RPA NEPHROLOGY CODING AND BILLING SEMINARS

2012
Coding and Billing for Nephrology Practices

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Breaking News

CRIME RATES RISE

Perpetrators caught
Accomplices named
Details at 11
IT CAN’T HAPPEN TO ME!

- Been in practice for years and every time they look it’s been OK
- I’ll “fly under the radar” so they won’t look at me
- It happened to Dr. Joe, but everyone knows he’s a crook
- I’m a small fish, they will go after the big guys
WHAT MAKES YOU A TARGET?

- Time lapse in getting to the documentation
- Lack of documentation
- Sloppy documentation
- Lack of knowledge of the documentation rules
- Thinking documentation is “just for billing” and is not important – it has nothing to do with medical care
- I’m a specialist – all my services are high level
WHO IS LOOKING?

The Audit Alphabet Soup
- CMS
- CERT
- RAC
- OIG
- MIC
- ZIP

Isn’t it amazing…..they can look at us, but who is looking at them!
WHY WOULD THEY LOOK AT ME?

- Billing for services not rendered
- Intentional upcording or downcoding services
- Billing one provider under another provider’s number
- Billing “incident to” services when the physician is not in the suite
- “Monotone” billing
WHO ARE THE TARGETS?

- Large practices
- Small practices
- Hospital owned practices
- Teaching practices
- Joint ventures
- YOU!
WHO ARE THE HIRED GUNS?

- RAC – As of March 27, 2008 CMS reported that the RAC had “succeeded” in correcting more than $1 billion in improper payments from Medicare – 96% ($992.7 million) in overpayments and 4% (37.8 million) in underpayments returned to providers
WHEN WILL THEY COME FOR YOU?

- The Tax Relief and Health Care Act of 2006 made the RAC permanent and mandated that CMS expand the program to all 50 states by 2010.
- Third party auditors hired by CMS will conduct the audits.
- They will keep a percentage of what is collected.
HOW DO THEY IDENTIFY PROBLEM CLAIMS?

- Automated review – conducted without review of the medical record supporting the claim
- Complex review – analyzes actual medical records supporting claims under investigation
- Cannot review any claims prior to Oct. 2007
COMPLEX REVIEWS

- On-site reviews look at the provider’s records in person
- May request a mail or secure transmission of the records to the RAC
- May review 10 records per 45 days for solo practitioners
- If not received within 45 days RAC may render a overpayment decision without review
PROVIDER’S RIGHTS

- May request an extension to secure and forward records to the RAC
- RAC must follow Medicare policies, regulations, national and local carrier determinations and manual instructions
- Must follow Medicare coverage, coding and billing policies and may not apply their own
APPEAL OF A RAC DECISION

- Redetermination – 120 days from denial
- Reconsideration – 180 days from redetermination by Qualified Independent Contractor (QIC)
- Administrative Law Judge hearing (60 days after QIC)
- Medicare Appeals Council (MAC) hearing (60 days after ALJ)
- Federal District Court (60 days after MAC)
SUCCESS RATE IN APPEAL?

- Providers have been successful 34% of the time the claims were challenged.
- This may be low given the number of appeals still pending.
- Because of the incentive given the RAC to find errors, providers should consider an appeal if they think the RAC is erroneous.
ARE THEY ALWAYS RIGHT?

- Just because you have gotten information about a RAC determination, don’t always assume it is the correct decision.
- Recently there was an erroneous decision by Connolly Consulting Associates (Region “C” RAC) that involved numerous providers from West Virginia to Texas. This decision was involving hospital admissions during a month the MCP was provided.
HOW DO WE PREPARE FOR AN AUDIT?

- “An ounce of prevention is worth a pound of cure” applies to auditing as much as to medicine
- Look at how things are done….objectively not just in how is should be done
- Education
- Corrective action – if you are not going to take the step…don’t do the audit
DOCUMENTATION GUIDELINES
ICD 9

- What is the patients problem that YOU are addressing?
- Is it a symptom or a diagnosed condition?
- Is it singular or multiple?
- Is the clinical picture reflected complete?
- How is it recorded?
  - In the chart
  - On the bill
CPT

- What is the physician service **YOU** performed?
  - Are the elements of documentation guidelines reflected?
  - Where did you do it? (site of service)
  - How is it categorized? (screening or treatment)
  - How is it recorded?
    - In the chart
    - On the bill
INTRODUCTION

- “The proof is in the detail”
- The medical record is not only a document for billing but also a chronological record of the care that is rendered to the patient
- The medical record protects both the patient and the provider in the event of a malpractice case
- In an audit, the medical record is the only thing an auditor will review
Descriptors for the levels of E/M services recognize seven components:

- History
- Exam
- Medical Decision Making
- Counseling
- Coordination of Care
- Nature of Presenting Problem
- Time
E/M DOCUMENTATION HISTORY

- History includes some or all of the following elements:
  - Chief Complaint (CC)
  - History of Present Illness (HPI)
  - Review of Systems (ROS)
  - Past, Family and/or Social History (PFSH)

  - DG: The CC, ROS, and PFSH must be listed as separate elements of history, or may be included in the description of the recorded history of the present illness
– DG: An earlier ROS and/or PFSH need not be re-recorded if evidence shows update. The review and update may be documented by:

- Describing any new ROS and/or PFSH or noting no change in info; and/or
- Noting the date and location of the earlier ROS and/or PFSH
E/M DOCUMENTATION HISTORY

– DG: The ROS and/or PFSH may be recorded by staff or on a form completed by patient. There must be a notation supplementing or confirming the info recorded by others to document that the physician reviewed the info.

– DG: If the physician is unable to obtain history, the record should describe condition or circumstance which precludes obtaining history. **IMPORTANT**
 DOCUMENTATION
CHIEF COMPLAINT

-The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter

- **DG:** The medical record should clearly reflect the chief complaint

  - **Without a chief complaint there is no element of history**
HPI – chronological description of development of patient’s present illness from first sign to the present

- Location – pain in leg
- Quality – aching, burning, radiating
- Severity – 10 on a scale of 1-10
- Duration – started 3 days ago
- Timing – comes & goes
- Context – lifted large object @ work
- Modifying factors – better with heat
- Associated signs and symptoms – numbness
TIPS FOR PREVENTING CODING ERRORS WITH E/M CODING

- Describe the history of the present illness fully and in such a way that the nature of the presenting problem in clear.
  - The documentation guidelines specify elements that must be recorded. Higher services require four or more elements.
  - Medical necessity of an E/M encounter is often viewed through the characteristics captured in specific HPI elements.
A *problem pertinent* ROS relates directly to the problem(s) identified in the HPI

- **DG:** The patient’s positive responses and pertinent negatives for the system related to the problem should be documented

- An *extended* ROS inquires about system directly related to problem(s) identified in the HPI and a limited number of additional systems
– DG: The patient’s positive responses and pertinent negatives for two to nine systems must be documented

- A *complete* ROS inquires about the system(s) directly related to problem(s) identified in HPI plus all additional body systems
– DG: At least ten organ systems must be reviewed. Those systems with positive or pertinent responses must be individually documented. For the remaining systems, a notation indicating “all other systems reviewed and are negative” is permissible. In the absence of such a notation, at least ten systems must be individually documented.
TIPS FOR PREVENTING CODING ERRORS WITH E/M CODING

- Record the ROS appropriate for the clinical circumstance of the encounter. Expansive ROS is unnecessary for lower-level services.
  - When using “negative” notation, always identify which systems are queried and found to be negative
- Don’t record unnecessary information solely to meet documentation requirements for a high-level service when the nature of the presenting problem dictates a lower-level of service to be medically appropriate
The PFSH consists of a review of three areas:

- Past History
- Family History
- Social History

For sub. Hospital care, established pt visits, and sub. Nursing facility care, CPT requires only interval history (not necessary to record PFSH)
TIPS FOR PREVENTING CODING ERRORS WITH E/M CODING

- Don’t use the terms “unremarkable”, “non-contributory” or “irrelevant”.
- Record information about all three realms to document “complete” PFSH for these services:
  - New patient, new consults, initial hospital, observation, nursing home
- Don’t record unnecessary information solely to meet requirements for higher-level service.
DOCUMENTATION
EXAMINATION

- Problem Focused
- Expanded Problem Focused
- Detailed
- Comprehensive
ORGAN SYSTEMS RECOGNIZED
EXAMINATION

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, Nose, Mouth, and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
ORGAN SYSTEMS RECOGNIZED
EXAMINATION

- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic
TIPS FOR PREVENTING CODING ERRORS WITH E/M CODING

- Understand the difference in “Expanded Problem Focused” and “Detailed” exams under 1995 guidelines
  - The difference is not the number of systems required (2-7 for both exams)
  - The difference is in the detail in which the examined system is described
- Always examine the system(s) related to the presenting problem
  - Use “normal” or “negative” and “WNL” notations only to describe unaffected or asymptomatic organ systems
- Code the Physical Exam by the clinical circumstances of the encounter, not to meet high-level requirements
Medical Decision Making is measured by:

- The number of possible diagnoses and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed
- The risk of significant complications, morbidity and/or mortality
NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

– DG: For each encounter, an assessment, clinical impression, or diagnosis should be documented

  ▪ For a presenting problem with an established diagnosis, the records should indicate whether the problem is: improved, well controlled, resolving or resolved or inadequately controlled, worsening, or failing to change as expected
NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

– For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as “possible”, “probable” or “rule out” (R/O) diagnoses

– **DG:** The initiation of, or changes in treatment should be documented. Treatment includes patient instructions, nursing instructions, therapy and meds

*(NOTE: All changes in meds and refills must be documented)*

*RENAL PHYSICIANS ASSOCIATION*
AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

- Test or procedures ordered or scheduled must be documented
- Review of diagnostic tests should be documented
- Decision to obtain additional info/records should be documented
- Relevant finds from review of records/info should be documented
- Discussion of findings from tests with performing physician should be documented
- Direct interpretation of tests previously interpreted should be documented
RISK OF COMPLICATIONS, MORBIDITY AND/OR MORTALITY

- Co morbidities/underlying diseases that increase the complexity of Medical Decision Making must be documented
- If procedure is ordered at time of E/M encounter, that test must be documented
- If procedure is done at time of E/M service, that must be documented
- The referral for procedure must be documented
TIPS FOR PREVENTING CODING ERRORS WITH E/M CODING

- Record relevant impressions, tentative diagnosis, confirmed diagnoses and all therapeutic options chosen related to every problem for which E/M is clearly documented in the record of the other key components
  - Don’t count existent old diagnoses unless the record clearly demonstrates their presence increased physician work related to the encounter
TIPS FOR PREVENTING CODING ERRORS WITH E/M CODING

- Summarize old records or other outside information reviewed and incorporated into decision-making.

- **Beware of templates** that over-estimate decision-making. Understand the logic of templates and/or computer programs used for E/M service coding.
If counseling and/or coordination of care dominates more than 50% of the physician/patient and/or family encounter, time is considered the key or controlling factor to qualify for a particular level of E/M services.
DOCUMENTATION
ENCOUNTER DOMINATED BY
COUNSELING / COORDINATION OF CARE

- **DG:** If the physician elects to report the level of care based on time, the total length of time of the encounter must be documented along with the amount of time spent in counseling and the content of the counseling session
  - Who was present
  - What was discussed
  - Conclusions met
TIPS FOR PREVENTING CODING ERRORS WITH E/M CODING

- Subsequent hospital services – Pay attention to medical necessity – strongly consider the “nature of the presenting problem”
  - 99231 – usually the patient is stable, recovering or improving
    - A problem focused interval history
    - A problem focus examination (a limited examination of the affected body area or organ system)
    - Medical decision making that is straightforward or of low complexity
TIPS FOR PREVENTING CODING ERRORS WITH E/M CODING

– 99232 – usually the patient is responding inadequately to therapy or has developed a minor complication

- An expanded problem focused interval history
- An expanded problem focused examination (a limited examination of the affected body area or organ system and other symptomatic or related organ system(s))
- Medical decision making of moderate complexity
TIPS FOR PREVENTING CODING ERRORS WITH E/M CODING

– 99233 – usually the patient is unstable or has developed a significant complication or significant new problem

- A detailed interval history
- A detailed examination (an extended examination of the affected body area(s) and other symptomatic or related organ system(s))
- Medical decision making of high complexity
CONSULTATION SERVICES
BILLING FOR CONSULTATIONS

- Consult codes 99251-99255 are no longer recognized for Medicare Part B payment
- In the inpatient hospital setting the initial evaluation by any physician will be 99221-99223
- This change will result in multiple billings of the initial hospital code
BILLING FOR CONSULTATIONS

- Modifier “-AI” will be utilized by the admitting or attending physician and is identified as “Principal Physician of Record”
- Each time the patient is admitted to the hospital and a physician provides an initial evaluation, this code may be used
BILLING FOR CONSULTATIONS

- Even for an established dialysis patient, where a consultation code would not have been appropriate, 99221-99223 can be used.
- If the patient also has dialysis on the day of the initial evaluation (not necessarily the day of admission) both the 99221-99223 and 90935/37/45/47 can be used – append modifier “-25” to the 99221-99223.
BILLING FOR CONSULTATIONS

- Providers must pay close attention to the complexity level performed when choosing the level of service billed

- A crosswalk from the consultation codes would be:
  - 99251-99253 = 99221 (watch documentation requirements)
  - 99254 = 99222
  - 99255 = 99223
BILLING FOR
CONSULTATIONS

- Follow up care in the hospital settings use the subsequent visits appropriate for the location
- 99231-99233 are used for inpatient hospital follow-up care
BILLING FOR CONSULTATIONS

- Reminder – when using the higher levels of the initial hospital visit codes (99222-99223) there must be a comprehensive history and physical exam
  - For the history of present illness there must be at least four of the elements:
    - Location
    - Severity
    - Quality
    - Timing
    - Context
    - Modifying factors
    - Associated signs & symptoms
  - Past, family and social history obtained at this visit
  - At least a 10 organ system review
  - At least an 8 organ system physical exam
BILLING FOR CONSULTATIONS

- Observation care presents some different issues
- Only the physician who ordered the outpatient observation admission may bill the observation admission codes 99218-99220
- Other physicians providing care in the observation setting are to bill 99201-99205 new office/outpatient visit code or 99211-99215 established office/outpatient visit code depending on the status of the patient’s relationship with the evaluating physician
BILLING FOR CONSULTATIONS

- Office/outpatient consultation codes (99241-99245) are also not recognized for Medicare Part B payment
- Unlike the hospital codes that allow physicians to bill the inpatient initial hospital care code each time the patient is admitted to the hospital, in the outpatient setting, the provider must determine if the patient is new or established
- If the patient has been seen by any member of the group during the past 3 years, the patient is established
BILLING FOR CONSULTATIONS

- This care could have been provided in the inpatient or the outpatient setting
- If the patient is new to the practice bill 99201-99205 as appropriate based on the elements and nature of the presenting problem
- If the patient has been seen within three years, regardless of the diagnosis, the patient is established and you must use 99211-99215
BILLING FOR CONSULTATIONS

- There is a direct crosswalk to these codes making the billing simpler
  - 99241 = 99201
  - 99242 = 99202
  - 99243 = 99203
  - 99244 = 99204
  - 99245 = 99205 – remember at this level the intensity of the visit is high
BILLING FOR CONSULTATIONS

- Documentation of all elements are required including the chief complaint (reason for the visit)
- I also suggest that the provider continue to document who requested the “consultation” if this is an initial encounter either new or established
- If any portion of the encounter is performed by a NPP, and the billing is done under the physician’s provider number, the physician would have to be physically present in the suite and see the patient as a “shared” visit
OIG TARGETS

“What the inspectors are looking for”
OIG WORK PLAN

- “The size and scope of the Medicare system places it at high risk for payment errors”
- OIG audits help to avoid fraud and protect the solvency of the Medicare Trust.
- These reviews have revealed payments for unallowable services, improper coding, and other types of improper payments.
2012 TARGETS

- Place of Service Errors
- Incident to Services
- Impact of Opting out of Medicare
- Trends in Coding of Claims
- E&M during Global Surgical Periods
2012 TARGETS

- Modifiers During Global Surgical Periods
- Potentially Inappropriate Payments
2012 TARGETS

- Place of Service Errors
  - OIG will determine whether physicians properly coded the place of service on claims for services provided in ambulatory surgical centers and hospital outpatient departments.
  - Medicare regulations provide for different levels of payments to physicians depending on where the service is performed.
  - Medicare makes higher payments for physician office services.
2012 TARGETS

- Incident to Services
  - OIG will review physician billing for “incident-to” services to determine whether payment for such services had a higher error rate than that for non-incident-to services.
  - We will also assess CMS’s ability to monitor services billed as “incident-to.” Medicare Part B pays for certain services billed by physicians that are performed by non-physicians incident to a physician office visit. A 2009 OIG review found that when Medicare allowed physicians’ billings for more than 24 hours of services in a day, half of the services were not performed by a physician.
2012 TARGETS

- Incident to Services
  - We also found that unqualified non-physicians performed 21 percent of the services that physicians did not perform personally. Incident-to services represent a program vulnerability in that they do not appear in claims data and can be identified only by reviewing the medical record. They may also be vulnerable to overutilization and expose Medicare beneficiaries to care that does not meet professional standards of quality.
Impact of Opting Out of Medicare

- OIG will review the extent to which physicians are opting out of Medicare and determine whether physicians who have opted out of Medicare are submitting claims to Medicare. We will also examine whether specific areas of the country have seen higher numbers of physicians opting out and its potential impact on beneficiaries. Physicians are permitted to enter into private contracts with Medicare beneficiaries. (Social Security Act, §1802(b).) As a result of entering into private contracts, physicians must commit that they will not submit a claim to Medicare for any Medicare beneficiary.
2012 TARGETS

- **Trends in Coding of Claims**
  - OIG will review evaluation and management (E/M) claims to identify trends in the coding of E/M services from 2000-2009. We will also identify providers that exhibited questionable billing for E/M services in 2009. Medicare paid $32 billion for E/M services in 2009, representing 19 percent of all Medicare Part B payments. Providers are responsible for ensuring that the codes they submit accurately reflect the services they provide. E/M codes represent the type, setting, and complexity of services provided and the patient status, such as new or established.

(CMS’s Medicare Claims Processing Manual, Pub. No. 100-04, ch. 12, § 30.6.1.)
2012 TARGETS

- **Evaluation and Management Services Provided During Global Surgery Periods**
  - OIG will review industry practices related to the number of E/M services provided by physicians and reimbursed as part of the global surgery fee to determine whether the practices have changed since the global surgery fee concept was developed in 1992. Under the global surgery fee concept, physicians bill a single fee for all of their services that are usually associated with a surgical procedure and related E/M services provided during the global surgery period.

2012 TARGETS

- Use of Modifiers During the Global Surgery Period
  - OIG will review the appropriateness of the use of certain claims modifier codes during the global surgery period and determine whether Medicare payments for claims with modifiers used during the global surgery period were in accordance with Medicare requirements. Prior OIG work has shown that improper use of modifiers during the global surgery period resulted in inappropriate payments. The global surgery payment includes a surgical service and related preoperative and postoperative E/M services provided during the global surgery period.

*Medicare Claims Processing Manual, Pub. 100-04, ch. 12, § 40.1.*
2012 TARGETS

- Potentially Inappropriate Payments
  - OIG will assess the extent to which CMS made potentially inappropriate payments for E/M services and the consistency of E/M medical review determinations. We will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service based upon the content of the service and have documentation to support the level of service reported.
END STAGE RENAL DISEASE
PHYSICIAN COMPENSATION

BILLING FOR THE MONTHLY
CAPITATION PAYMENT

MCP
REGULATIONS

- Conditions of coverage?? or
- MCP??
- Are there conflicting regulations?
- Which should be followed?
MEDITICARE AND ESRD

“A match made in Congress”
ESRD DEFINED

- Medicare regulations define ESRD as “that stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis treatment or kidney transplantation to survive”.

- 1972, Congress changed the Social Security Act to instruct CMS to pay the cost of treating ESRD via Medicare eligibility.
MEDICARE ENTITLEMENT DATE - ESRD

- Entitlement begins after completion of three month waiting period for in-center patients
- Waiting period waived for home dialysis
- Waiting period also waived for transplants
MEDITCARE SECONDARY PAYER (MSP)

- Beneficiary is working
- Beneficiary is disabled
- Completion of coordination period
  - 30 months as Medicare Secondary
  - Primary coverage must be an employer group plan
MONTHLY CAPITATION PAYMENT

- CMS method to reimburse Nephrologists for all outpatient care of patients with ESRD

- MCP is comprehensive, per patient, per month payment for all outpatient renal-related care
MONTHLY CAPITATION PAYMENT

Not included in MCP:

- Non-renal related evaluation and management
- Hospital inpatient services
- All non-renal procedures
- Evaluation for transplant or LRD evaluation
- Training of patients to perform home dialysis
MONTHLY CAPITATION PAYMENT

Included in the MCP

- All renal-related **outpatient** services rendered to the dialysis patient
- Interpretation of ancillary testing (nerve conduction studies, bone density, doppler studies)
- Services rendered to the dialysis patient while on dialysis
- Physicals required by the dialysis facility for the renal patient
MONTHLY CAPITATION PAYMENT

Included in the MCP

- Certification of the need for items & services such as DME & home health care
- Care plan oversight services described by CPT code 99375
MONTHLY CAPITATION PAYMENT

Included in the MCP

- Periodic visits to the patient during dialysis to determine if the dialysis is working well both physiologically & psychologically. During this encounter the physician will determine if any elements of the plan need to be revised to optimize the patient’s treatment and/or care.

- Coordination & direction of the multi-disciplinary team involved in the patient’s care.
OUTPATIENT SETTINGS

- The MCP covers all **outpatient** services related to the patient’s renal condition
- Services may be rendered in the in-center dialysis unit, patient’s home, practitioner’s office, outpatient hospital, observation care, emergency room and outpatient surgery
  - Inpatient services cannot count as MCP encounters
PRACTITIONER DEFINITIONS

- MCP physician is the **physician** who performs the “major” (care plan) visit during the month. This physician is the billing physician.

- Non-physician practitioner – NP/PA who is employed by the same entity as the physician
  - Must be able under statute to furnish services that would be physician services.

- Non-MCP physician – must have a relationship with the MCP physician such as partner.
USE OF NON-PHYSICIAN PRACTITIONERS

- **MCP** physician (billing physician) must provide the visit with the complete assessment of the patient, establish the plan of care, and submit the bill for the monthly service – *Must see the patient at least once a month*
  - Non-physicians can provide some of the visits to equal total # submitted
  - Non MCP physician can provide some of the visits
  - Non-physician must have a relationship with the physician (employee)
PARTIAL MONTH RULE

- 90967-90970 ESRD related services for dialysis less than a full month of service
- Use limited to:
  - Transient patients
  - Home dialysis patients
  - Patients who have a permanent change in their MCP physician during the month
  - Partial month with one or more face-to-face visits without the complete (care plan) visit but only in patients with
    - Dialysis stopped due to death.
    - Dialysis patient transplanted
    - Dialysis patient hospitalized during the month
PARTIAL MONTH RULE (cont.)

- Partial month rule does not apply to patients who start dialysis during the month.
- Without a complete (care plan) visit, these patients cannot be billed for this first month on dialysis.
- Cannot bill 90967-90970.
TRANSIENT PATIENTS

- Only one physician can bill for the management of a patient per month
- Bill 90970 for the number of days the patient is under the transient physician’s care
- If the transient patient is in the transient dialysis unit for a full month, then the same rules apply as with any other in-center patient. Transient MD becomes MCP physician
PATIENTS WITH LESS THAN A FULL MONTH MCP

- Bill as if the patient had a full month of dialysis with the appropriate CPT code for the number of encounters if:
  - Dies during the month
  - Transplants during the month
  - Transfers during the month
  - Hospitalized

Patient must have complete (care plan) visit to bill using the appropriate CPT code
HOSPITAL OBSERVATION STATUS

- ESRD-related visits furnished in hospital observation status count as an MCP encounter
- Visit will count towards the total number of encounters submitted (CPT code)
- Describe (document) in the medical record the type of ESRD-related service rendered in observation status
HOSPITALIZATION & THE MCP IN-CENTER PATIENTS

- ESRD patients, other than home dialysis patients, hospitalized during the month will be billed for the number of face-to-face encounters that occurred when the patient was **not** in the hospital.

- Since the MCP is no longer “time” dependent, but based on encounters face-to-face, the practitioners no longer “carve out” hospital days.

- Bill inpatient care **and** the CPT code for the number of outpatient face-to-face encounters.
HOME DIALYSIS

- Payment based on 2-3 visit payment level approximately $221.66
- Monthly visit is the **REQUIRED** in 2011 – bill using full month code 90966 for 20+ years old)
- If patient has less than full month at home— bill using by day code 90970 for 20+ years old)
- Home patients are billed similarly to how MCP was billed historically
HOME DIALYSIS (cont)

- If the home patient receives in-center dialysis during the month, the provider would still bill the management fee for the month under the home dialysis provision.

- The physician cannot bill the in-center CPT code or CPT 90935-90937 for the encounters in-center.
HOSPITALIZATION & THE MCP
HOME DIALYSIS

- Home patients continue to be billed in a full month or partial month format similar to prior codes.
- If the patient is home for the 1st-10th hospitalized from the 11th-20th, then back home from the 21st-30th, you would bill for the 90970 (adult) for the 1-10 (10 days), inpatient codes for 11-20, then 90970 for the 21-30 (10 days)
MODALITY CHANGES

- If a patient switches modalities during the month, bill the entire month using the appropriate HOME dialysis code 90963-90966

- If partial month care bill using 90967-90970
 DOCUMENTATION REQUIREMENTS

- CMS stopped short of dictating documentation requirements however were very specific on what was necessary.
- With requirements now for verification of physician’s face to face visits, documentation of encounters will be necessary.
- RPA documentation tool has been revised to meet CMS recommendations.
DOCUMENTATION REQUIREMENTS (cont)

- Document what is clinically relevant including but not limited to:
  - patient's current status and complaints,
  - a clinically appropriate physical examination, assessment of the patient's treatment for ESRD that includes assessment of the adequacy of the dialysis treatment, the status of the patient's vascular access, assessment and treatment of the other conditions associated with ESRD, such as anemia, electrolyte management, and bone density, as well as changes to the patient's management
ADDITIONAL DOCUMENTATION NEEDED FOR PEDIATRIC PATIENTS

- In addition to the requirements for adult patients, pediatric nephrologists also need to:
  - Monitor the patient for adequacy of nutrition
  - Assess for growth and development
  - Counsel parents

Documentation must show these elements

In addition to the adult documentation requirements
CHANGES IN DOCUMENTATION REQUIREMENTS (cont)

- Documentation of the complete (care plan) visit is required
- Documentation that the physician performed a service for the patient is required for the other encounters
- Signing a dialysis flow sheet or any other form if not enough...the physician must document they are performing a service at each encounter
MCP CONCLUSIONS

- Documentation will be key in managing new MCP changes.
- Administrative challenges will create additional requirements for excellent record keeping.
- Complete visit, including disease appropriate physical exam is necessary to bill the in-center CPT code.
NEPHROLOGY SPECIFIC CPT CODING
**INPATIENT DIALYSIS CODES**

- **90935** - Single physician evaluation of hemodialysis
- **90937** - Multiple physician evaluation of hemodialysis
- **90945** - Single physician evaluation of continuous forms of dialysis
- **90947** - Multiple physician evaluation of continuous forms of dialysis

Includes E&M services rendered on the same day
INPATIENT DIALYSIS CODES

To bill physician must meet the following:

- Be present *during* the dialysis treatment
- Documentation must reflect presence during the treatment
- The need for repeated visit should be noted in the patient’s chart. The note should include the problem or anticipated problem which required the physician’s repeat evaluation
INPATIENT DIALYSIS CODES

Four E/M services that can be billed on the same day as dialysis services rendered in the inpatient setting:

- Hospital admission
- Hospital discharge
- Inpatient consultation (for commercial payers only)
- Critical Care
  - Most carriers require the use of a “-25” modifier on the E/M code on the same day as a procedure
HOSPICE SERVICES
WHAT IS HOSPICE?

- Hospice is a program of care and support for people who are terminally ill
- To get Hospice benefits from Medicare the patient must meet all of the following conditions:
  - Be eligible for Medicare Part A (Hospital Insurance).
  - The patient’s doctor and the hospice medical director certify that the patient is terminally ill and has 6 months or less to live if their illness runs its normal course.
  - The patient must sign a statement choosing hospice care instead of other Medicare-covered benefits to treat the terminal illness.
  *Medicare will still pay for covered benefits for any health problems that aren’t related to the terminal illness.
  - Care comes from a Medicare-approved hospice program.
WHO DO YOU BILL FOR SERVICES?

- Hospice pays for all care related to the hospice condition
- The patient must use standard Medicare to cover any health care not related to the terminal condition
- “GV” modifier is used to bill Medicare by the attending physician not employed by a hospice for the evaluation and treatment of a terminal condition
WHO DO YOU BILL FOR SERVICES?

- Any physician providing services to the hospice patient for the terminal condition other than the attending must have a contract with the hospice and bill to the hospice.
- “GW” modifier is used to report all physician services to Medicare that are unrelated to a patient’s terminal condition.
HOME DIALYSIS TRAINING
HOME TRAINING DIALYSIS MANAGEMENT

- **90989** - Dialysis training, patient, including helper where applicable, any mode, complete course
- **90993** - Dialysis training, patient, including helper where applicable, any mode, course not completed, per training session (billed by units completed)
- Physician **must** have direct participation in the training to bill
HOME TRAINING DIALYSIS MANAGEMENT

- Example of billing for training
  - Patient on hemodialysis March 1-15, 2011
    - Seen with comprehensive visit 2 times
  - Patient began home PD training March 16
    continued through March 21, 2011.
    - Physician participated directly in training – 90989, PD training complete, March 16, 17, 19, 20, 21, 2011
  - Patient at home for the full month (90963-90966)
HOME TRAINING DIALYSIS MANAGEMENT

- A completed course is reimbursed with a maximum $500 allowable
- A completed course should be reported with 90989 with a quantity of “one”
- For a training course not completed bill 90993 for the number of sessions completed and reimbursed at a $20 per session allowable
BILLING FOR ERYTHROPOIETIC STIMULATING AGENTS
CAUTION!

- POLICIES CHANGE QUICKLY!!
- Please review your own carriers LCD on a monthly basis.
- Knowledge in this arena is vital.
- An ounce of prevention.........
INITIAL PROCRIT® (Epoetin Alfa) & ARANESP® (Darbepoetin Alfa) ADMINISTRATION EXAMPLE GUIDELINES

- Pretreatment HCT Level of less than 30
- Creatinine of 3.0 or greater OR
- Documented renal insufficiency (stage 3-5)
- Patient’s current weight in kilograms
- Date of lab (within 7 days - this may vary by location)

Please understand this is an example & not intended to be taken as policy!
FOLLOW-UP PROCRIT® (Epoetin Alfa)  
ARANESP® (Darbepoetin Alfa)  
ADMINISTRATION EXAMPLE GUIDELINES

- Current HCT level to max of 30 or multiply of Hgb x 3 (watch the LCD, this level varies by state)
- Date of Laboratory Data (within the last 30 days)
- ICD-9 code appropriate for state
BILLING FOR ADMINISTRATION OF PROCRIT AND ARANESP

- Drug and administration is covered “incident to” physician service
- If the purpose of the visit is for an injection, use 96372 for the subcutaneous administration of either Procrit or Aranesp
- 99211 is only used when another service, not protocol for the injection, is provided
BILLING FOR ADMINISTRATION OF PROCRIT AND ARANESP

- When the drug is administered “incident to” a physician’s visit, bill the appropriate level of E&M for the physician visit with a “-25” modifier (CCI edit effective 10/1/05), the administration fee 96372 and the drug.

**REMEMBER:** The provider must be physically present in the suite when the injection is given to bill for the administration or the drug.
“INCIDENT TO” AND “SHARED” SERVICE BILLING

“GETTING THE MOST FROM THE WORK PHYSICIAN EXTENDERS PERFORM”
BILLING OPTIONS FOR NPPs

- NPPs own provider number receiving 85% of the MPFS (Medicare Physician’s Fee Schedule) amount
- “Incident-to” the physician receiving 100% of the MPFS
- Split/Shared service rendering 100% of MPFS
WHAT IS “INCIDENT TO”

- Incident to services are:
  - Services performed by non-physician practitioners
  - Services paid as physician’s services
- “Furnished as a part of the physician’s personal, professional service in the course of diagnosis or treatment of an injury or illness”
  - Medicare Benefits Policy Manual, Chapter 15, Section 60.1
REQUIREMENTS FOR “INCIDENT TO BILLING”

- Services must be of the type that would be covered by Medicare if rendered by a physician.
- Services must be of the type that an NP or PA can perform under state statute as defined in scope of practice.
- Services must be performed under direct supervision by the physician.
REQUIREMENTS FOR “INCIDENT TO BILLING”

- Cost of the “Incident to” services must be incurred by the entity that bills for the service.
- Medicare does not cover services that are not medically necessary or are not of the type of service that would normally be performed in the physician’s office.
REQUIREMENTS FOR “INCIDENT TO BILLING”

- NP or PA must be an employee of the physician or group
- Applies only to office services
- Physician must be physically present in the office suite to qualify, even if the physician does not personally see the patient
“The availability of a physician by telephone and the presence of the physician somewhere in the institution does not constitute direct supervision”

– Medicare Benefit Policy Manual, Chapter 15, Section 60.1.B

If the non-physician practitioner outpatient service does not meet all the qualifications of “incident to” bill under the NP or PA at 85%
REQUIREMENTS FOR “INCIDENT TO BILLING”

- Remember….. Incident-to cannot be for new patient visits
- “Incident to” must be an integral part of the physician’s established plan of care for the patient
- Does not apply cover new problems
SHARED SERVICE BILLING

- Services provided by both the physician and the extender in the hospital setting
- Each provider must document the face-to-face services rendered
- If NP or PA does dictation for services, documentation must show that both providers saw the patient and “shared” in the patient’s care
- Statement of “Sally Jones, NP for Dr. Sam Smith” is not adequate to show physician’s involvement
SHARED SERVICE BILLING

- Cannot report shared service in the skilled nursing facility (SNF) or nursing facility (NF) setting
- Each provider (physician & NPP) must personally perform a substantive portion of the E/M visit...face-to-face...with the same patient on the same day
- The physician & the NPP must be a member of the same practice
NPP sees the hospital inpatient early in the day and the physician follows with a later face-to-face encounter. This service may be reported by either the physician or the NPP.
DOCUMENTATION OF SPLIT/SHARED BILLING

- Each physician/NPP should personally document in the medical record his/her portion of the E/M split/shared visit
- The physician’s documentation must show face-to-face component...suggest exam
- Documentation must support the combined service level reported on the claim
- Staff may document ROS & PFSH but the physician & NPP must show review
EXAMPLES OF UNACCEPTABLE DOCUMENTATION

- Agree with above
- Rounded, reviewed, agree
- Discussed with NPP agree
- Seen & agree
- Patient seen and evaluated
- Legible Countersignature
EXAMPLES OF ACCEPTABLE DOCUMENTATION

- I performed a history & PE of the patient and discussed his management with the NPP. I reviewed the NPP note & I agree with the documented findings and plan of care.

- I saw and evaluated the patient. I reviewed the NPP’s note and agree except that picture is more consistent with acute tubular necrosis. Will begin XYZ therapy.
EXAMPLES OF ACCEPTABLE DOCUMENTATION

- I saw and evaluated the patient. Agree with the NPP’s note but lower extremity edema is increased. Will increase lasix and monitor closely
EXTENDERS AND THE MCP

- Can provide some of the visits to equate to the total billed
- Watch any state regulations that may apply
- If extender providers the “Care Plan” visit, then the MCP must be billed under the extender’s provider number at 85% of physician’s fee
- For 100% reimbursement, physician must see the patient for the major “Care Plan” visit
BILLING PHYSICIANS AS “INCIDENT TO”

- DO NOT bill an uncredentialed physician “incident to” another physician
- CMS policy prohibits use of “incident to” billing from one physician to another
CODING FOR OBSERVATION CARE

23 Hour short stay
Observation Status
OBSERVATION STATUS CARE

- “23 hour” short stay – can extend depending on hospital’s interpretation
- Outpatient hospital services
- Bill using outpatient hospital place of service "22"
- Renal-related services are part of the MCP
- Outpatient consult codes will be subject to practice expense adjustment – 25% of reimbursement
OBSERVATION STATUS CARE

- For services that cross over more than one calendar day
- Billed by supervising or admitting MD
  - 99218-99220 for observation admission day
  - 99217 for observation discharge day services
- Obs encounters by other physicians bill 99241-99245 or 99224-99226 as appropriate
OBSERVATION STATUS CARE

- When observation care is within same calendar day – but exceeds 8 hours
- Bill 99234-99236 only
- Do not bill discharge care – 99217
- Other services such as Emergency room services are part of the observation status code
OBSERVATION STATUS CARE

- For observation care of less than 8 hours, bill only the appropriate observation admit code 99218-99220
- Do not bill a discharge code
SUBSEQUENT OBSERVATION CARE

- 99224-99226 are used to bill subsequent observation care by any physician
- Document changes in the history, physical condition and response to management since the last assessment by the physician
CODING FOR CRITICAL CARE
Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes
CPT DEFINITION
CRITICAL ILLNESS OR INJURY

“"A critical illness or injury acutely impairs one or more vital organ system(s) such that there is a high probability of imminent or life threatening deterioration in the patient’s condition."
CPT DEFINITION
CRITICAL CARE SERVICES

- “Critical care is the **direct delivery** by a physician(s) of medical care for a critically ill or injured patient.”
- “Involves decision making of high complexity to assess, manipulate, and support system function(s), to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient’s condition.”
Examples of Vital Organ System Failure

- Central nervous system failure
- Shock
- Circulatory failure
- Renal failure
- Hepatic failure
- Respiratory failure
- Metabolic failure
Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.
Critical care services require direct personal management by the physician. They are life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician.

Failure to provide these interventions on an urgent basis would result in life threatening deterioration in the patient’s condition.
“FULL ATTENTION” REQUIREMENT

- “Critical care is used to report the total duration of time spent by a physician providing critical care services to a critically ill or injured patient, even if the time spent by the physician on that date is not continuous. For the time spent, the physician must devote his or her full attention to the patient…”
WHERE IS THE CARE PROVIDED

- Time spent with the individual patient **must** be recorded in the patient’s record.
- Time spent can be reported if spent is at the bedside or on the unit or floor, i.e., Coordinating care, but **cannot** be in caring for another patient.
- Can include time spent with family, etc. when the patient cannot make decisions for self.
**DOCUMENTATION FOR MEDICAL REVIEW**

- Must indicate full attention provided
- Since time based, must contain documentation of total time involved
- Time involved with family to gain pertinent history or make decisions must be documented
- Telephone calls to family members to be considered must meet same criteria as face-to-face
SERVICES NOT INCLUDED IN CRITICAL CARE TIME

- Time spent providing services not bundled into critical care time such as dialysis or access placement are not included.

- Services rendered earlier in the day prior to the patient’s need for critical care. This service can be reported separately, but documentation needs to be sent with the claim and a modifier (-25) needs to be appended to this service. **CR 5792**

- Time spent updating patient’s family about status not meeting previous criteria regardless of how lengthy.
Dialysis (90935, 90937, 90945, 90947) is not included in Critical Care time

Make sure a separate note is made for dialysis and all the criteria for billing dialysis are met…physical presence during the treatment

Append a “-25” modifier to the Critical Care code
CRITICAL CARE TIDBITS

- 99291 is used to report first hour (30-74 minutes) of critical care
- 99292 is used to report each additional 30 minutes
- 99292 is used to report final 15-30 minutes of critical care
- Critical care of less than 30 minutes is reported using appropriate E/M code
- Only one physician may bill for a given hour of critical care even if more than one physician is providing care
TIPS FOR PREVENTING CODING ERRORS WITH E/M CODING

- Critical Care
  - Does the documentation demonstrate all of the following?
    - Direct personal management.
    - Frequent personal assessment and manipulation (not just the general once-a-day visit).
    - High-complexity decision-making to assess, manipulate and support vital system function(s) to treat single or multiple organ system failure or to prevent further deterioration.
TIPS FOR PREVENTING CODING ERRORS WITH E/M CODING

- Critical Care – cont.
  - Interventions of a nature that failure to initiate these interventions on an urgent basis would likely result in sudden clinically significant or life-threatening deterioration in the patient’s condition.
  - What about the time spent providing critical care?
    - Is specifically recorded?
    - Is it reasonable considering the documented work provided?
    - Does it exclude time spent performing procedures separately billable?
    - If it includes time spent with family, was the family members operating as a surrogate decision-maker because the patient was unable to make decisions?
CKD EDUCATION BENEFITS

IMPLEMENTATION

JANUARY 1, 2010
CKD EDUCATION BENEFIT

- Limited to beneficiaries with Stage IV CKD
- Defined as six, 60 minute sessions
- Allows for individual or group sessions
  - G0420 – for individuals
  - G0421 – for group sessions
- The RVUs for G0420 was multiplied by 4 and G0421 was multiplied by 2
- G0420 would pay approximately $108.18
- G0421 would pay approximately $25.60
“Incident to” does not apply – education must be rendered by a physician, physician assistant, nurse practitioner or clinical nurse specialist

Dialysis facilities expressly are excluded from providing this service
EDUCATION TALKING POINTS

- Basic information regarding CKD, how the kidneys work, what happens when the kidney fail and the permanence of the disease
- Survival rates with and without renal replacement therapy and survival rates if the patient refused treatment for the CKD
- The need for kidney transplantation
EDUCATION TALKING POINTS

• Unbiased information about RRT options including advantages and disadvantages for all modalities
• Adequate information regarding why some RRT options were not viable for a patient
• How different RRT options affected the patient’s co-morbid conditions
• Effects of RRT choices on lifestyle such as treatment flexibility & session length
EDUCATION TALKING POINTS

- Whether a patient will need assistance based on RRT modality choice and training requirements for helpers
- The right to refuse treatment
- Effects of the disease and the subsequent treatment on the patient’s physical appearance
- Patient recognition of the symptoms that would empower the patient with the knowledge to seek help
EDUCATION TALKING POINTS

- Disease and treatment complications related to renal replacement therapy such as hypertension, catheter migration, temporary/permanent loss of dialysis access and risk of infection at the access site.
- How to control and manage consequences of complications and symptoms (for example: treatment for itchy skin or insomnia).
EDUCATION TALKING POINTS

- The ability to travel and organize holidays depending on RRT choice
- Maintenance of social relationships, activities and commitments
- How the disease and RRT may affect the patient’s ability to continue working
- Available support services
- Medication management
POST- EDUCATION ASSESSMENT

- Requires beneficiaries to be assessed at the conclusion of the sessions
- Providers must develop outcome assessments tailored to beneficiaries
- At this point CMS is seeking comment on the factors to include in the outcomes assessment
Although the regulations did not address specific documentation requirements, it will be necessary to documentation the elements covered in each session

- Maintain the documentation in the patient’s chart
- RPA has developed a documentation tool to assist our physicians in this task
### Kidney Disease Education Documentation Tool

**Patient Name:** ____________________________

**Identification Number:** ____________________________

<table>
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<th>Kidney Disease Education (KDE)</th>
<th>Session 1</th>
<th>Session 2</th>
<th>Session 3</th>
<th>Session 4</th>
<th>Session 5</th>
<th>Session 6</th>
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**Topics Reviewed:**
- Discuss management of co-morbidities
  - Diabetes Mellitus
  - Hypertension
- Therapeutic Options
  - Discuss Treatment Modalities (advantages/disadvantages and settings of each)
    - Hemodialysis/HomeHD/Nocturnal
    - Peritoneal
    - Transplantation
    - Dialysis Access Options
- Participating in choice of treatment/tailoring of treatment
- Prevention of uremic complications
  - Smoking Cessation
  - Avoidance NSAIDS
- Anemia
- Bone Disease
- Blood Transfusion Impact
- Nutrition
- Conservative Management/Palliative Care
- Advanced Directives

**Outcomes Assessment Date:** ____________

**Conducted By:** ____________

**Attending/Supervising MD Signature:** ____________________________
MEDICARE PREVENTIVE SERVICES

Section 4103 of the Affordable Care Act of 2010
Annual Wellness Visit
G0402 – Initial preventive physical exam (IPPE)
- Within first 12 months of having Part B Medicare
- No deductible applies but coinsurance applies
- Can bill separate E&M service with modifier “-25”
- EKG no longer is required (deductible & coinsurance do apply if performed)
WELCOME TO MEDICARE PHYSICAL (IPPE)

- Review of medical & social history with emphasis on disease detection
- Review of risk for depression
- Review of functional ability & level of safety
- PE including height, weight, BP, visual screen
- Referral, education & counseling as needed including written plan for appropriate screening and other preventive services
ANNUAL WELLNESS VISIT (AWV)

- G0438 - beneficiary is no longer within 12 months after effective date of first Medicare Part B coverage period and did not receive the IPPE benefit during the 1st 12 months
- Once in a lifetime benefit
- G0439 – subsequent AWV annually thereafter
ANNUAL WELLNESS VISIT (AWV) ELEMENTS

- Establishment of medical/family history
- Measurement of height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other measurements as deem appropriate
- List of current providers and suppliers used regularly for beneficiary
- Detection of any cognitive impairments
- Review of risk for depression using screening tests
- Review of functional ability & level of safety based on observation and screening questions or questionnaires
ANNUAL WELLNESS VISIT (AWV) ELEMENTS

- Establishment of written screening schedule such as a check list for the next 5 to 10 years, include immunizations and health screening as age appropriate.
- Personalized health advice and referrals as appropriate for health education and preventive counseling services or programs to reduce risk and promote self-management and wellness including weight loss, smoking cessation, fall prevention & nutrition.
- Voluntary advance care planning.
- Any other elements as deemed appropriate through the National Carrier Determination process (NDC).
ANNUAL WELLNESS VISIT (AWV)

- May be performed by MD, DO, or qualified NPP, health educator, registered dietitian, nutrition professional or other licensed practitioner or a team of such professionals
- As a result of the Affordable Care Act, the deductible and coinsurance for the AWV is waived
SUBSEQUENT AWV ELEMENTS

- Update the individual’s medical/family history
- Measure the patients weight, BP and other routine measurements
- Update list of patient’s current providers and suppliers
- Detection of any cognitive impairments that the patient may have
- Update the individual’s written screening schedule developed at the first AWV providing PPPS (personal preventive plan services)
- Update the list of risk factors and conditions
SUBSEQUENT AWV ELEMENTS

- Furnish appropriate personalized health advice to the individual and referrals as necessary to health education or preventive counseling or programs
- Voluntary advance care planning upon agreement with the patient
- Other elements that may be added through the National Carrier Determination process (NCD)
- Deductible and coinsurance are waived for the subsequent AWV as well as the initial
PAYMENT FOR AWV

- Payment for G0438 AWV is approximately $155.19
- Payment for G0439 subsequent AWV is approximately $103.88.
ICD-9-CM CODING

WHY YOU DID WHAT YOU DID
ICD-9 Coding

- Detail is very important today in billing the diagnosis our patients have
- But as we approach October, 2013 detail becomes far more important
- Diseases that are associated with Kidney disease are sometimes more challenging than CKD or ESRD
- Let’s take a different approach at ICD-9
Diabetes insipidus (DI) is an uncommon condition that occurs when the kidneys are unable to conserve water as they perform their function of filtering blood. The amount of water conserved is controlled by antidiuretic hormone (ADH), also called vasopressin. (ICD-9 253.5)
ADH is a hormone produced in a region of the brain called the hypothalamus. It is then stored and released from the pituitary gland, a small gland at the base of the brain.

DI caused by a lack of ADH is called central diabetes insipidus. When DI is caused by a failure of the kidneys to respond to ADH, the condition is called nephrogenic diabetes insipidus. (ICD-9 588.1)
Nephrogenic DI involves a defect in the parts of the kidneys that reabsorb water back into the bloodstream. It occurs less often than central DI. Nephrogenic DI may occur as an inherited disorder in which male children receive the abnormal gene that causes the disease from their mothers.

Nephrogenic DI may also be caused by:

- Certain drugs such as lithium
- High levels of calcium in the body (hypercalcemia) (275.42)
- Kidney disease (such as polycystic kidney disease)

**Symptoms**

- Excessive thirst (783.5)
  - May be intense or uncontrollable
  - May involve a craving for ice water
- Excessive urine volume (788.42)
SIADH

- Syndrome of Inappropriate Antidiuretic Hormone secretion or SIADH
- The body normally maintains very tight control over its total amount of water and its concentration of sodium
- Certain disease states can upset the delicate balance of water and salt in the body
- If there is too much ADH in the body, or if the kidneys overreact to the ADH they receive, the body retains excess water and the serum sodium concentration becomes diluted and falls to abnormal levels
- Treatment includes water restriction and salt administration and diagnosis of the underlying cause of the SIADH, usually a neoplasm (ICD-9 Code 253.6)
Hypertension Table found under the main term “hypertension” in the index, contains a complete listing of all conditions due to or associated with hypertension and classifies them according to malignant, benign, and unspecified.
HYPERTENSION

- Hypertension, essential, or NOS
  - Assign hypertension to category code 401 with the appropriate fourth digit to indicate malignant (0), benign (1), or unspecified (9). Do not use either .0 malignant or .1 benign unless the medical record documentation supports such a designation.
HYPERTENSION

- Hypertension with heart disease
  - Heart conditions (425.8, 429.0-429.3) are assigned to a code from category 402 when a causal relationship is stated (due to hypertension) or implied (hypertensive). Use an additional code from category 428 to identify the type of heart failure in those patients with heart failure. More than one code from category 428 may be assigned if the patient has systolic or diastolic failure and CHF.
Hypertension with heart disease (cont.)

- The same heart conditions with hypertension without a stated causal relationship are coded separately. Sequence according to the circumstances of the encounter.
HYPERTENSION

- Hypertensive chronic kidney disease
  - Assign codes from category 403 when conditions classified in categories 585-587 are present. Unlike hypertensive heart disease, there is a presumed cause and effect relationship between hypertension and CKD
  - Fourth digit is type of hypertension
  - Fifth digit “0” is stage 1-4
  - Fifth digit “1” is stage 5-6
HYPERTENSION

- Hypertensive chronic kidney disease
  - If the physician states that the hypertension and CKD are unrelated code the conditions separately sequencing according to the encounter
HYPERTENSION

- Hypertension secondary – two codes are required; one to identify the underlying etiology and one from category 405 to identify the hypertension. Sequencing of the codes is determined by the reason for the encounter.

- Elevated blood pressure reading without a diagnosis of hypertension is coded 796.2
During diabetic nephropathy, the kidney becomes damaged and more protein than normal collects in the urine. As the disease progresses, more of the kidney is destroyed. Over time, the kidney's ability to function starts to decline, which may eventually lead to chronic kidney failure.
DIABETES MELLITUS

- 250 is the main category for diabetes
- The fourth digit is the manifestation of the diabetes such as 250.4X is diabetes with renal manifestations
- The fifth digit defines the type of diabetes
  – “0” is type II or unspecified not stated as uncontrolled
  – “1” is type I not stated uncontrolled
  – “2” is type II uncontrolled
  – “3” is type I uncontrolled
DIABETES MELLITUS

- The age of the patient is not the sole determining factor of the type of diabetes
- All type I diabetics must use insulin
- However the use of insulin does not mean the patient is type I
- Add the code V58.67 for long term insulin use
DIABETES MELLITUS

- Assign and sequence manifestation and association conditions with the 250.XX code before associated codes
- For example: 250.40 is diabetes II with renal manifestations, if the patient has diabetic nephropathy add 583.81 (nephropathy) add the stage of CKD (ie. 585.3) then add V58.67 if there is long term insulin use
SECONDARY DIABETES MELLITUS

- Used to report diabetes when the disease process is “due to” some other situation such as drug induced or chemical induced
- Code the situation that caused the diabetes
- 249.XX is the series of codes
- Do not use for sequencing diabetes when the primary reason for the encounter was another problem
SECONDARY DIABETES MELLITUS

- 249.4X – Secondary diabetes mellitus with renal manifestations
- Fifth digit “0” not stated as uncontrolled or unspecified or “1” uncontrolled
- Use additional code to identify manifestation
  - CKD (585.1-585.9)
  - Diabetic nephropathy (583.81)
  - Intercapillary glomerulosclerosis (581.81)
A cyst is a fluid-filled sac. There are two types of kidney cysts.

Polycystic kidney disease (PKD) runs in families. In PKD, the cysts enlarge and destroy surrounding normal tissue. As the cysts enlarge, the kidneys lose function, leading to progressive kidney failure.
POLYCYSTIC KIDNEY DISEASE

• PKD can cause kidneys to fail requiring dialysis or transplant
• PKD can cause blood in the urine
• PKD can cause cysts to develop on other organs
• Symptoms of PKD
  – Pain in the back and lower side
  – Headache
  – Urinary tract infections

• Diagnosis is made with imaging and patient history
• Treatments are medication and RRT (renal replacement therapy)

ICD-9 Code 753.12 – Polycystic unspec
753.13 PKD, autosomal dominant
753.14 PKD, autosomal recessive (rare disease causing cysts on the kidney & liver causing renal and kidney failure in children and adolescents
ACQUIRED CYSTIC KIDNEY DISEASE

- Acquired cystic kidney disease (ACKD) happens when people are on dialysis.
- Unlike PKD, patients with ACKD do not develop cysts on other organs.
- The kidneys are normal size.
- ACKD usually is symptom free.
- ACKD is harmless and does not need treatment.

ICD-9 Code 593.2
NEPHROLITHIASIS (KIDNEY STONE)

A kidney stone is a crystal that forms in the kidney from substances in the urine. It may get stuck in the urinary tract, block the flow of urine and cause great pain +/- or kidney failure.

ICD-9 Code  592.0

Uric acid stone 274.11
STAGES OF CKD

- eGFR of 90 or above is considered normal
- eGFR stays below 60 for 3 months
- Moderate decrease in eGFR (30 to 59)
- Severe reduction in eGFR (15 to 29)
- Kidney failure (eGFR less than 15)
- Stage 1 (585.1)
- Stage 2 (585.2)
- Stage 3 (585.3)
- Stage 4 (585.4)
- Stage 5 (585.5) or Stage 6 if on dialysis (585.6)
ACUTE KIDNEY FAILURE

- Acute (sudden) kidney failure is the sudden loss of the ability of the kidneys to remove waste and concentrate urine +/or excrete electrolytes.
- Physician may list as AKI (acute kidney injury)
- May have AKF in the setting of CKD
- Code the AKF primary with the underlying stage of CKD secondary
  
  ICD-9 Code 584.9
  Acute on Chronic 584.9 followed by the stage of CKD prior to the exacerbation 585.X
• Acute tubular necrosis (ATN) is damaging and loss of tubular cells usually caused by lack of oxygen and/or chemical insult to the kidney tissues (ischemia of the kidneys). It may also occur if the kidney cells are damaged by a poison or harmful substance.
• Diabetes can make more susceptible
• Common in hospitalized patients
  – Blood transfusions
  – Injury or trauma that damages muscle
  – Hypotension > 30 mins
  – Major surgery
  – Septic Shock
  – Contrast
  – Medication Toxicity
• ATN is often recoverable but may need short-term dialysis to support the body while the kidney recovers.

ICD-9 Code 584.5
ACUTE KIDNEY FAILURE

- Acute Kidney Failure with lesion of renal cortical necrosis (ICD-9 584.6)
- Acute Kidney Failure with lesion of renal Medullary (papillary) necrosis (most often diabetic or associated with NSAID use) (ICD-9 584.7)
- Acute Kidney Failure with other specified pathological lesion in kidney (ICD-9 584.8)
- These lesions may require a biopsy to prove presence of which type lesion
In renal biopsy, a small sample of kidney tissue is removed with a needle. The test is used to evaluate a malfunctioning transplanted kidney. It is also used to evaluate an unexplained decrease in kidney function, persistent blood in the urine (ICD-9 599.70), or protein in the urine (ICD-9 791.0).

Many glomerular diseases will need a kidney biopsy for definitive diagnosis.
ANALGESIC NEPHROPATHY

- Caused by use of painkillers such as aspirin, ibuprofen, and naproxen sodium as well as prescription NSAIDs
- Use can be a single dose or more long term
- Can cause acute or chronic kidney disease
- Most frequent in women over 30

- Statistics show that 4 out of every 100,000 people will develop Analgesic Nephropathy
- Blood test should be done frequently to monitor kidney involvement
- A less nephrotoxic substance should be used when possible to avoid damage

ICD-9 Code 583.89
IgA NEPHROPATHY

- IgA is a protein called an antibody that helps the body fight infections. IgA nephropathy (Berger's disease) occurs when too much of this protein is deposited in the kidneys. IgA builds up inside the small blood vessels of the kidney. Structures in the kidney called glomeruli become inflamed and damaged.

- Risk factors include:
  - A personal or family history of IgA nephropathy or Henoch Schonlein purpura, a form of vasculitis that affects many parts of the body
  - Caucasian or Asian ethnicity
  - IgA nephropathy most often affects males in their teens to late 30s

- Symptoms include:
  - Blood in the urine
  - Repeated blood or dark urine
  - Swelling of hands and feet

ICD-9 Code 583.9
LUPUS NEPHRITIS

- An inflammation of the kidney caused by systemic lupus erythematosus (SLE) (ICD-9 Code 710.0)
- Lupus can affect the connective tissues of multisystem
- Fever, muscle & joint pain, rash of a butterfly pattern

- Additionally code as a secondary code for the manifestation of the disease
  - Endocarditis (424.91)
  - Nephritis (583.81)
    - Chronic (582.81)
    - Nephrotic Syndrome (581.81)

Coding Note: Watch use of 583.81
This code is a secondary code and cannot be used as a primary code
FOCAL SEGMENTAL GLOMERULOSCLEROSIS

- Focal Segmental GS is scar tissue that forms in the glomeruli
- Focal means that some of the glomeruli become damaged while others remain normal
- Segmental means that only part of the individual glomeruli becomes damaged
- FSGS affect children and adults but most frequently African-Americans
- Known causes are:
  - Heroin use
  - HIV
  - Inherited genetic problems
  - Obesity
  - Reflux Nephropathy (a condition in which urine flows backward from the bladder to the kidney)
  - Sickle Cell Disease
- Most are unknown etiology

ICD-9 Code 582.1; with Nephrotic syndrome 581.1
GOODPASTURE’S SYNDROME

ICD-9 Code 446.21

- Is a rare disease that targets the lungs and kidneys
- Is an autoimmune syndrome that the body's own defense system attacks itself
- Symptoms include
  - Blood in urine (599.70)
  - Protein in urine (791.0)
  - Fatigue and tiredness (780.79)
  - Hemoptysis (786.30)
- Goodpasture’s may be diagnosis using blood tests, but biopsy of the lung or kidney may be necessary
- Treatment may be immunosuppressive therapy or plasmapheresis
- Patients may need dialysis or kidney transplantation
SECONDARY HYPERPARATHYROIDISM

- Kidney failure is a common cause of secondary hyperparathyroidism. Kidney failure can interfere with the body's ability to remove phosphate.

- Too much phosphate can cause a change in calcium levels in the body. The calcium needs to be corrected in these patients as well.

ICD-9 Code for Secondary hyperparathyroidism of Renal origin 588.81

ICD-9 Hypocalcemia 275.41

Secondary hyperparathyroidism of non-renal origin 252.02
Kidney stones form when a change occurs in the normal balance of water, salts, minerals, and other substances found in urine. Other chemical compounds that can form stones in the urinary tract include uric acid and the amino acid cystine.
NEPHROLITHIASIS

- Symptoms and signs of a kidney stone include excruciating, cramping pain in the lower back and/or side, groin, or abdomen as well as blood in the urine.
- Kidney stones can be hereditary.

One out of every 20 people develop a kidney stone at some time in their life.

ICD-9 Uric acid stone 274.11; kidney stone 592.0; stone in ureter 592.1
INTRODUCTION TO ICD-10CM

PROPOSED EFFECTIVE DATE
OCTOBER 1, 2013
ICD-10-CM/PCS

- Enacted in the Health Insurance Portability and Accountability Act (HIPAA) of 1996
- All covered entities must implement the new code sets for dates of service or date of discharge for inpatients that occur on or after October 1, 2013
- Health and Human Services has no plans to extend the implementation date
ICD-10-CM/PCS

- Consists of two parts:
  - ICD-10-CM – The diagnosis classification system developed for the CDC and all other US treatment settings
  - ICD-10-PCS – procedure classification system developed by CMS for use in the US for inpatient hospital settings ONLY. ICD-10 uses 7 alpha/numeric digits where ICD-9 uses 3-5 numeric digits
ICD-10-CM/PCS

- Incorporates much greater specificity and clinical information which allows for
  - Improved ability to measure health care services
  - Increased sensitivity when refining groupings and reimbursement methodologies
  - Enhanced ability to conduct public health surveillance
  - Decrease need to including supporting documentation with claims
ICD-10-CM/PCS

- Includes updated medical terminology and classification of disease
- Provides codes to allow comparison of mortality and morbidity data
- Provides better data for
  - Measuring care furnished to patients
  - Designing payment systems
  - Making clinical decisions
ICD-10-CM/PCS

– Processing claims
– Tracking public health
– Identifying fraud and abuse
– Conducting research
STRUCTURAL DIFFERENCES BETWEEN THE TWO CODING SYSTEMS

- ICD-9-CM Diagnosis Codes
  - 3-5 digits
  - First digit is alpha (E or V) or numeric
  - Digits 2-5 are numeric
  - Examples
    - 496 – Chronic airway obstruction NEC
    - 511.9 – Unspecified pleural effusion
    - V42.0 – Renal transplant
STRUCTURAL DIFFERENCES BETWEEN THE TWO CODING SYSTEMS

- ICD-10-CM Diagnosis Codes
  - 3-7 digits
  - Digit 1 is alpha
  - Digit 2 and 3 are numeric
  - Digits 4-7 are alpha or numeric (alpha digits are not case sensitive)
STRUCTURAL DIFFERENCES BETWEEN THE TWO CODING SYSTEMS

– Examples
  - N18.6 – End stage renal disease
  - S52.131a - Displaced fracture of neck of right radius, initial encounter for closed fracture
  - N28.9 – Acute Renal Failure
  - N18.1-5 – Stages of CKD
  - I12.0 – ESRD due to Hypertension
WHAT GENERATES THE RESISTANCE?

- Perceptions regarding impact on practice management
  - General office staff lack sufficient expertise
  - May require certified coders and current coders may need to recertify, incurring costly training and exam fees

- Costly investment in new infrastructure
  - New information technology tools required
  - New billing and collection systems required
  - Limited resources for staff training
WHAT GENERATES THE RESISTANCE?

- Impact on reimbursement
  - Decreased short-term coding accuracy and productivity
- Physician practice changes
  - Greater medical record documentation to support more detailed codes
GET PHYSICIAN BUY-IN

- Provide evidence that simplifies the process
- Work with organized medicine to deliver the message
- Partner with key professionals that can help facilitate training
- Leverage existing relationships between health information management professionals and physicians
KNOCK IT DOWN TO SIZE!

- Although the coding book is huge, we will only use a small segment of the information.
- Work with your physicians to develop crosswalks between ICD-9 and ICD-10 codes they frequently use.
- Begin discussions now to reduce anxiety but train later – needs to be done “just in time.”
- Training should have both a general and practice specific focus.
IMPLEMENTATION PLANNING

- Start to organize your implementation effort
- Establish who will be the lead person in your organization to oversee the implementation effort
- Look at all areas that will be impacted by the change
  - Practice Management System
  - Electronic Medical Records
  - Superbills
  - Clinical areas
IMPLEMENTATION PLANNING

- Schedule regular meetings to keep everyone in the organization informed of the progress
- Develop a budget – Look at what the costs will be
  - What resources will be required for implementation
  - Practice management system – disc space
  - Software costs
  - Training
IMPLEMENTATION PLANNING

- Develop a reasonable timeline that can be accomplished – frustration will only end in failure and more frustration
- Keep the physicians involved – assess the physician’s acceptance to change
- Documentation changes will need to be made to accommodate more specificity in coding
IMPLEMENTATION PLANNING

- Contact your system vendors early
  - Will they be ready to accommodate ICD-10 on schedule?
  - What costs will be involved with the transition?
  - Will they be ready to accept the 5010 electronic transaction standard required by HIPAA by January 1, 2012?
  - What are their plans for implementation?
  - When will they have software ready for testing?
  - Is your current hardware adequate?
IMPLEMENTATION PLANNING

- Develop your training plan
  - Who needs training – physicians, coders, billing staff, administrative staff, clinical staff
  - How much training will each classification of personnel need
  - Establish your training schedule – be realistic

- Determine if temporary staff or overtime will be needed during the training process

- What materials will be needed
IMPLEMENTATION PLANNING

- Analyze your business processes
  - Identify all systems that utilize or are tied to ICD-9
  - Review existing policies related to ICD-9
  - Do you have any payer contracts that are tied to ICD-9
  - If so modify those contracts before the payers get wise
  - Carefully review any new contracts that are received during implementation process
IMPLEMENTATION PLANNING

- Work with vendors to ensure that testing is done before implementation dates
  - Volunteer to be a “beta” site for testing
  - Integrate software into your systems
  - Make internal customizations
  - Test systems with your clearinghouses, payers, electronic systems
  - Ensure vendors will maintain and update codes during the transition period
GEMs are a crosswalk developed by CMS and CDC for use by all providers, payers, and data users. The mappings are free of charge and can be found in the public domain.

ICD-10-CM CODING

WHAT YOUR NEW CODING WORLD WILL LOOK LIKE
HYPERPARATHYROIDISM

- E21.3 – Unspecified Hyperparathyroidism
- E21.0 – Primary hyperparathyroidism
- N25.81 – Secondary hyperparathyroidism (renal)
- E21.2 – Secondary hyperparathyroidism (non-renal)
- E21.2 – Hyperparathyroidism specified, Not elsewhere classified
- E21.2 – Tertiary hyperparathyroidism
DIABETES MELLITUS DUE TO UNDERLYING CONDITIONS

- Code first the underlying condition such as Malignant neoplasm (C00-C96)
- Use additional code for any insulin use (Z79.4)
  - E08.21 – DM due to underlying condition with Diabetic Nephropathy
  - E08.22 – DM due to underlying condition with Diabetic Chronic Kidney Disease
    - Use additional code for stage of CKD (N18.1-N18.6)
  - E08.29 – DM due to underlying condition with other Diabetic Kidney Complications
DRUG/CHEMICAL INDUCED DIABETES MELLITUS

- Code first (T36-T65) to identify drug or chemical involved
- Use additional code to identify insulin use (Z79.4)
  - E09.21 - Drug or chemical induced DM with Diabetic Nephropathy
  - E09.22 – Drug or chemical induced DM with Diabetic CKD
    - Code additionally the stage of CKD (N18.1-N18.6)
  - E09.29 – Drug or chemical induced DM with other Diabetic Kidney Complication
TYPE I DIABETES MELLITUS

- E10.21 – Type I DM with Diabetic Nephropathy
- E10.22 – Type I DM with Diabetic CKD
  - Use additional code to identify the stage of CKD (N18.1-N18.6)
- E10.29 – Type I DM with other Diabetic Kidney Complications such as DM with Renal Tubular Degeneration
TYPE II DIABETES MELLITUS

- Use additional code to identify any insulin use (Z79.4)
- E11.21 – Type II DM with Diabetic Nephropathy
- E11.22 – Type II DM with Diabetic Kidney Disease
  - Use additional code to identify stage of CKD (N18.1-N18.6)
- E11.29 - Type II DM with other Diabetic Kidney Complications such as DM with Renal Tubular Degeneration
ESSENTIAL PRIMARY HYPERTENSION

- I10 – Includes high blood pressure
  Malignant Hypertension
  Benign Hypertension
HYPERTENSION CHRONIC KIDNEY DISEASE

- I12.0 – Hypertensive chronic kidney disease
  Stage 5 CKD or End Stage Renal Disease
    – Use additional code to identify stage of CKD
      (N18.5 or N18.6)

- I12.1 – Hypertensive chronic kidney disease
  Stage 1-4 or unspecified CKD
    – Use additional code to identify stage of CKD
      (N18.1 - N18.4)
SECONDARY HYPERTENSION

- Code also underlying primary condition
- I15.0 – Renovascular Hypertension
- I15.9 – Secondary Hypertension, unspecified
CHRONIC KIDNEY DISEASE

- Code first any associated:
  - Diabetic chronic kidney disease (E08.22, E09.22, E10.22, E11.22, E13.22)

- Use additional code to identify kidney transplant status, if applicable (Z94.0)
CHRONIC KIDNEY DISEASE

- N18.1 – Chronic kidney disease, Stage 1
- N18.2 – Chronic kidney disease, Stage 2
- N18.3 – Chronic kidney disease, Stage 3
- N18.4 – Chronic kidney disease, Stage 4
- N18.5 – Chronic kidney disease, Stage 5
- N18.6 – End Stage Renal Disease requiring dialysis
  – Use additional code to identify dialysis status (Z99.2)
ACUTE KIDNEY FAILURE

- Code also associated underlying condition
- N17.0 – AKF with tubular necrosis
- N17.1 – AKF with acute cortical necrosis
- N17.2 – AKF with medullary necrosis
- N17.8 – Other acute kidney failure
- N17.9 – Acute kidney failure, unspecified
KIDNEY TRANSPLANT

- Z94.0 – Kidney transplant status
- Do not code with complications of transplant
  - T86.10 – Unspecified complication of kidney transplant
  - T86.11 – Kidney transplant rejection
  - T86.12 – Kidney transplant failure
  - T86.13 – Kidney transplant infection
    - Use additional code to specify infection
  - T86.19 – Other complication of kidney transplant
Final Thoughts

The Driving Force - $$$

Been there-done that!

Prove it!
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  - www.aapc.com