Coding for Ancillary Services

by Stacy Hartstine RHIT, CCS

As an experienced coder we often take for granted the “ease” of coding for ancillary services. I look back myself and I think of ancillary coding as a care setting for beginners, “something anybody can code”. In reality this is not a true statement. Ancillary coders face many challenges, which most are due to the limited documentation. It is essential for every facility to have a good set of internal guidelines for coding of Ancillary services. These guidelines should address what will actually be coded, (i.e: first listed only, chronic conditions, will you code “mild/moderate” findings from reports, will you code only from the final impression or include all significant findings). The facility guidelines should also address what source documents will be required for coding (i.e: Physician Order, Facesheet, Proof of Services provided, Radiology/Pathology reports) and when to query. For compliance these days, we’ve GOT to query – on all levels of care – not just inpatients.

Other issues an ancillary coder might face are having physician orders without a diagnosis or reason for the visit/test or orders with invalid/incomplete codes. Facilities should have a policy in place that directs the coder on how to obtain the necessary documentation. Facilities should also educate the providers on the importance of providing a written diagnostic statement in lieu of the code numbers. Per regulatory and accreditation guidelines, providers must supply clear and legible documentation of the diagnosis (Ref: CC 4Q 2015, pg 34).

Ancillary coders need to be very familiar with the guidelines for coding of Aftercare vs Follow-up and for Screening exams vs Diagnostic exams. Insurance coverage is different for screening vs diagnostic. Screening exams are normally covered at 100% but they have frequency limitations, whereas diagnostic exams could be subject to deductibles and coinsurance. A patient could be faced with unnecessary expenses if these services are not coded properly. Keep in mind that we are the coders, not the doctors! If you are routinely finding a provider documenting examinations/tests as screening when they are actually diagnostic, the provider should be educated. Notify your supervisor of your concerns, as these issues need to be resolved.

Ancillary coders tend to deal with much more than just simply applying the codes and sending the claim on its way. Some procedures and services provided to Medicare and Medicaid beneficiaries must be considered medically necessary and are only covered for certain conditions. Review CMS’s National Coverage Determination (NCD) and your FI’s Local Coverage Determination (LCD) for medical necessity. Many physicians will require certain lab test (such as PT/PTT) before they perform surgery regardless of patient’s medical history. It is possible that you may receive a rejection for preliminary lab work/tests if medical necessity has not been met. The majority of these claims will come back as a rejection and must be reviewed and resubmitted. Due to the time/cost associated with correcting these claims, each facility will need to determine what procedures/tests will be queried or written off. Developing facility guidelines that not only address what will actually be coded but also address payor issue are essential for accurate coding and reporting.

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The new buzz word for 2016 is “MACRA”. By now I’m sure you’ve heard the term and are wondering how the new rules will affect you and your practice. Some of you may have even attended a webinar or two on Advanced Alternative Payment Models (APMs) only to end up staring blankly into space, as the words fly over your head (it may have even been my presentation at OrHIMA’s Fall Institute). In this article, we’ll go over some of the key things you need to know about MACRA, MIPS, APMs and whole shebang.

The Medicare Access and CHIP Reauthorization Act (MACRA) final rule was released on Oct 14, 2016. MACRA combines Meaningful Use, Physician Value-based Payment Modifier (VM) and Physician Quality Reporting System (PQRS) and by combining those existing programs, aims to simplify things. According to the October 14th AHA Special Bulletin, “starting in 2019, the MIPS will be the default payment system for eligible clinicians, which includes physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists.”

Perhaps the most important thing to consider is that what you do in 2017 affects your payments in 2019. There are some misconceptions out there that MIPS and APM doesn’t start until 2019 but it is tied to what you do in just a few short months. So to reiterate, your 2019 payments are tied to your performance during 2017.

Another key point is that CMS is giving providers a choice or a “pick your pace” option for participating in MACRA in the first year, 2017, at the “level at which [you] feel comfortable”. The only way to fail and receive a negative payment adjustment for 2019 is to not participate at all either by choice or oblivion. So, it’s recommended that eligible clinicians choose one of four options to participate in MACRA provided by CMS.

**Pick Your Pace**

Clinicians who do choose to participate in MACRA are required to report data for any 90 continuous days during CY 2017.

1. Three options: (from AHA)
   - A. Report “some” data to avoid a penalty and no incentive payments
   - B. Report more than one measure
   - C. Report all required data in all MIPS categories
2. Participate in an APM

**APMs**

Many of you may be exploring the APM option under MACRA but know that APM efforts are narrow, with less than 10 percent of clinicians qualifying for the APM option. If you do qualify to participate in an APM, providers may receive a five percent bonus payment. Also according to AHIMA, eligible clinicians may also participate in MIPS but it’s not mandatory.

**Exemptions**

Clinicians billing $30,000 or less of Medicare charges or 100 or fewer Medicare patients are not required to participate in MIPS. If you do fall into the exemption for MIPS, but are eligible to continue to participate in Medicaid Meaningful Use, then you may continue participating in order to continue earning incentives for several more years. As long as you’re meeting the requirements, you can continue to attest and receive the incentives.

**Incentive Categories**

MACRA unifies the separate reporting structures into one Quality Payment Program with four pillars or MIPS Incentive categories for 2017:

1. **Quality measures**: According to CMS, “in many cases, MIPS quality measures are the same as those available under PQRS, so we believe that using PQRS data is appropriate for a MIPS benchmark.” CMS has also created specialty-specific measure sets that may be utilized by specialist. Quality measures will be selected annually and published by November 1st.
2. **Resource Utilization/Cost measures**: According to CMS, “cost measures do not require reporting of any data by MIPS eligible clinicians to CMS” at this time.
3. **Clinical practice improvement activities (CPIAs)**: For 2017, the transition year of MIPS, this pretty much means any improvement activities and clinicians don’t necessarily have to “show that the activity led to an improvement” (CMS, 2016);
4. **Advancing care information (ACI)**: Focuses on the “secure exchange of health information and use of certified electronic health record technology (CEHRT)” (CMS, 2016) and replaces Meaningful Use. Examples of required measures include:
   - Security Risk Analysis
   - E-prescribing
   - Providing Patient Access

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MACRA Continued...

In choosing your measures, consider these points:

- Be efficient and don’t make things harder than they already are with MU: find measures that are applicable across multiple measure sets and organizational initiatives and strategies, current performance, prebuilt measures in EMR
- Prioritize measures where you have higher volume of patients
- Select measures where you can improve and show improvements over time

The overall scoring under MIPS is complicated but luckily CMS has said it will provide interim reports on how well providers are doing. Pay attention to these reports and make adjustments. CMS will also use the data to set a national threshold for payment incentives: if you score above, it’s a positive incentive but if you score below, it’s a negative adjustment.

According to Susan Clark at eHealthcare Consulting, “one of the best things about MIPS is that it is not all-or-nothing.” CMS has learned a lot through the implementation of Meaningful Use, Accountable Care Organizations and appears to be willing to work with providers in order to shift the paradigm to value based reimbursement. The bottom line is, don’t stop doing what you’re doing but rather keep the momentum going. MIPS may change things but it’s not going to be as painful as you may think. The final rule includes a large portion of comments and responses by CMS in relation to over 4,000 comments received. These comments and responses give additional information as it relates to the program specifics.

References


Aurae Beidler, MHA, RHIA, CHC, CHPS has worked in the health care industry since 2002, for health systems and outpatient clinics including behavioral and dental health, with an emphasis in compliance operations and program implementation, training, auditing and privacy and security of health records. Aurae has experience with coding and billing issues, risk assessments, regulatory interpretations, internal investigations, responding to external audits and investigations, writing appeals for denied claims, policy and procedure creation, provider education and training, risk management and provider malpractice insurance and determining clinical billing risk by performing audits and investigations. She has overseen and assisted with the implementation of a privacy and security program for outpatient clinics and developed an institutional compliance program. She has also published several articles in Compliance Today and the Journal of AHIMA. She serves on AHIMA’s Privacy and Security Practice Council. Aurae earned a Master’s degree in Healthcare Administration (MHA) from Pacific University in 2010, a graduate certificate in biomedical informatics from Oregon Health and Sciences University and a B.A. in Journalism from University of Oregon in 2002. Aurae is currently credentialed as a CHC, certified in healthcare compliance, RHIA, registered health information administrator and CHPS, Certified in Healthcare Privacy and Security.

Clinical Validation in the ICD-10 World

Marquita Rawlins RHIA, CCS

The physician documented it, so we coded it. For countless years, that was the thought process for many coding professionals. However, in recent years that has changed. Coders have been challenged to not only review what is documented, but to also make sure the diagnosis is clinically supported. Clinical validation is defined as the clinical review of the medical record to see if the patient actually has the disease documented. This consists of reviewing the patient’s signs or symptoms, test results, and treatments to ensure the diagnosis is clinically supported. Clinical validation reviews are being performed by RAC and other commercial auditors, they are denying claims where the diagnoses are not clinically supported by the medical record documentation. Coders used to rely on the fact that the doctor documented a diagnosis. However, auditors are digging deeper. In 2013, CMS published the RAC Scope of Work which stated “Clinical validation is an additional process that may be performed along with DRG validation. Clinical validation involves a clinical review of the case to see whether or not the patient truly possesses the conditions that were documented in the medical record. Recovery Auditor clinicians shall review any information necessary to make a prepayment or post-payment claim determination. Clinical validation is performed by a clinician (RN, CMD or therapist). Clinical validation is beyond the scope of DRG (coding) validation, and the skills of a certified coder. This type of review can only be performed by a clinician or may be performed by a clinician with approved coding credentials.” Many hospitals experienced an increase in claim denials that were due to a clinical review of the medical record. Clinical validation primarily targets inpatient coding; however, facilities should look to decipher clinical validation in the outpatient setting as well. Many facilities now have a clinical documentation improvement (CDI) program that works hand in hand for the inpatient coding and there are also many facilities that are starting CDI for outpatient coding.

The Official ICD-10 CM Coding Guidelines effective with October 1, 2016 discharges included a new update which states “The Continued on following page...
Assignment of a diagnosis code is based on the provider's diagnostic statement that the condition exists. The provider's statement that the patient has a particular condition is sufficient. Code assignment is not based on clinical criteria used by the provider to establish the diagnosis.”

This update in the Official Coding Guidelines caused much confusion in the coding world. Many coders had questions that management was unable to answer. We wondered if clinical documentation improvement (CDI) was going away, should we revert to our previous coding practices and code every diagnosis the physician documents, and should we continue to query the physician if the clinical indicators do not match the documented diagnosis? Our confusion was short lived as the intent of the update was clarified in Coding Clinic, Fourth Quarter 2016. CDI is not going away. This new guidelines is addressing coding and not clinical validation. Although they work together, clinical validation is a separate function. Coding is still based on physician documentation. If there is any conflicting, contradictory, unclear, or inconsistent documentation coders are still encouraged to query to ensure accurate coding. Coding professionals should review the entire medical record especially the Progress Notes to ensure the diagnoses show progression.

The goal of clinical validation is to ensure that the medical record is not only coded correctly, but also correctly reflects the clinical scenario within the health record, which requires collaboration among providers, CDI, and coders. There are several ways to prevent clinical validation denials and we have pinpointed a few which include:

- Develop a strong audit team consisting of coding professionals and CDI
- Review specific DRGs before the bill is dropped (a.k.a pre bill audits)-The results from the audits can be used as a great education tool for the coders.
- Stay current with coding risks thru OIG, MAC, and CMS compliance newsletter-Analyze date for your facility and compare/contrast where your facility lands.

In the unlikely circumstance that a facility receives a clinical validation denial, the denial should be read thoroughly and in complete detail. If the facility decides to appeal the denial, the appeal letter should be well written, clear, and to the point. The appeal letter should include specific documentation within the medical record to support the code assignment and Official Sources (i.e. Coding Clinic, Official Coding Guidelines) to support your argument. Stay focused on your determination and summarize your argument in a positive manner. It is also helpful to complete a joint letter with Chief of Staff or Physician Champion to further strengthen your appeal.

Clinical validation is extremely controversial! Each facility should make their own determination on what they would like for their coders to do. Working with CDI and physicians to address documentation issues are critical for success. Teamwork is important to ensure accurate coding and reporting, which is the ultimate goal.

References:

ICD-10-CM Official Guidelines for Coding and Reporting, effective October 1, 2016-September 30, 2017


Marquita Rawlins, RHIA, CCS, AHIMA Approved ICD-10 CM/PCS Trainer joined RMC in 2015 as Senior Manager of Coding Services. In this role, Marquita manages a team of coders providing coding services. Marquita is a graduate of the University of Alabama in Birmingham, with a Bachelor’s of Science in Health Information Management and has numerous years of experience in HIM. Marquita’s past positions include Manager of Audit Services, DRG RAC Auditor, and most recently an ICD-10 Auditor for acute care facilities nationwide. Marquita enjoys providing education to coders, mentoring team members, and performing audits.

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Since its implementation in 1996, the National Correct Coding Initiative (CCI/NCCI) has been promoting correct coding and has been working to prevent duplicate payments for services that can and should be billed with a single code. You might have heard this also called bundling of services. Is your facility having claims denied for bundled services? Here are some tips on how to understand what this means.

CCI edits are pairs or groups of CPT and/or HCPCS codes that are not separately payable except under certain circumstances. These edits apply to services being billed by the same provider for the same patient on the same date of service. There are two different types of CCI edits; the first of which is Procedure to Procedure (PTP) edits. PTP edits are for two procedures that should not be billed together. The second type of CCI edit is called a Medically Unlikely Edit (MUE). MUE edits are used to prevent payment when an inappropriate unit of service is billed on a particular day. All claims billed by a provider are processed against the CCI tables when submitted to the insurance carrier, so it is important that you understand what codes are bundled before you bill. It is not acceptable for providers to use ABNs in order to bill patients for services denied for bundling errors.

The CMS website contains a full list of CCI edits that is available for free download, as well as a helpful document titled “How to use the National Correct Coding Initiative Tools”. On the CCI edit listing you will see columns similar to that listed below:

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>* = In existence prior to 1996</th>
<th>Effective Date</th>
<th>Deletion Date</th>
<th>Modifier 0=not allowed 1=allowed</th>
<th>PTP Edit Rationale</th>
</tr>
</thead>
</table>

What do these columns mean?

- **Column 1** = Comprehensive/Major Codes
- **Column 2** = Component/Secondary Codes
- **Third column** edit in existence prior to 1996
- **Fourth column** effective date of edit
- **Fifth column** deletion date of edit
- **Sixth column** identified if a modifier is permitted

  - **Modifier Indicator 0 (Not Allowed)** – There are no modifiers associated with NCCI that are allowed to be used with this code pair; there are NO circumstances in which both procedures of the PTP (procedure to procedure) code pair should be paid for the same beneficiary on the same day by the same provider
  - **Modifier Indicator 1 (Allowed)** – The modifiers associated with NCCI are allowed with this PTP code pair when appropriate. DO NOT automatically append a modifier to bypass the edit. Documentation MUST support why a particular modifier is appropriate.
  - **Modifier Indicator 9 (Not Applicable)** – This indicator means that an NCCI edit does not apply to this PTP code pair. The edit for this code pair was deleted retroactively.

- **Seventh column** provides the basis/rationale for the PTP edit
- The following modifiers are allowed with CCI edits: E1, E2, E3, E4, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, LC, LD, RC, LT, RT, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9 The following global surgery modifiers are allowed: 25, 58, 78, 79 Other modifiers that are allowed: XE, XP, XS, XU, 59, and 91.

**Remember these CCI edits are updated every quarter. Please be sure to check for updates on codes you frequently use. The CMS NCCI page can be found at: [http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html](http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html)**

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**Chris Breithoff, CPC, CPCO, CRC** is the Manager of Physician Coding Services at RMC. She has worked in the medical arena since 1985 with an emphasis on coding & compliance for 18 years. Her background includes managing large private practices, as well as managing a physician coding department for a large teaching hospital. Chris’ areas of expertise are E/M, Critical Care, ER, GI, Pulmonary, Cardiology and Sleep Medicine.

**Monique Vanderhoof, RHIT, CPC, CCA, CRC** joined RMC in 2011, and is the Manager of Coding Services. She has over 15 years of experience in health care as a Coding Manager and a Clinic Manager with extensive experience working in outpatient physician settings with an expertise in cardiology. Her skills also include EHR implementation, HIPAA, eRx and Meaningful Use readiness and attestation. Ms. Vanderhoof is an AHIMA approved ICD-10 trainer and is dedicated to preserving coding quality by leading coding education presentations.
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