her two grown daughters, cooking, reading and travelling with her husband. Laura is very active in her church and hopes to do missionary work after she retires.
2012 SERIES 2 SCHEDULE:

July 19th
Coder Confidence
with Laura Legg, RHIT, CCS

August 16th
Home Health
with Laura Legg RHIT, CCS

September 20th
ICD-10 & DRG Analysis:
How to Prepare
with Linda Dawson RHIT

October 18th
CHF, Renal Failure
& Respiratory Failure
with Deb Couch RHIT, CCS

November 15th
Endoscopy with Jane Barta, RHIA

December 20th
Basic ICD-9 for the Physician Office
Part 1

Note this is a 3 part series!
One of the myths floating around the health care industry today is “encryption is addressable which means I don’t need to encrypt protected health information (PHI) if I send it via email.” It’s important to remember that times have changed and “addressable” does not mean optional.

When the security rule was published in the Federal Register in 2003 encryption was not mature and it could be costly. That is not the case today. Even the smallest of covered entities and business associates can afford an encryption solution.

Addressable means you adopt the requirements defined in an implementation specification, you implement an equivalent safeguard or you document the heck out of why you do not intend to address the implementation specification. You would be very hard pressed today to document why you will not encrypt PHI transmitted across the Internet. Solutions are generally interoperable and fit with the budget of organizations of all sizes.

I agree the security rule does not "require" encryption but, again, you would be hard pressed to justify not encrypting PHI sent via email. Also, if it is intercepted, it represents a breach of unsecure PHI and may require reporting to the individual who is the subject of the PHI and OCR. This is true whether a patient has been warned about the dangers of transmitting PHI across the Internet or not. If you're the covered entity or business associate sending the PHI, you are the responsible party and not the patient if the PHI is breached - you sent it and not the patient.

Also, it is not clearly articulated in the HIPAA rules, but I see asking a patient to sign an agreement that it's OK to send their PHI unencrypted over the Internet is not all that dissimilar to asking a patient to waive his or her privacy rights. Asking patients to waiver their privacy rights is expressly forbidden by the HIPAA Privacy Rule. Covered entities (from a practical and legal perspective) should not ask patients to give up the right to have their PHI secure when sent to them.

Do you want to accept the risk of a breach, documenting why you are not encrypting PHI sent over the Internet to find it doesn't pass muster with the Office for Civil Rights (OCR) or battle a civil suit related to individual harm because of, say, identity theft? It's all about how much risk do you want to accept. It's also about patient quality of care. What damage will there be to your patient and your patient's health if specially sensitive PHI were exposed to the public?

Chris Apgar, founder of Apgar & Associates is a Certified Information systems Security Professional (CISSP). He is one of the country's foremost experts and spokespersons on healthcare privacy, security, regulatory arraifs, state and federal compliance and secure and efficient electronic health information exchange. Chris has more than 19 years of experience in regulatory compliance and is a leader of regional and national privacy, security and health information exchange forums. As a member of Workgroup for Electronic Data Interchange, and serving on the Board of Directors since 2006, Chris is an honest, reliable, trustworthy expert in the field of privacy and security. Email capgar@apgarandassoc.com for more details.

5010 enforcement begins July 1, 2012. Are you ready?

All HIPAA covered entities will be required to submit transactions using 5010 format or face claim rejections. The Centers for Medicare and Medicaid Services (CMS) had initially planned on enforcing this by January 1, 2012 but decided to give a discretion period to complete testing and software installation. You should be prepared now. If you are still experiencing problems contact your clearinghouse or payers immediately. CMS has additional information and valuable resources available as well at https://www.cms.gov/Medicare/Coding/ICD10/Version_5010.html.
Caution in Coding from Code Number Instead of Diagnosis
By Marcia Vaqar, MPH, RHIA, CCS, CCS-P, CCDS

HIM managers, “do you know what your coders are doing”? As coding directors, managers, or coordinators it is important to know what information the coders are using for the assignment of the codes. There needs to be internal guidelines for coders to follow so consistency is established.

All too often, we see a diagnosis code written in the medical record, in lieu of a narrative diagnosis. In those instances, we should not code what has been written for two important reasons:

First, coding is done based on the narrative documentation in the medical record--with no narrative, no coding should take place. Second, there's no way of telling if the diagnosis code in the chart is correct (i.e., what the provider meant to be coded).

This question comes up time and again, “is it appropriate for providers to submit code numbers in lieu of a written diagnosis?” but Coding Clinic, Q1 2012, has decided to address it. Their answer, in part reads:

"There are regulatory and accreditation directives that require providers to supply documentation in order to support code assignment. Providers need to have the ability to specifically document the patient's diagnosis, condition, and/or problem. Therefore, it is not appropriate for providers to list the code number or select a code number from a list of codes in place of a written diagnosis."

Coding Clinic was asked about physicians choosing a diagnosis code in an EMR vs. using a written diagnosis--but this advice applies to handwritten or dictated notes as well. One important point that Coding Clinic made relates to something we see frequently--physicians just picking the diagnosis code and a short descriptor of the code and using it as an assessment. Coding Clinic said:

"...it is not appropriate for providers to list the code number or select a code number from a list of codes in place of a written diagnostic statement. ICD-9-CM is a statistical classification, per se, it is not a diagnosis."

An example that might be seen is:

250.40--Diabetes with renal manifestations

This is not a diagnosis, but a category of diseases, or in ICD-9 terms, a statistical classification. The clinician is responsible for providing a diagnosis, so they may need to add to the short descriptor of a diagnosis code in the EMR. What the clinician might add:

250.40--Diabetes with renal manifestations – stage V due to DM

This provides an actual assessment (diagnosis) of the patient's condition, which allows for correct coding.

Now is the time to review and update facility-based coding guidelines to make sure that if the policy previously allowed the practice of code numbers instead of a narrative diagnosis that this no longer will be an acceptable practice. Coders need to be educated about the new Coding Clinic update and that this is no longer a practice that may be accepted and physician now will need to document the actual diagnosis and not just a code number.

It is important to be able to distribute this information to physicians, providers, clinics, physician offices, admitting staff, and any others who might be involved with this area and who have a need to know. So--the next time you're asked if a provider can just write the code in the chart--you'll know where to direct them for clear guidance.

Marcia Vaqar, MPH, RHIA, CCS, CCS-P spent over twenty years as a coding manager, project manager/coordinator of Health Information Management Operations, Inpatient/Outpatient Coder, Health Information Coordinator, and Medical Record Administrative Aide before joining our team. Today Marcia offers her extensive knowledge background to healthcare systems in cooperation with RMC, Inc. which includes but is not limited to coding; severity of illness data collection and verification; clinical documentation improvement; and coding management skills.
Evaluation and Management (E/M) services recognize medical decision making as one of three key components to be considered when selecting a level of service. Medical decision making refers to the complexity of establishing a diagnosis and/or management options. The risk of significant complications, morbidity, and/or mortality to the patient is one of the measures to be considered in overall medical decision making. The Table of Risk, found in the 1995 and 1997 CMS Documentation Guidelines, may be used to help determine whether the risk to the patient is minimal, low, moderate, or high. The assessment of risk is based upon the disease process and the expected course between the present encounter and the next one. The Documentation Guidelines instruct that the highest level of risk in any one category in the Table of Risk – Presenting Problem(s), Diagnostic Procedure(s), or Management Options – determines the overall risk.

Prescription drug management can be found under moderate risk management options in the Table of Risk. But, what is prescription drug management? It is not clearly defined in the Documentation Guidelines. If we consider risk to patient (not physician work), we need to think on a broad basis. Because of the way we’re instructed to use the Table of Risk in determining risk to the patient and overall complexity of medical decision making, one can easily argue that when a prescription is given for a new problem, this would be moderate risk, even if the nature of the presenting problem itself may be low risk. There is risk to the patient in initiating a new treatment regimen: the patient’s response to drug treatment is an unknown factor and comes with inherent risk.

So, how about the scenario for a recurrent, acute uncomplicated illness? The provider prescribes the same drug in the same manner with little to no documentation to support the decision making. Could it be argued that this is still moderate risk to the patient? A medical necessity review may find not. Medical decision making is driven by the patient’s presenting problem. Per the Documentation Guidelines, “The assessment of risk of the presenting problem is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment.” So, if the patient has already received the same treatment for the same problem previously, it could be argued that the risk to the patient is lower than if the selected management option is a new one for the patient. Unless the provider includes some documentation of the reasoning, the decision making, for management of the recurrent problem with the same medication, the nature of the presenting problem becomes a determining factor for risk to the patient for previously utilized management options.

A decision not to change a dosage may involve as much medical consideration, deliberation and risk management as prescribing a medication for the first time. If a simple refill is offered, the risk is lower to the patient. Again, documentation of management of the patient’s prescription medications is key.

This type of rationalization can be daunting for providers, coders and auditors who struggle with leveling each service on an individual basis, as supported by the documentation. Too often, the rules are applied mechanically toward getting the “right number of elements” to level a service without consideration for the context of the service and the concept of medical necessity. The relationship between the clinical judgment of the provider and the nature of the patient’s presenting problem(s) is integral to coding and documentation, and the basis for supporting the medical necessity of the service.

If determining the level of risk associated with prescription drug management is an area of confusion and inconsistency in your coding department or practice, consider defining what prescription drug management means to your group. There needs to be an objective method for determining risk to patient so that prescription drug management is applied consistently by providers and coders alike. Gather input from your providers and your payers. Then, establish a policy by which prescription drug management is determined and measured and educate to that end.


Connie Eckenrodt RHIT, CHCA has over 15 years in the HIM field. Focusing on outpatient coding, with particular emphasis on professional fee coding and documentation improvement, Ms. Eckenrodt’s areas of expertise include: new provider coding orientations; individual and group coding education for providers and professional fee coders; pre-bill and retrospective coding audits; and risk assessment and focus review audits for internal compliance initiatives and compliance initiatives pursuant to federal investigations. Consulting has been provided in myriad settings, from small practices to large multi-specialty practice groups.
In 2012, CMS still allows facilities to choose their methodology for determining levels of service in the Emergency Department or clinics. They have not published “national standards” for these services and continue to monitor the submission of claims and currently are reviewing claims from 2010. Per CMS, the review continues to indicate a “normal and relatively stable distribution of clinic and emergency department visit levels”. At this time, they are not moving forward with implementation of a national system for facility E&M selection.

Physicians working in these same areas (ED, clinics) have to follow national guidelines for determining their level of service. The physician guidelines are based on documentation involving a matrix based on 3 components, history, physical and medical decision making. Facilities, however, may choose their system as long as the services provided are medically necessary, the coding methodology is accurate, consistently reproducible and correlates with institution resources utilized to provide a given level of service.

Various systems are available. Some are based on a point system where each service provided, such as the taking of vital signs, assistance with ambulation, etc., is assigned points. Based on the total points (services) a patient receives, an E&M level is assigned. Computerized systems are available that tallies each completed nursing staff entry and automatically selects the level of service. The American College of Emergency Physicians (ACEP) has a sample model available on their website. This model is a combination of presenting problems and possible interventions. A matrix is included with the system where the presenting problem, such as abdominal pain, is located on the matrix and then based on the interventions, CT scans, multiple reassessments, social worker intervention, the appropriate level of service is determined. Another well-known system was created by the American Hospital Association (AHA) and the American Health Information Management Association (AHIMA). The basics of this system are also found on the internet and can be adapted for individual facility use. It takes the 5 CPT E&M levels (99281-99285) and puts them into 3 levels of care, low, mid and high.

One major risk area with hospital systems involves “double-dipping.” An example of this would be assigning a higher level or giving more points when a Foley catheter is placed and then also billing a CPT (51702). This is an issue of concern to CMS, so verification that “double billing” scenarios are not likely to occur with your facility E&M guidelines is essential.

Even though each system is different and can be adapted to each specific facility, CMS has provided direction in the form of general principles which facilities should review and ensure their coding system follows. These “guiding principles” were published in the 2008 OPPS Final Rule. They state the E&M coding guidelines should follow the intent of the CPT code descriptor and reasonably relate the intensity of hospital resources to the different levels of effort represented by the code.

- Guidelines should be based on hospital facility resources, not physician resources.
- Guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits.
- Guidelines should meet the HIPAA requirements.
- Guidelines should require documentation that is clinically necessary for patient care.
- Guidelines should not facilitate upcoding or gaming.
- Guidelines should be written or recorded and well-documented.
- Guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.
- Guidelines should not change with great frequency.

Continued on following page...
Guidelines should be readily available for fiscal intermediary (or, if applicable, MAC) review and should result in coding decisions that could be verified by other hospital staff, as well as outside sources.

To help ensure cooperation with the principles, facilities should have in place a mechanism for regular review of the guidelines, adoption by the appropriate departmental and hospital regulatory committees, and perform coding reviews to ensure adherence to the guidelines by the coding and billing staff. When guidelines are changed or new systems are adopted, previous guidelines should be retained with dates of use so that reviews done by outside agencies may be completed with the appropriate guidelines. For example, a review of claims from 2010 should be performed with the facility guidelines that were in place during that time period and not with the current guidelines.

Jane Barta, RHIA has worked in hospitals both small (5 bed) and large (350+ beds) in Colorado, Montana and Idaho before contracting with RMC in 2000. Her past experience covers Quality Assurance, Utilization Review and departmental management in addition to Coding Quality. With RMC, Jane concentrates on the areas of Ambulatory Surgery, Emergency and Urgent Care coding. During the last 10 years, she has worked with over 38 hospitals in addition to multiple physician offices and insurance companies. She currently lives in Eugene, Oregon with her husband, Jim, and is learning to become a “duck”. RMC is proud to have Jane on our team, as she is a vital asset to our ER department and specialized clinic coding and compliance.

RAC UPDATES WITH RMC

April RAC report-Hospital only

DCS-DCS Healthcare added two new issues for skilled nursing facility claims to its CMS-approved list for providers in Region A states. (See link for individual state applicability.)

According to the DCS website, the new issues are:

- **CT scans, head and neck, incorrect billing.** Potential incorrect billing of CT scans not supported by medical necessity (NGS LCD 28516 (A48015)).
- **CT scans, trunk and extremities, incorrect billing.** Potential incorrect billing of CT scans not supported by medical necessity (NGS LCD 28516 (A48015)).

CGI-CGI added a new issue for medical necessity claims to its CMS-approved list for providers in all Region B states.

According to the CGI website, the new issue is:

- **Minor musculoskeletal procedures ; MS-DRGs 479, 484, 494, 497, 499, 502, 508, 509, 512, 517.** The purpose of this complex review is to identify claims that have been reviewed validating medical necessity in short stay, uncomplicated admissions. This review will identify if medical necessity was met per Medicare guidelines.

Connolly-Connolly Healthcare added three new issues across two categories—two for outpatient hospital – unspecified claims—to its CMS-approved list for all providers in Region C states.

According to the Connolly website, the new issues are as follows:

For outpatient hospital – unspecified claims

- **Hospice related services – outpatient CMS issue number: C000162012.** Services related to a hospice terminal diagnosis provided during a hospice period are included in the hospice payment and are not paid separately.
- **Colony-stimulating factors- outpatient CMS issue number: C000192012.** Local coverage determination policy has indicated specific conditions or diagnoses that are covered for colony-stimulating factor injections. These outpatient claims have been identified where the first-listed and/or other diagnosis codes do not match to the covered diagnosis codes in the LCD policies.

HDI-HealthDataInsights (HDI) added two new issues for medical necessity claims to its CMS-approved list for providers in all Region D states.
According to the HDI website, the new issues are:

- **OR procedure with principal diagnoses of mental illness (DRG 876).** Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation will be reviewed to determine that services were medically necessary.

- **Major male pelvic procedures with CC/MC (DRG 707).** Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation will be reviewed to determine that services were medically necessary.

### May RAC report-Hospital only

Connelly-Connolly Healthcare added 12 new issues across five categories—four for DRG validation claims, three for medical necessity claims, three for physician claims, one for outpatient hospital claims, and one for home health agency claims—to its CMS-approved list for all providers in Region C states.

According to the Connolly website, the new issues are as follows:

#### DRG validation claims

- **Skin debridement w/o CC/MCC MS-DRG 572, CMS issue number: C000562012.** DRG validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary’s medical record. Reviewers will validate for MS-DRG 572, previously DRG 440, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.

- **Skin debridement w/ CC MS-DRG 571, CMS issue number: C000552012.** DRG validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital in its claim, matches both the attending physician description and the information contained in the beneficiary’s medical record. Reviewers will validate for MS-DRG 571, previously DRG 440, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.

- **Skin debridement w/ MCC MS-DRG 570, CMS issue number: C000542012.** DRG validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary’s medical record. Reviewers will validate for MS-DRG 570, previously DRG 440, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRG.

- **Autologous bone marrow transplant w/o CC/MCC: MS DRG 017, CMS issue number: C000572012.** DRG validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary’s medical record. Reviewers will validate for MS-DRG 017—autologous bone marrow transplant w/o CC/MCC, principal diagnosis, secondary diagnosis and procedures affecting or potentially affecting the DRG.

#### Medical necessity claims

- **Diseases and disorders of the hepatobiliary system and pancreas MS-DRG’S 417, 420, 421 and 422 W/MCC, W/CC, w/o MCC/CC, CMS issue number: C000522012.** RACs will review documentation to validate the medical necessity of short stay, uncomplicated admissions. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. Medical documentation will be reviewed to determine that the services were medically necessary and were billed correctly for MS-DRG’S 417, 420, 421 and 422.

- **Diseases and disorders of the digestive system: MS- DRG’S 334, 335, 336, 337, 344, 345 And 346, W/MCC, W/CC, w/o MCC/CC, CMS issue number: C000512012.** RACs will review documentation to validate the medical necessity of short stay, uncomplicated admissions. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. Medical documentation will be reviewed to determine that the services were medically necessary and were billed correctly for MS-DRG’S 334, 335, 336, 337, 344, 345 and 346.

- **Ventricular shunt procedures MS-DRG 033 W/O CC/MCC, CMS issue number: C000462012.** RACs will review documentation to validate the medical necessity of short stay, uncomplicated admissions. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. Medical documentation will be reviewed to determine that the services were medically necessary and were billed correctly for MS-DRG 033.
Outpatient hospital claims

Incorrect billing of erythropoiesis stimulating agents (ESAs) – Outpatient, CMS issue number: C00012012. CMS has determined that ESA treatment is not reasonable and necessary for beneficiaries with certain clinical conditions, either because of a deleterious effect of the ESA on their underlying disease or because the underlying disease increases their risk of adverse effects related to ESA use.

Home health agency claims

RAP claim without corresponding home health claim, CMS issue number: C000682011. Home health billing requires that the home health agency (HHA) submit a request for anticipated payment (RAP), for determination of home health PPS payment, in addition to a home health final claim. Payment was made in response of the RAP claim bill, with expectation that a home health claim was billed. After data research of Medicare claims database, RAP claims were identified without a corresponding home health final claim.

June RAC report-hospital only

DCS Healthcare added two issues across two categories—one for hospital outpatient and one for hospital inpatient, Part B—to its CMS-approved list for providers in New York and Connecticut.

According to the DCS website, the new issue is:

- MRI scans. Potential incorrect billing of MRI scans not supported by medical necessity (NGS LCD L28518 [A48016])

DCS Healthcare added eight new issues across six categories—three for hospital outpatient claims, and one each for critical access hospital, hospital inpatient Part B, physician/nonphysician practitioner, skilled nursing facility, and ambulatory surgery center claims—to its CMS-approved list for providers in Region A states. (See link for individual state applicability.)

According to the DCS website, the new issues are:

- Radiologic exam of the chest, incorrect billing for indications that are not medically necessary. Potential incorrect billing of chest X-rays not supported by medical necessity [National Government Services (NGS) LCD L26901 (A46201)]

For hospital inpatient, Part B claims

- Radiologic exam of the chest, incorrect billing for indications that are not medically necessary. Potential incorrect billing of chest X-rays not supported by medical necessity (National Government Services (NGS) LCD L26901 (A46201)

For hospital outpatient claims

- Bevacizumab (AvastinTM) injection, 10 mg, for indications that are not medically necessary. Potential incorrect billing occurred for claims billed for bevacizumab with ICD-9-CM codes that are not listed by National Government Services (NGS) LCD L25820 (A46095) as medically necessary.

- Vitamin D assay testing. Potential incorrect billing of Vitamin D assay tests not supported by medical necessity (NGS LCD L29510 (A49254) and Novitas LCD L30273).

Radiologic exam of the chest, incorrect billing. Potential incorrect billing of chest X-rays not supported by medical necessity (NGS LCD L26901 (A46201)

For skilled nursing facility claims

Vitamin D assay testing. Potential incorrect billing of Vitamin D assay tests not supported by medical necessity [NGS LCD L29510 (A49254) and Novitas LCD L30273].

For ambulatory surgery center claims

Ambulatory surgery centers (ASC) / skilled nursing facility (SNF) consolidated billing. Under SNF consolidated billing, the SNF is responsible for the entire package of services that its residents receive during the course of a Part A stay with some exceptions. Potential billing error exists when an ASC bills Medicare Part B directly instead of SNF for reimbursement which also increases out-of-pocket liability for beneficiaries.

Connelly-Connolly Healthcare added 10 new issues for medical necessity claims to its CMS-approved list for all providers in Region C states.
According to the Connolly website, the new issues are as follows:

- **Diseases and disorders of the musculoskeletal system and connective tissue MS-DRG’S 506-514 W/CC, W/MCC, w/o CC/MCC, CMS issue number: C000592012.** RACs will review documentation to validate the medical necessity of short stay, uncomplicated admissions. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. Medical documentation will be reviewed to determine that the services were medically necessary and were billed correctly for MS-DRG’S 506, 507, 508, 509, 510, 511, 512, 513 and 514.

- **Diseases and disorders of the musculoskeletal system and connective tissue MS-DRG’S 469-470,479,494,497-499, 503-505 W/CC, W/MCC, w/o CC/MCC, CMS issue number: C000582012.** RACs will review documentation to validate the medical necessity of short stay, uncomplicated admissions. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. Medical documentation will be reviewed to determine that the services were medically necessary and were billed correctly for MS-DRG’S 469, 470, 479, 494, 497, 498, 499, 503, 504, and 505.

- **Diseases and disorders of the skin, subcutaneous tissue and breast MS-DRG’S 570, 571, 572, 579, 584 and 585 W/CC, W/MCC, w/o CC/MCC, CMS issue number: C000602012.** RACs will review documentation to validate the medical necessity of short stay, uncomplicated admissions. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. Medical documentation will be reviewed to determine that the services were medically necessary and were billed correctly for MS-DRG’S 570, 571, 572, 579, 584 and 585.

- **Endocrine, nutritional and metabolic diseases and disorders MS-DRG’S 614-621, W/CC, W/CC, w/o CC/MCC, CMS issue number: C000612012.** RACs will review documentation to validate the medical necessity of short stay, uncomplicated admissions. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. Medical documentation will be reviewed to determine that the services were medically necessary and were billed correctly for MS-DRG’S 614, 615, 616, 617, 618, 619, 620 and 621.

- **Diseases and disorders of the kidney and urinary tract MS-DRG’S 656, 659, 662, 665, 671, 686, 687, 709, 710 and 711 W/CC, W/MCC, w/o CC/MCC, CMS issue number: C000622012.** RACs will review documentation to validate the medical necessity of short stay, uncomplicated admissions. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. Medical documentation will be reviewed to determine that the services were medically necessary and were billed correctly for MS-DRG’S 656, 659, 662, 665, 671, 686, 687, 709, 710 and 711.

- **Disease And disorders of the kidney and urinary tract MS-DRG’S 713, 715, 717, 722, 723, 724, 725, 726, 729 and 730 W/CC, W/MCC, W/CC/MCC, w/o CC/MCC, CMS issue number: C000632012.** RACs will review documentation to validate the medical necessity of short stay, uncomplicated admissions. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. Medical documentation will be reviewed to determine that the services were medically necessary and were billed correctly for MS-DRG’S 713, 715, 717, 722, 723, 724, 725, 726, 729 and 730.

- **Disease and disorders of the female reproductive system MS-DRG 750, w/o CC/MCC, CMS issue number: C000642012.** RACs will review documentation to validate the medical necessity of short stay, uncomplicated admissions. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. Medical documentation will be reviewed to determine that the services were medically necessary and were billed correctly for MS-DRG 750.

- **Other ear, nose, mouth, and throat O.R. procedures MS-DRG 113 W CC/MCC, CMS issue number: C000652012.** RACs will review documentation to validate the medical necessity of short stay, uncomplicated admissions. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. Medical documentation will be reviewed to determine that the services were medically necessary and were billed correctly for MS-DRG 133.

- **Other endocrine, nutrit, and metabol O.R. procedures MS-DRG 628 W/CC, CMS issues number: C000662012.** RACs will review documentation to validate the medical necessity of short stay, uncomplicated admissions. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. Medical documentation will be reviewed to determine that the services were medically necessary and were billed correctly for MS-DRG 628.
Other O.R. procedures of the blood and blood forming organs MS-DRG 802-804 W/MCC, W/CC, w/o CC/MCC, CMS issue number: C000672012. RACs will review documentation to validate the medical necessity of short stay, uncomplicated admissions. Medicare only pays for inpatient hospital services that are medically necessary for the setting billed and that are coded correctly. Medical documentation will be reviewed to determine that the services were medically necessary and were billed correctly for MS-DRG 802, 803 and 804.

Connolly Healthcare added four new issues across two categories—two for inpatient hospital-acute care claims, and two for outpatient hospital-unspecified claims — to its CMS-approved list for all providers in Region C states.

According to the Connolly website, the new issues are as follows:

For inpatient hospital – acute care claims

- Hospice related services –inpatient issue number: C000252012. Services related to a Hospice terminal diagnosis provided during a hospice period are included in the hospice payment and are not paid separately.

- Hospice related services billed with condition code 07- inpatient issue number: C000362012. Services related to a Hospice terminal diagnosis provided during a Hospice period are included in the Hospice payment and are not paid separately.

For outpatient hospital – unspecified

- Hospice related services billed with Condition code 07- outpatient issue number: C000332012. Services related to a Hospice terminal diagnosis provided during a Hospice period are included in the Hospice payment and are not paid separately.

National correct coding initiative edits (Mutually exclusive and non-mutually exclusive)- outpatient issue number: C001292011. National Correct Coding Initiative (NCCI) Edits identify CPT/HCPCS code combinations that should not be reported together by the same Provider for the same Beneficiary and the same date of service. Each NCCI edit has an assigned modifier indicator. A modifier indicator of “0” indicates that NCCI-associated modifiers cannot be used to bypass the edit. A modifier indicator of “1” indicates that NCCI-associated modifiers may be used to bypass an edit under appropriate circumstances. Overpayments due to NCCI edits may be identified under the same claim number or under different claim numbers.

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