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Buck's 2020 STEP-BY-STEP Medical Coding

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NOTE: The *2020 ICD-10-CM* and *2020 ICD-10-PCS* were used in preparing this text.

NOTE: *Current Procedural Terminology, 2020,* was used in preparing this text.

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Dedication

To the students, whose drive and determination to learn serve as our endless source of inspiration and enrichment.

To teachers, whose contributions are immense and workloads daunting. May this work make your preparation for class a little easier.

Carol J. Buck

Jackie L. Koesterman

About the authors

Carol J. Buck, MS, is a leading coding author and educator. Her *Step* series of textbooks were the first in the market to help coders and coding students develop their skills to advanced and specialized levels. Carol has dedicated herself to the growth and advancement of the coding profession.

Carol has a Master's degree in Education. She began authoring textbooks when she was Program Director of the Medical Secretarial programs at Northwest Technical College in Minnesota, recognizing the need for classroom texts that could be used to teach medical coding. It was then that she began developing classroom lectures, abstracting medical reports, and compiling materials to prepare her students for careers as medical coders. These materials later became *Buck's Step-by-Step Medical Coding*.

Carol expanded on the original text with a line of annual products for advanced coding, certification, specialization, and reference manuals, providing quality educational materials from the first day of a coding program to preparation for national certification.

Jackie L. Koesterman, CPC, has been a Certified Professional Coder and Medical Assistant for over 20 years. Jackie has also served as an instructor at the Minnesota Northland Technical College in the medical clerical and medical assistant programs. Jackie is employed by a large medical health system as a Senior Coder III and Reimbursement Specialist, specializing in multi-specialty coding and multi-payer denial review in both the inpatient and outpatient settings. She also serves as a trainer and mentor to the coders.

Since the inception of *Buck's Step-by-Step Medical Coding,* Jackie has been involved in the development and review of the texts, serving as both a technical collaborator and reviewer.

Acknowledgments

This book was developed in collaboration with educators and employers in an attempt to meet the needs of students preparing for careers in the medical coding allied health profession. Obtaining employers' input about the knowledge, skills, and abilities desired of entry-level coding employees benefits educators tremendously. This text is an endeavor to use this information to better prepare our students.

There are several other people who deserve special thanks for their efforts in making this text possible.

Patricia Cordy Henricksen, Query Manager, who graciously lends her amazing knowledge and attention to detail to the query process. Her dedication to excellence consistently improves this work.

Brandi Graham, Senior Content Strategist, who maintains an excellent sense of humor and is a valued member of the team. **Josh Rapplean,** Senior Content Development Specialist, who manages the developmental duties of this text with calm, confidence, and tremendous efficiency. **Megan Chandler,** Senior Project Manager, Graphic World, who has assumed responsibility for many projects while maintaining a high degree of professionalism.

Preface

Thank you for purchasing *Buck's Step-by-Step Medical Coding*, the leading textbook for medical coding education. This 2020 edition has been carefully reviewed and updated with the latest content, making it the most current textbook for your class. The author and publisher have made every effort to equip you with skills and tools you will need to succeed on the job. To this end, *Buck's Step-by-Step Medical Coding* presents essential information for all major health care coding systems and covers the skills needed to be a successful medical coder. No other text on the market brings together such thorough coverage of the coding systems in one source.

Organization of this textbook

Developed in collaboration with employers and educators, *Buck's Step-by-Step Medical Coding, 2020 Edition,* takes a practical approach to training for a successful career in medical coding. The text is divided into four units covering Reimbursement, ICD-10-CM, CPT and HCPCS, and Inpatient Coding.

Unit 1, Reimbursement, is a chapter that introduces the reimbursement, HIPAA, and compliance processes, noting the connections between coding and reimbursement.

Unit 2, ICD-10-CM, provides an overview of the ICD-10-CM codes and their use in medical coding. A highlight of this unit is the inclusion of the *ICD-10-CM Official Guidelines for Coding and Reporting* within the chapter text, as they apply to the content.

Unit 3, CPT and HCPCS, begins with an introduction to the CPT manual, followed by an in-depth explanation of the sections found in the code set. Organized by body systems to follow the CPT codes, the chapters include important information about anatomy, terminology, and various procedures, as well as demonstrations and examples of how to code each service.

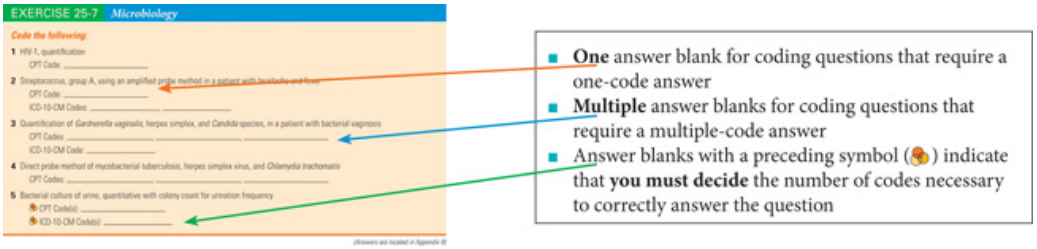
Unit 4, Inpatient Coding, provides an overview of reporting facility services provided to patients in acute inpatient facilities and the reporting of these services with ICD-10-PCS procedures codes.

Some of the CPT code descriptions for physician services include physician extender services. Physician extenders, such as nurse practitioners, physician assistants, and nurse anesthetists, etc., provide medical services typically performed by a physician. Within this educational material the term "physician" may include "and other qualified health care professionals" depending on the code. Refer to the official CPT® code descriptions and guidelines to determine codes that are appropriate to report services provided by non-physician practitioners.

Distinctive features of our approach

This book was designed to be the first step in your coding career, and it has many unique features to help you along the way.

- The repetition of skills in each chapter reinforces the material and creates a logical progression for learning and applying each skill—a truly "step-by-step" approach!
- In-text exercises further reinforce important concepts and allow you to check your comprehension as you read (answers are located in Appendix B).
- The format for coding answers guides you in the development of your coding ability by including three response variations:



- Chapter learning objectives help readers focus on essential chapter content.
- **Theory (Part I) and Practical (Part II) questions** have returned to the print book and may be found in the end-of-chapter reviews. Answers are available on Evolve and can be made available to students at the discretion of the instructor.
- In addition, there are questions to reinforce chapter learning objectives and provide practice with relevant glossary terms. (All answers available in Appendix C.)

CHAPTER 25

"There are many acronyms used in the code descriptions for these codes. Such as TDM: therapeutic drug monitoring. If you don't know what the acronym means, look it up. Never pass a term, abbreviation, or acronym that you don't know without taking the time to do a bit of research, and in turn expand your knowledge base."

Pathology/Laboratory

http://evolve.elsevier.com/Buck/step

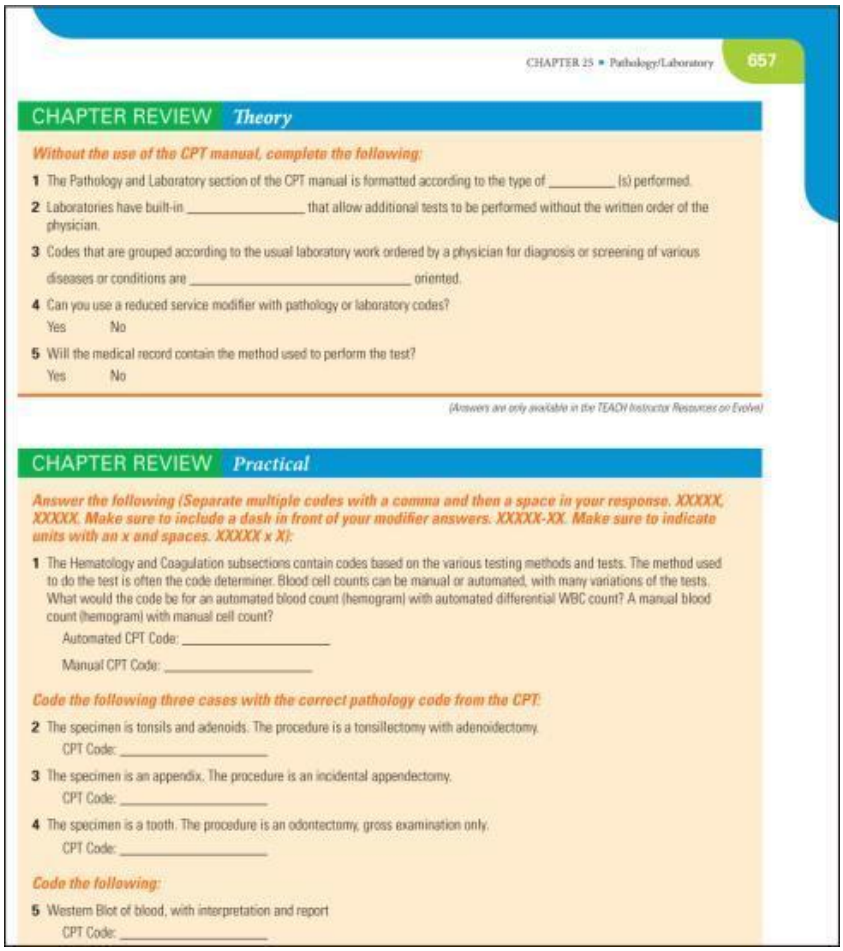
Chapter Topics

Format
Organ or Disease-Oriented Panels
Drug Assay
Therapeutic Drug Assays
Evocative/Suppression Testing
Consultations (Clinical Pathology)
Urinalysis, Molecular Pathology, and Chemistry
Hematology and Coagulation
Immunology
Transfusion Medicine
Microbiology
Anatomic Pathology
Cytopathology and Cytogenic Studies
Surgical Pathology

Learning Objectives

After completing this chapter you should be able to

1. Explain the format of the Pathology and Laboratory section.
2. Understand the information in the Pathology and Laboratory Guidelines.
3. Demonstrate an understanding of Pathology and Laboratory terminology.
4. Differentiate amongst the Organ or Disease-Oriented Panels codes.
5. Recognize Drug Assay codes.
6. Identify Therapeutic Drug Assays codes.
7. Classify Evocative/Suppression Testing codes.
8. Explain Consultations (Clinical Pathology) codes.
9. Interpret Urinalysis, Molecular Pathology, and Chemistry codes.
10. Evaluate Hematology and Coagulation codes.
11. Describe Immunology codes.
12. Discriminate amongst Transfusion Medicine codes.
13. Interpret Microbiology codes.
14. Evaluate Anatomic Pathology codes.



CHAPTER 25 • Pathology/Laboratory 657

CHAPTER REVIEW *Theory*

Without the use of the CPT manual, complete the following:

1 The Pathology and Laboratory section of the CPT manual is formatted according to the type of _____ (s) performed.

2 Laboratories have built-in _____ that allow additional tests to be performed without the written order of the physician.

3 Codes that are grouped according to the usual laboratory work ordered by a physician for diagnosis or screening of various diseases or conditions are _____ oriented.

4 Can you use a reduced service modifier with pathology or laboratory codes?
Yes No

5 Will the medical record contain the method used to perform the test?
Yes No

(Answers are only available in the TEACH Instructor Resources on Evolve)

CHAPTER REVIEW *Practical*

Answer the following (Separate multiple codes with a comma and then a space in your response. XXXXX, XXXXX. Make sure to include a dash in front of your modifier answers. XXXXX-XX. Make sure to indicate units with an x and spaces. XXXXX x X):

1 The Hematology and Coagulation subsections contain codes based on the various testing methods and tests. The method used to do the test is often the code determiner. Blood cell counts can be manual or automated, with many variations of the tests. What would the code be for an automated blood count (hemogram) with automated differential WBC count? A manual blood count (hemogram) with manual cell count?

Automated CPT Code: _____

Manual CPT Code: _____

Code the following three cases with the correct pathology code from the CPT:

2 The specimen is tonsils and adenoids. The procedure is a tonsillectomy with adenoidectomy.
CPT Code: _____

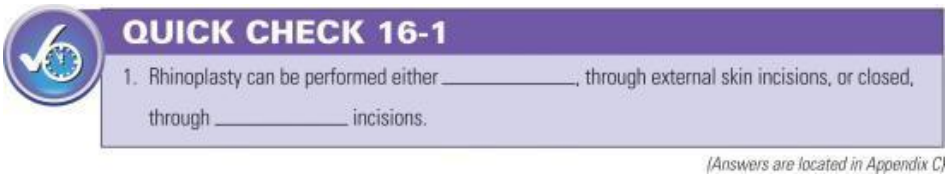
3 The specimen is an appendix. The procedure is an incidental appendectomy.
CPT Code: _____

4 The specimen is a tooth. The procedure is an odontectomy, gross examination only.
CPT Code: _____

Code the following:

5 Western Blot of blood, with interpretation and report
CPT Code: _____

■ *Quick Checks* are located throughout the chapters, providing short follow-up questions after a key concept has been covered to immediately assess learning (answers are located in Appendix B).



QUICK CHECK 16-1

1. Rhinoplasty can be performed either _____, through external skin incisions, or closed, through _____ incisions.

(Answers are located in Appendix C)

■ A full-color design visually reinforces concepts and examples.
■ Medical procedures or conditions are illustrated to help you understand the services being coded.

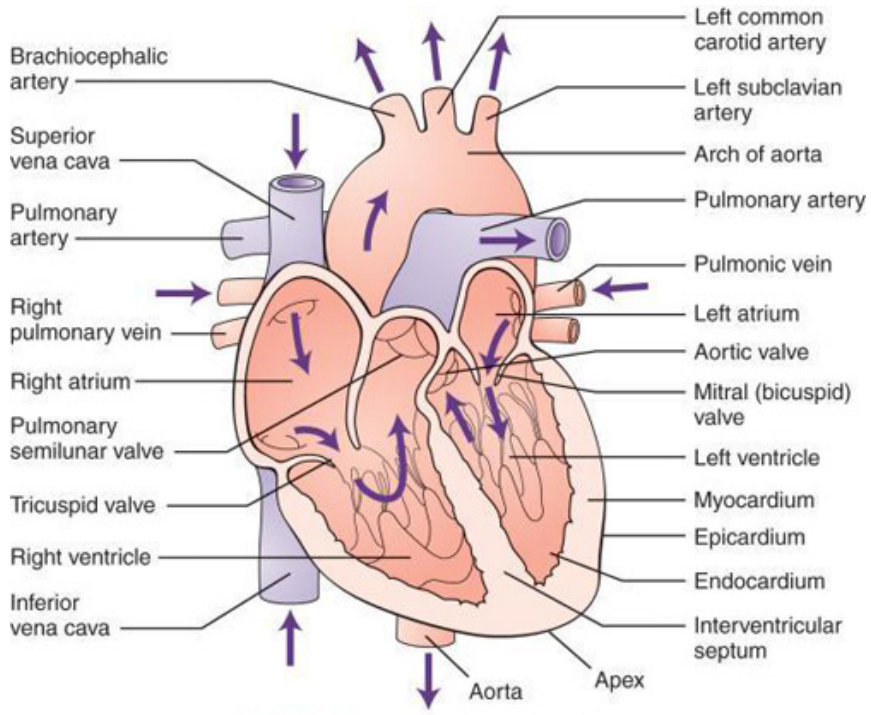


FIGURE 17–2 Internal view of heart.

■ Concrete "real-life" examples illustrate the application of important coding principles and practices.

Example

A lesion was excised and determined to be malignant. The patient was returned to the operating room a few days later for a re-excision of the malignancy. Report the re-excision with modifier -58 because the second procedure was performed within the global period of the first procedure and related to the first procedure.

■ *ICD-10-CM Official Guidelines for Coding and Reporting* boxes contain excerpts of the actual guidelines, presenting the official wording alongside in-text discussions.

ICD-10 OFFICIAL GUIDELINES FOR CODING AND REPORTING

SECTION I.B.

6. Conditions that are not an integral part of a disease process

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

■ *From the Trenches* boxes highlight a different real-life medical coding practitioner in each chapter, with photographs throughout the chapter alongside quotes that offer practical advice or motivational comments.

From the Trenches

"The pressure to improve medical revenue is a constant pressure in today's workplace. We need to stay focused and firm when it comes to coding as the documentation has to support what we are billing to any given payer."

KATHY BUCHDA, CPC, CPMA, REVENUE RECOGNITION, FOREST CITY, IA

■ *Coding Shots* contain tips for the new coder.

CODING SHOT

Included in the Biopsy codes are codes for biopsies of mucous membranes. A mucous membrane is tissue that covers a variety of body parts, such as the tongue and the nasal cavities.

■ *CMS Rules* boxes highlight correct coding methods as required for Medicare claims.

CMS RULES

When a covered colonoscopy is attempted but cannot be completed due to extenuating circumstances (e.g., the inability to extend beyond the splenic flexure), Medicare will usually pay for the interrupted colonoscopy at the rate of a flexible sigmoidoscopy (45331-45347).

■ *Toolbox* features are located throughout the chapters, providing scenarios and questions to help apply chapter content to realistic scenarios (answers are located in Appendix B).

TOOLBOX 1-1

Susan recently graduated as a medical coder and has been employed at Island Clinic for three months. While coding last Monday, she encountered a superbill for a Medicare patient for an office visit for $62, but there was no supporting documentation in the patient's medical record. Susan questioned the physician and he said that he just forgot to do the paperwork and asked her to send the claim to Medicare with a promise to complete the paperwork later.

QUESTIONS

Susan should do which of the following:

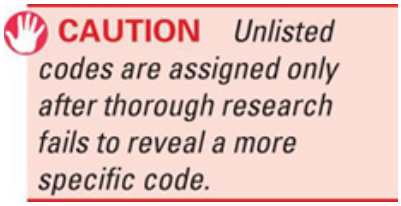
a. Complete the claim and send it in, and write a reminder to the physician to complete the documentation.
b. Wait until the physician completes the documentation.
c. Inform the physician that she cannot submit a claim without appropriate documentation in the medical record.

Answers are located in Appendix D.

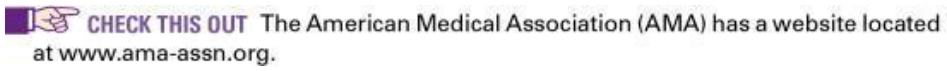
■ *Stop* notes halt you for a reality check, offering a brief summary of material that was just covered and providing a transition into the next topic.

STOP *You have examined each of the three key components and seen how they apply to the assignment of an E/M code. You will be referring to the information as you are presented with additional cases. Make note of the important points and remember that the information about the key components is in the E/M Guidelines in the CPT manual.*

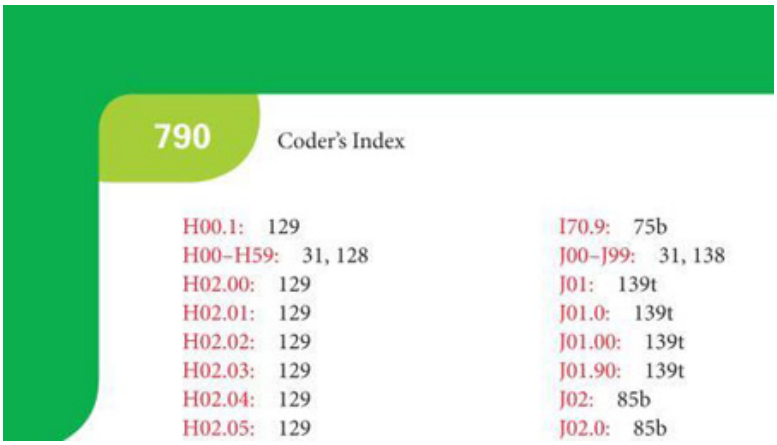
■ *Caution!* notes warn you about common coding mistakes and reinforce the concept of coding as an exact science.



■ *Check This Out!* boxes offer notes about accessing reference information related to coding, primarily online.



■ A *Coder's Index* is located in the back of the book, providing easy reference when looking for specific codes.



Extensive supplemental resources

Considering the broad range of students, programs, and institutions using this content, we have developed an extensive package of supplements designed to complement *Buck's Step-by-Step Medical Coding*. Each of these comprehensive supplements has been developed with the needs of both students and instructors in mind.

Student workbook

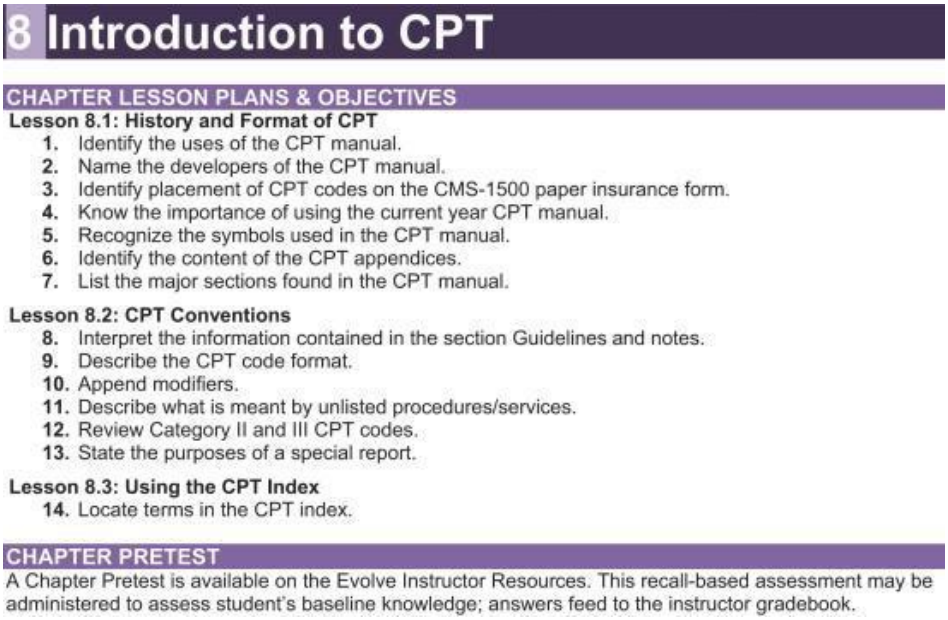
The fully updated workbook supplements the text with more than 1250 questions and terminology exercises, including 100 original source documents to familiarize the user with documents he or she will encounter in practice. (Odd-numbered answers are located in Appendix B, and the full answer key is available only in the TEACH Instructor Resources on Evolve.) Reports are included in a variety of areas, including arthroscopy, muscle repair, thoracentesis, tubal ligation, and endarterectomy. The workbook questions also follow the same answer format of the main text, improving coding skills and promoting critical thinking.

Teach instructor resources on evolve

No matter what your level of teaching experience, this total-teaching solution will help you plan your lessons with ease, and the author has developed all the curriculum materials necessary to use *Buck's Step-by-Step Medical Coding* in the classroom. Instructors can access:

- Extensive testing resources that include three distinct sets of exams:
    1. **TEACH Pretests** are recall-based assessments that may be administered to assess student's baseline knowledge.
    2. **Ready-Made Tests** are split into Theory and Practical tests that correlate to each chapter of the text.
    3. **Test Banks** include a wide variety of multiple choice, true/false, matching, and completion questions that correlate to each chapter of the text.
- The ExamView test generator will help you quickly and easily prepare quizzes and exams, and the test banks can be customized to your specific teaching methods.
- **Online Activities.** Located on Evolve, the online activities offer additional instructor assessment options with 47 chapter activities and 35 coding cases. The variety of activity styles include multiple choice, fill in the blank, matching, and coding exercises. These activities will reinforce material learned in the text and offer students another study tool. (Answers are available in the TEACH Instructor Resources on Evolve, or instructors can enable answers within the application at their discretion.)

- **Answer Keys** for Theory and Practical Chapter Reviews, all Workbook questions, and TruCode® Practice Exercises.
- Course calendar and syllabus.
- Comprehensive PowerPoint collection that can be easily customized to support your lectures, formatted with PowerPoint as overhead transparencies, or formatted as handouts for student note-taking.
- Instructor Content Updates.
- Curriculum guides and TEACH lesson plans. With TEACH (Total Education and Curriculum Help), every textbook chapter is divided into 50-minute lessons designed to promote active student learning and involvement in classroom discussions and activities.



8 Introduction to CPT

CHAPTER LESSON PLANS & OBJECTIVES

Lesson 8.1: History and Format of CPT

1. Identify the uses of the CPT manual.
2. Name the developers of the CPT manual.
3. Identify placement of CPT codes on the CMS-1500 paper insurance form.
4. Know the importance of using the current year CPT manual.
5. Recognize the symbols used in the CPT manual.
6. Identify the content of the CPT appendices.
7. List the major sections found in the CPT manual.

Lesson 8.2: CPT Conventions

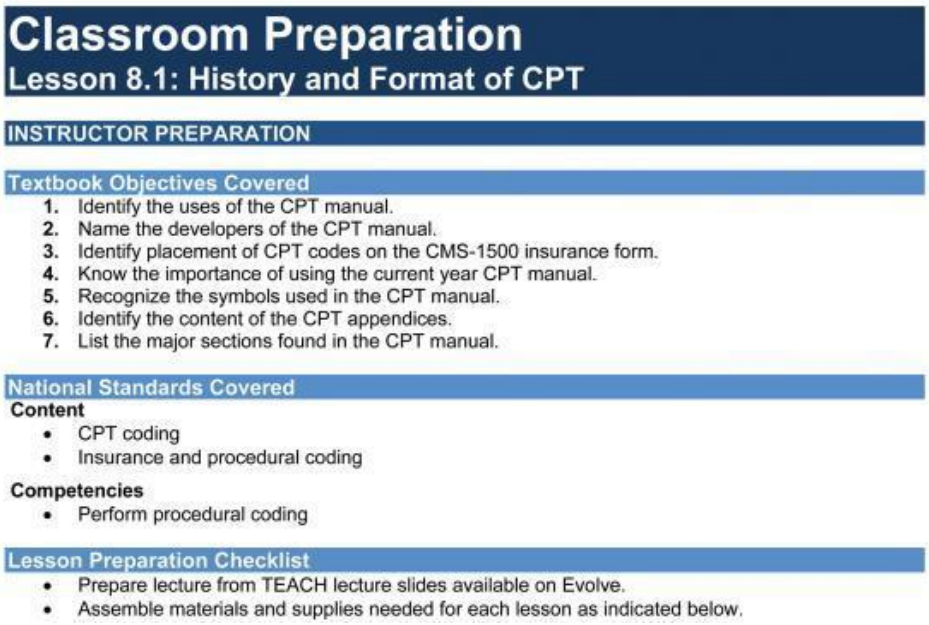
8. Interpret the information contained in the section Guidelines and notes.
9. Describe the CPT code format.
10. Append modifiers.
11. Describe what is meant by unlisted procedures/services.
12. Review Category II and III CPT codes.
13. State the purposes of a special report.

Lesson 8.3: Using the CPT Index

14. Locate terms in the CPT index.

CHAPTER PRETEST

A Chapter Pretest is available on the Evolve Instructor Resources. This recall-based assessment may be administered to assess student's baseline knowledge; answers feed to the instructor gradebook.



Classroom Preparation
Lesson 8.1: History and Format of CPT

INSTRUCTOR PREPARATION

Textbook Objectives Covered

1. Identify the uses of the CPT manual.
2. Name the developers of the CPT manual.
3. Identify placement of CPT codes on the CMS-1500 insurance form.
4. Know the importance of using the current year CPT manual.
5. Recognize the symbols used in the CPT manual.
6. Identify the content of the CPT appendices.
7. List the major sections found in the CPT manual.

National Standards Covered

Content

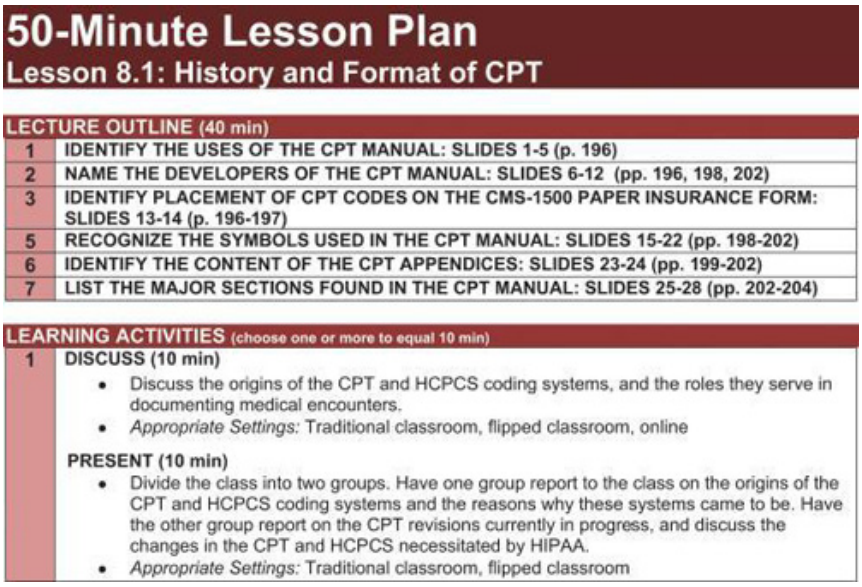
- CPT coding
- Insurance and procedural coding

Competencies

- Perform procedural coding

Lesson Preparation Checklist

- Prepare lecture from TEACH lecture slides available on Evolve.
- Assemble materials and supplies needed for each lesson as indicated below.



50-Minute Lesson Plan
Lesson 8.1: History and Format of CPT

LECTURE OUTLINE (40 min)	
1	IDENTIFY THE USES OF THE CPT MANUAL: SLIDES 1-5 (p. 196)
2	NAME THE DEVELOPERS OF THE CPT MANUAL: SLIDES 6-12 (pp. 196, 198, 202)
3	IDENTIFY PLACEMENT OF CPT CODES ON THE CMS-1500 PAPER INSURANCE FORM: SLIDES 13-14 (p. 196-197)
5	RECOGNIZE THE SYMBOLS USED IN THE CPT MANUAL: SLIDES 15-22 (pp. 198-202)
6	IDENTIFY THE CONTENT OF THE CPT APPENDICES: SLIDES 23-24 (pp. 199-202)
7	LIST THE MAJOR SECTIONS FOUND IN THE CPT MANUAL: SLIDES 25-28 (pp. 202-204)

LEARNING ACTIVITIES (choose one or more to equal 10 min)	
1	**DISCUSS (10 min)** • Discuss the origins of the CPT and HCPCS coding systems, and the roles they serve in documenting medical encounters. • *Appropriate Settings:* Traditional classroom, flipped classroom, online **PRESENT (10 min)** • Divide the class into two groups. Have one group report to the class on the origins of the CPT and HCPCS coding systems and the reasons why these systems came to be. Have the other group report on the CPT revisions currently in progress, and discuss the changes in the CPT and HCPCS necessitated by HIPAA. • *Appropriate Settings:* Traditional classroom, flipped classroom

Evolve learning resources

The Evolve Learning Resources offer helpful material that will extend your studies beyond the classroom.

30-day access to trucode® encoder essentials

NOTE: It is recommended that you only activate your TruCode® Encoder Essentials access as a CAPSTONE at the end of your course, after you have completed all of the text exercises using your print coding manuals.

TruCode® We've included 30-day access to TruCode® Encoder Essentials, with every new *Buck's Step-by-Step Medical Coding, 2020 Edition* book purchase.

- When ready to activate **(we recommend at the end of the course)**, scratch off the gray sticker at the bottom right of the inside front cover of the main text to reveal an access code.
- Next, access http://evolve.elsevier.com/trucode
- Enter the access code when prompted on screen. **Access codes will only be valid during the current coding year, and once entered access will be limited to 30 days.**

Trucode® instructions and practice exercises

For more specific instructions and practice using TruCode® Encoder Essentials, click the *TruCode® Instructions and Practice Exercises* asset on the main *Step-by-Step Medical Coding* Evolve site.

Answers for the TruCode® Practice Exercises are available to students by default; instructors have the option to block answers as part of their course if preferred.

Content updates, coding tips, and links

Official Guidelines for Coding and Reporting, content updates, and coding links help you stay current with this ever-changing field.

Refer to the front inside cover of this text for registration instructions to access these comprehensive online resources.

Buck's step-by-step medical coding online

Designed to accommodate diverse learning styles and environments, *Buck's Step-by-Step Medical Coding Online* is an online course supplement that works in conjunction with the textbook to provide you with a wide range of visual, auditory, and interactive learning materials. The course amplifies course content, synthesizes concepts, reinforces learning, and demonstrates practical applications in a dynamic and exciting way. As you move through the course, interactive exercises, quizzes, and activities allow you to check your comprehension and learn from immediate feedback while still allowing you to use your textbook as a resource. Because of its design, this course offers students a unique and innovative learning experience.

CHAPTER 4: USING ICD-10-CM

Chapter Outline | Glossary

Chapter Introduction and Learning Objectives

Chapter Introduction

Carol J. Buck

Jackie Grass Koesterman

Welcome to **Chapter 4**, in which you will learn about using the I-10. As you learned in Chapter 3, ICD-10-CM *Official Guidelines For Coding and Reporting* have been developed and approved for coding and reporting by the Cooperating Parties for I-10: the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), the Centers for Medicare and Medicaid Services (CMS), and the National Center for Health Statistics (NCHS). The Central Office of the AHA staffs guideline development for I-10, and the Cooperating Parties oversee the Guidelines.

It is very important that you are familiar with the learning objectives, or goals you will be expected to accomplish in this chapter. Be sure to read them carefully before you begin Lesson 4-1. Click **Next** to view the Chapter 4 Learning Objectives.

Development of this edition

This book would not have been possible without a team of educators and professionals, including practicing coders and technical consultants. The combined efforts of the team members have made this text an incredible learning tool.

Advisory board

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Jennifer Winchell, MS.Ed., RHIA, CCS-P, HIM Program Chair, Mercy College of Health Sciences, Des Moines, Iowa

Editorial review board

To ensure the accuracy of the material presented in this textbook, many reviewers have provided feedback over several editions of this text. We are deeply grateful to the numerous people who have shared their suggestions and comments. Reviewing a book or supplement takes an incredible amount of energy and attention, and we are glad so many colleagues were able to take the time to give us their feedback on the material. It takes a village of coders to keep this work relevant. If you have input, suggestions, or criticisms regarding this material, or if you are interested in reviewing this book, please contact us at BuckStep@elsevier.com. Any updates, including corrections, will be posted to the Evolve site and included in the next edition.

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Introduction

The number of people seeking health care services has increased as a result of an aging population, technologic advances, and better access to health care. At the same time, there is an increase in the use of outpatient facilities. This increase is due in part to the government's tighter controls over patient services. The government continues to increase its involvement in and control over health care through reimbursement of services for Medicare and Medicaid patients. Other insurance companies are following the government's lead and adopting reimbursement systems that have proved effective in reducing third-party payer costs but place further pressure on the health care system.

Health care in America has undergone tremendous change in the recent past, and more changes are promised for the future. These changes have resulted in an ever-increasing demand for qualified medical coders. The Bureau of Labor Statistics states that employment of medical records and health information technicians "is projected to grow 13 percent from 2016 to 2026, faster than the average for all occupations. An aging population will require more medical service . . . this will mean more claims for reimbursement from insurance companies."[1]

There is also an increase in the number of medical tests, treatments, and procedures, as well as an increase in claims review by third-party payers. Credentialed coders are on average paid more than the non-credentialed coder. According to the 2018 AAPC Salary Survey (which was the latest available upon publication of this text) the average annual salary for a credentialed AAPC member is $54,500![2] Figure 1 illustrates the earnings by region; Figure 2 shows salary by job responsibility; and Figure 3 shows credential averages. CPC®, the physician outpatient certification, pays on average $54,401, while members with any AAPC credential have an average salary of $54,506.[2] A high percentage of respondents work for large group practices (11%) or health systems (19%), earning an average of $51,862 and $54,633, respectively.[2] Further information can be obtained about

the AAPC and the certifications offered by the organization at www.aapc.com.

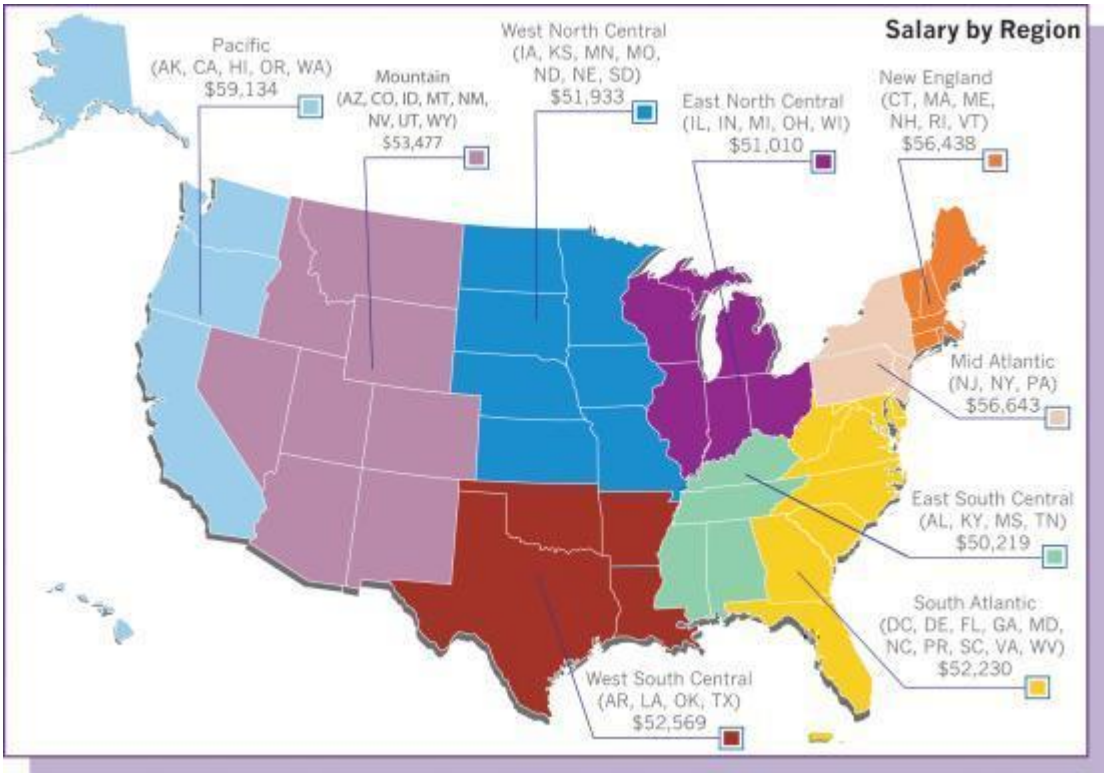


FIGURE 1 Average Salary by Region. Source: (From Blackmer D: 2018 Salary Survey: Credentials Serve Our Members Well, AAPC (website): https://www.aapc.com/blog/45517-2018-salary-survey-credentials-serve-our-members-well/. Accessed March 26, 2019.

FIGURE 2 Average Salary by Job Responsibility.
Source: (From Blackmer D: 2018 Salary Survey: Credentials Serve Our Members Well, AAPC (website): https://www.aapc.com/blog/45517-2018-salary-survey-credentials-serve-our-members-well/. Accessed March 26, 2019.

FIGURE 3 Credential Averages (Salary, Experience, Certifications Held). Source: (From Blackmer D: 2018 Salary Survey: Credentials Serve Our Members Well, AAPC (website): https://www.aapc.com/blog/45517-2018-salary-survey-credentials-serve-our-members-well/. Accessed March 26, 2019.

CHECK THIS OUT Be sure to check your free Evolve student resources for updated salary figures. Go to the *Course Content*

section, click *Resources,* then click *Content Updates – Student.*

From the trenches

"Certification doesn't necessarily mean you are an expert coder. It does mean that you have achieved a level of competence in coding that establishes your aptitude and willingness. Certification is the best way to prove you mean business when you say you want to be a professional coder."

SHERI POE BERNARD, CPC-I, CDEO, CCS-P, PRINCIPAL, POE BERNARD CONSULTING, SALT LAKE CITY, UT

CHECK THIS OUT Be sure to check your free Evolve student resources for updated salary figures. Go to the *Course Content* section, click *Resources,* then click *Content Updates – Student.*

From the trenches

"Certifications demonstrate a willingness to develop and grow and is key to employment advancement. They quantify knowledge and

experience. They are vital to helping you stand out in the employment process."

RACHEL E. BRIGGS, BA, CPC, CPMA, CENTC, CEMC, MEDICAL CODER AND AUDITOR, COLUMBUS, OH

Medical coding is far more than assigning numbers to services and diagnoses. Coders abstract information from the patient record and combine that information with their knowledge of reimbursement and coding guidelines to optimize physician payment. Coders have been called the "fraud squad" because they optimize but never maximize and code only for services provided to the patient that are documented in the medical record.

According to AAPC's 2018 Salary Survey, "If you want to move your career forward, we strongly encourage certification."[2] There is a demand for skilled coders, and you can be one of those in demand. Put your best efforts into building the foundation of your career, and you will be rewarded for a lifetime.

References

1. U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, Medical Records and Health Information Technicians. https://www.bls.gov/ooh/healthcare/medical-records-and-health-informationtechnicians.htm#tab-6. Accessed March 26, 2019.
2. Blackmer D: 2018 Salary Survey: Credentials Serve Our Members Well, AAPC (website): https://www.aapc.com/blog/45517-2018-salary-survey-credentials-serve-our-members-well/. Accessed March 26, 2019.

UNIT 1
Reimbursement

OUTLINE

CHAPTER 1

Reimbursement, HIPAA, and compliance

"It is vitally important that you, as the Medical Coder, be skillful at abstracting information from the medical record to correctly report services provided. The documentation and your abstracting skills form the foundation of correct coding."

CHAPTER TOPICS

Learning objectives

After completing this chapter you should be able to

1 Distinguish among Medicare Parts A, B, C, and D.

2 Interpret rules of the Health Insurance Portability and Accountability Act (HIPAA).

3 Locate information in the *Federal Register*.

4 Explain the RBRVS system.

5 Understand the framework of Medicare Fraud programs.

6 Identify the major components of Managed Health Care.


http://evolve.elsevier.com/Buck/step

Introduction

Coding systems are used in the outpatient and inpatient health care settings. Each of the coding systems plays a role in the reimbursement of patient health care services. As a medical coder, it is your responsibility to ensure that you code accurately and completely to optimize reimbursement for services provided. To accomplish this, you not only need to know the coding systems but also the environment in which the modern medical office functions.

Medical advances allow people to live longer and healthier lives than ever before. According to the U.S. Census Bureau, "by 2030, more than 20 percent of U.S. residents are projected to be aged 65 and over, compared with 13 percent in 2010 and 9.8 percent in 1970."[1] Furthermore, "in 2050, the population aged 65 and over is projected to be 83.7 million, almost double its estimated population of 43.1 million in 2012."[2] The elderly compose the fastest growing segment of our population, and this growth will place additional demands on health care providers and facilities.

Increasing numbers of elderly people, technologic advances, and improved access to health care have increased consumer use of health care services. As more people utilize health care services, coding becomes even more important to appropriate reimbursement and cost control.

As a coder, it is your responsibility to ensure that the data reported are as accurate as possible, not only for classification and study purposes but also to obtain appropriate reimbursement. Ethical issues will arise and will require attention by coding personnel. Guidelines must always be followed in the assignment of codes. Instruction from internal and external sources (e.g., administration, review organizations, third-party payers) that may increase reimbursement but conflict with coding guidelines must be discussed and resolved.

Reimbursement usually comes from third-party payers. By far, the largest third-party payer is the government through the Medicare program. Because the Medicare program plays such an important role in reimbursement, the rules and regulations that govern Medicare reimbursement will be the first topic of study.

Basic structure of the medicare program

The Medicare program was established in 1965 with the passage of the Social Security Act. The Medicare program dramatically increased the involvement of the government in health care and consists of **Part A** (Hospital Insurance) and **Part B** (Supplemental Medical Insurance). Part A pays for the cost of hospital/facility care, and Part B pays for physician services and durable medical equipment not paid for under Part A. Part A insurance also helps to cover hospice care and some care services that are rendered in the home.

Medicare was originally designed for people 65 and over. In 1972 people who were eligible for disability benefits from Social Security were also covered under the Medicare program, along with those patients experiencing end-stage renal disease. Individuals covered under Medicare are termed **beneficiaries**.

The Secretary of the Department of Health and Human Services (DHHS) is responsible for the administration of the Federal Medicare program. Within the Department, the operation of Medicare is delegated to the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA). The funds to run Medicare are generated from payroll taxes paid by employers and employees. The Social Security Administration is responsible for collecting and handling the funds. CMS's function is to promote the general welfare of the public, and its stated mission and vision are:

CMS's mission is to serve Medicare & Medicaid beneficiaries.

The CMS vision is to become the most energized, efficient, customer friendly Agency in the government. CMS will strengthen the health care services & information available to Medicare & Medicaid beneficiaries & the health care providers who serve them.[3]

CMS handles the daily operation of the Medicare program through the use of Medicare Administrative Contractors (MACs) (formerly Fiscal Intermediaries, FIs). The MACs do the paperwork for Medicare and are usually insurance companies that bid for a contract with CMS to handle the Medicare program in a specific area. The monies for Medicare flow from the Social Security Administration through the CMS to the MACs and, finally, are paid to beneficiaries and providers.

Originally, CMS proposed 15 Part A and B MACs (Fig. 1-1) and four Durable Medical Equipment (DME) MACs (Fig. 1-2). By 2014, CMS had

reduced the total number of jurisdictions to 12. The idea was to improve the efficiency and effectiveness of its contracted Medicare claims operations by forming larger A/B MAC jurisdictions, further reducing the size range among the A/B MACs. However, concerns about competitive balance led CMS to cancel the remaining consolidations by 2016.[4]

Part A and B MAC Jurisdictions

Original Jurisdiction	Current Jurisdiction	States Included in Jurisdiction
1	E	American Samoa, California, Guam, Hawaii, Nevada, and Northern Mariana Islands
2 & 3	F	Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming
4 & 7	H	Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas
5	5	Iowa, Kansas, Missouri, and Nebraska
6	6	Illinois, Minnesota, and Wisconsin
8	8	Indiana and Michigan
9	N	Florida, Puerto Rico, and U.S. Virgin Islands
10	J	Alabama, Georgia, and Tennessee
11	M	North Carolina, South Carolina, Virginia, and West Virginia
12	L	Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania
13 & 14	K	Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, and Vermont
15	15	Kentucky and Ohio

FIGURE 1–1 Part A and B MAC Jurisdictions.

Durable Medical Equipment (DME) MAC Jurisdictions

Jurisdiction	States Included in Jurisdiction
A	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont
B	Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin
C	Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia
D	Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington, and Wyoming

FIGURE 1–2 Durable Medical Equipment (DME) Jurisdictions.

CHECK THIS OUT For more information about MACs, visit: www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Medicare AdministrativeContractors.html

Physicians, hospitals, and other suppliers that furnish care or supplies to Medicare patients are called **providers**. Providers must be licensed by local and state health agencies to be eligible to provide services or supplies to Medicare patients. Providers must also meet various additional Medicare requirements before being eligible for payments.

Medicare pays for 80% of allowable charges, and the beneficiary pays the remaining 20% for office visits to a health care provider. The beneficiary pays deductibles, premiums, and coinsurance payments. (The 2019 deductible for Part A was $1364 for each benefit period; for Part B it was $185 per year.)[5] The **coinsurance** is the 20% that Medicare does not pay. Often, beneficiaries have additional insurance to cover out-of-pocket expenses or noncovered services.

Beneficiary Pays:	Deductible, premiums, coinsurance (20%), 100% of noncovered services
Medicare Pays:	Covered services (80%)

The maximum out-of-pocket amounts are set each year according to formulas established by Congress and published in the *Federal Register*. New amounts usually take effect each January 1.

Quality improvement organizations (QIOs)

As part of the Department of Health and Human Services' (HHS) strategy for "providing better care and better health at a lower cost," the Quality Improvement Organizations (QIOs) program is a national network of consumers, physicians, hospitals, and other caregivers who

work to refine care delivery systems at the state level, striving to improve the quality, timing, and cost of care for Medicare patients.

Core functions of the QIO Program are:

- Improving quality of care for beneficiaries;
- Protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and
- Protecting beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as expressed in QIO-related law.[6]

CMS directs two types of QIOs: Beneficiary and Family Centered Care (BFCC) and Quality Innovation Network (QIN).

BFCC-QIOs assist Medicare beneficiaries with quality of care reviews and complaints, along with handling appeals related to provider decisions on discharges or discontinuation of services. QIN-QIOs bring together Medicare beneficiaries, providers, and communities to work on data-driven initiatives involving safety, health quality, and care coordination.[6]

Part A: Hospital insurance

Hospitals report Part A services by using diagnosis codes and procedure codes that together determine Medical Severity-Diagnosis Related Groups (MS-DRG) assignment. You will be learning more about MS-DRGs in Chapter 27 of this text.

Beneficiaries are automatically eligible for Part A, hospital insurance, when they are eligible for Medicare benefits.

During a hospital inpatient stay, Part A pays for a semiprivate room (two to four beds), meals and special diet, plus all other medically necessary services except personal-convenience items and private-duty nurses. Also covered are general nursing, drugs as part of the inpatient treatment, and other hospital services and supplies. Part A can also help pay for inpatient care in a Medicare-certified skilled nursing facility if the patient's condition requires daily skilled nursing or rehabilitation services that can be provided only in a skilled nursing facility. Skilled nursing care means care that can be performed only by or under the supervision of licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by or

under the supervision of a professional therapist. The skilled nursing care and skilled rehabilitation services received must be based on a physician's orders. Part A pays for a semiprivate room in the skilled nursing facility, plus meals, nursing services, and drugs.

Part A can pay for covered home health care visits from a participating home health agency. The visits can include part-time skilled nursing care and physical therapy or speech therapy when the services are approved by a physician.

Hospice provides relief (palliative) care and support care to terminally ill patients. Part A also pays for hospice care for terminally ill patients when a physician has certified that the patient is terminally ill and is expected to live 6 months or less if the disease runs its normal course. Further, the patient has elected to receive care from a hospice rather than the standard Medicare benefits, and the hospice is Medicare-certified. Items covered include nursing services, physician services, services of a home health care aide, homemaker services, medical supplies, counseling, and any other Hospice item or service which is specified in the plan and for which payment may otherwise be made.[7]

Part B: Supplementary insurance

Part B is not automatically provided to beneficiaries when they become eligible for Medicare. Instead, beneficiaries must purchase the benefits with a monthly premium. Part B helps pay for medically necessary professional services, outpatient hospital services, home health care, and a number of other medical services and supplies that are not covered by Part A. Beneficiaries pay a premium each month. There are circumstances in which the premium may vary. If Medicare recipients do not sign up for Medicare when they become eligible, they will be penalized. The cost of enrolling in Medicare will increase by 10% each year that they could have obtained coverage, unless they qualify under a special case. The penalty will be in effect as long as they retain coverage. These Part B services are reported using diagnosis codes, CPT codes for the procedure (service), and HCPCS codes (National Level II codes) for the additional supplies and services.

Part C: Medicare advantage organizations

Medicare Part C is also known as Medicare Advantage Organizations (formerly Medicare + Choice) and is a set of health care options (that must cover all the same services Part A and B cover) from which Medicare beneficiaries can choose their health care providers. The options available under Part C are:

- Health Maintenance Organization (HMO)
- Preferred Provider Organization (PPO)
- Private Fee-for-Service Plan (PFFS)
- Special Needs Plan (SNP)
- Medical Savings Account (MSA)
- HMO Point of Service (HMOPOS)

Medicare Advantage Plans may offer the option to purchase additional benefits, such as vision, hearing, dental, and/or health and wellness programs, and prescription drug coverage that the original Medicare does not offer. The managed plan, such as an HMO, has a contract to deliver Medicare services under the plan and provides the same services to all beneficiaries enrolled under Part C. The beneficiary is still under the coverage of Medicare but has opted to utilize a different way of receiving services.

Part D: Prescription drugs

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173, enacted December 8, 2003) established a prescription drug benefit under Part D of the Medicare program. On January 1, 2006, Medicare beneficiaries could enroll in the Medicare prescription drug plan (Part D) and choose between several plans that offered drug coverage. Medicare beneficiaries are charged a premium each month to be a member of these plans and receive the Medicare Part D drug benefit, pay a deductible, and a copayment.

QUICK CHECK 1-1

Match the Medicare part(s) with the correct phrase(s) below.

a. Part A	b. Part B	c. Part C	d. Part D

1. Automatic coverage under Social Security _____
2. Optional coverage under Social Security _____
3. Hospice care coverage _____
4. Prescription drug coverage _____
5. Physician visit coverage _____
6. Beneficiary pays premium for coverage _____
7. Codes assigned for payment using diagnoses; CPT; and HCPCS _____

(Answers are located in Appendix B)

EXERCISE 1-1 Medicare

Using the information presented in this chapter, complete the following:

1 The major third-party payer in the United States is the _____.
2 The Medicare program was established in what year? _____
3 Hospital Insurance is Medicare Part _____.
4 Supplemental Medical Insurance is Medicare Part _____.

(Answers are located in Appendix B)

 **CHECK THIS OUT** The CMS website is located at www.cms.gov and contains information about the Medicare program. Through it, you can link to useful information concerning Medicare providers.

Health insurance portability and accountability act

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996 (also known as the Kennedy-Kassebaum Law) and includes provisions for governing:

- Health coverage portability
- Health information privacy
- Administrative simplification
- Medical savings accounts
- Long-term care insurance

The section of the Act that has resulted in the most major change to the health care industry is the administrative simplification portion of which there are four parts:

- Electronic transactions and code sets standard requirements
- Privacy requirements
- Security requirements
- National identifier requirements

Electronic transactions

Uniformity is one goal of the change that took place by adopting transaction standards for several types of electronic health information transactions. Third-party payers (insurers) could no longer have unique requirements for processing claims. Providers and payers covered by HIPAA are required to provide the same information using standard formats for processing claims and payments, as well as for the maintenance and transmission of electronic health care information and data. With HIPAA there is now only one way to process electronic claims.

Transactions are activities involving the transfer of health care information. **Transmission** is the movement of electronic data between two entities and the technology that supports the transfer. For example, if you send claims electronically to a payer, you utilize Electronic Data Interchange **(EDI)** technology.

Providers must complete a Standard Electronic Data Interchange (EDI) Enrollment Form before submitting electronic media claims (EMC) or other EDI transactions. The software that supports the electronic transmissions must be compatible with the HIPAA

transaction standard **Version 5010** and the National Council for Prescription Drug Programs (NCPDP) version **D.0.**

CODING SHOT

Years ago, each payer had different requirements for codes and forms in medical insurance billing. The federal government determined that in addition to providing an employee the opportunity to continue coverage during a job change or loss, and limiting coverage exclusion for pre-existing conditions, health care would benefit if every payer and provider used the same standardized forms and codes, and if everyone stored and transmitted medical insurance data electronically. But electronic information has the potential for unauthorized access, so legislation was needed to protect the public while at the same time streamlining medical reporting. HIPAA was created to govern health care portability, privacy of information, simplification of reporting by standardizing code sets, billing forms, and rules. Over 99 percent of Medicare Part A claims and over 96 percent of Medicare Part B claims transactions are received electronically.[8]

Code sets

Code sets are composed of numbers and/or letters that identify specific diagnosis and clinical procedures on claims and encounter forms. The CPT, ICD-10-CM, and ICD-10-PCS codes are examples of code sets for procedure and diagnosis coding. Other code sets adopted under the administrative simplification provisions of HIPAA include those for claims involving:

Groups	Code Sets
1. Physician services/other health services	HCPCS and CPT
2. Medical supplies, orthotics, and DME (durable medical equipment)	HCPCS (A-V codes)
3. Diagnosis codes	ICD-10-CM
4. Inpatient hospital procedures	ICD-10-PCS
5. Dental services	Dental codes (HCPCS, D codes)
6. Drugs/biologics	National Drug Classifications (NDC)

From the Trenches

"The pressure to improve medical revenue is a constant pressure in today's workplace. We need to stay focused and firm when it comes to coding as the documentation has to support what we are billing to any given payer."

KATHY BUCHDA, CPC, CPMA, REVENUE RECOGNITION, FOREST CITY, IA

Privacy requirements

HIPAA also has privacy requirements (known as the "privacy rule") that govern disclosure of patient protected health information (PHI) placed in the medical record by physicians, nurses, and other health care providers. This includes conversations with nurses and other staff about the patient's health care or treatment. All PHI is included in the privacy requirements.

Security requirements

There are security regulations that address the administrative, technical, and physical safeguards required to prevent unauthorized access to protected health care information. There are significant penalties for those who breach the security of the medical record or PHI. Do not access any medical documentation that you are not authorized to access. You are only to access information that you have a work-related reason to access.

Facilities must train their employees in their privacy procedures and designate an individual to be responsible for ensuring the procedures are followed. If an employee fails to follow the established procedures, the facility is required by law to take appropriate disciplinary action.

Security has become a significant concern since computers are being used to store patient information. The two major terms used to describe the format of the electronic health record are:

- Electronic medical record **(EMR)**—a computerized health record limited to one practice

- Electronic health record **(EHR)**—the entire health record compiled from multiple sources

National provider identification

HIPAA also requires health care providers, health plans, and employers to have National Provider Identification (NPI) numbers that are unique identification on transactions. The NPI is entered onto the claim forms to identify the provider(s) of the services.

Further information about HIPAA can be found at https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html and www.hhs.gov/hipaa.

Federal register

The *Federal Register* is the official publication for all "Presidential Documents," "Rules and Regulations," "Proposed Rules," and "Notices." When the government institutes national changes, those changes are published in the *Federal Register*. You must be aware of the changes listed in the *Federal Register* that relate to reimbursement of Medicare so as to submit Medicare charges correctly.

Most of the information in this chapter is about rules that the government developed and introduced through the *Federal Register*. You might wonder why so much time is to be spent on learning how to follow the guidelines set by the government for reimbursement when it is only one third-party payer. The answer is simple: Because the government is the largest third-party payer in the nation and even a slight change in the rules governing reimbursement to providers can have major consequences. For example, there was a 45% decrease in the number of inpatient hospital beds between 1975 and 1996,[9] directly related to a government-implemented inpatient reimbursement system that you will learn about in Chapter 27, the MS-DRGs. Often, more than half of the patients in a hospital are Medicare patients. Because the government is such an important payer in the health care system, you must know how to interpret the government's directives published in the *Federal Register*. In addition, most commercial insurers have adopted Medicare payment philosophies for their own reimbursement policies. The government has changed health care reimbursement through the Medicare program, and even more changes are promised for the future.

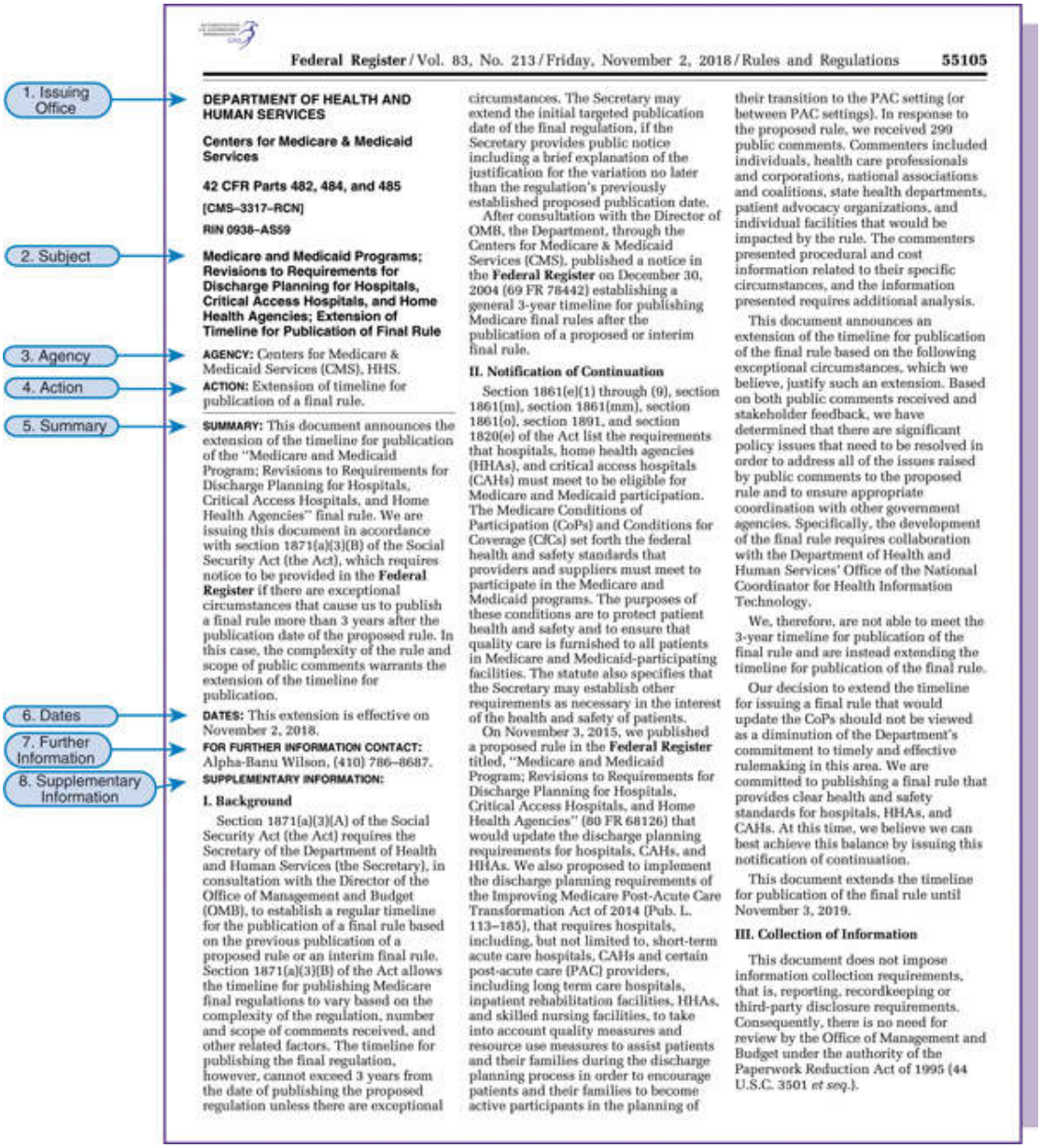

CHECK THIS OUT You can access the *Federal Register* at www.federalregister.gov/ or https://www.govinfo.gov/, the Federal Digital System. Locating and reviewing some of the issues would be an excellent educational activity.

The October editions of the *Federal Register* are of special interest to **hospital** facilities because the hospital updates are released in that edition. **Outpatient** facilities are especially interested in the November or December edition of the *Federal Register* because Medicare reimbursements for outpatient services are usually published in one of those editions. Each year, when changes to the various payment systems are proposed, those proposed changes are published early in the year, and a period of several months is offered to interested parties to comment and make suggestions on the proposed changes. The final rules are usually published in the fall editions and implemented in the following calendar year. Some addendums are particularly helpful to

the coder because they list the active codes, noncovered codes, bundled codes, etc.

Fig. 1-3 shows a copy of a portion of the *Federal Register;* it is marked to indicate the location of the following details:

1. The regulation's issuing office
2. The subject of the notice
3. The agency
4. The action
5. A summary
6. The dates
7. Contacts for further information
8. Supplementary information



Federal Register / Vol. 83, No. 213 / Friday, November 2, 2018 / Rules and Regulations 55105

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 482, 484, and 485

[CMS–3317–RCN]

RIN 0938–AS59

Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies; Extension of Timeline for Publication of Final Rule

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Extension of timeline for publication of a final rule.

SUMMARY: This document announces the extension of the timeline for publication of the "Medicare and Medicaid Program; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies" final rule. We are issuing this document in accordance with section 1871(a)(3)(B) of the Social Security Act (the Act), which requires notice to be provided in the **Federal Register** if there are exceptional circumstances that cause us to publish a final rule more than 3 years after the publication date of the proposed rule. In this case, the complexity of the rule and scope of public comments warrants the extension of the timeline for publication.

DATES: This extension is effective on November 2, 2018.

FOR FURTHER INFORMATION CONTACT: Alpha-Banu Wilson, (410) 786–8687.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1871(a)(3)(A) of the Social Security Act (the Act) requires the Secretary of the Department of Health and Human Services [the Secretary], in consultation with the Director of the Office of Management and Budget (OMB), to establish a regular timeline for the publication of a final rule based on the previous publication of a proposed rule or an interim final rule. Section 1871(a)(3)(B) of the Act allows the timeline for publishing Medicare final regulations to vary based on the complexity of the regulation, number and scope of comments received, and other related factors. The timeline for publishing the final regulation, however, cannot exceed 3 years from the date of publishing the proposed regulation unless there are exceptional circumstances. The Secretary may extend the initial targeted publication date of the final regulation, if the Secretary provides public notice including a brief explanation of the justification for the variation no later than the regulation's previously established proposed publication date.

After consultation with the Director of OMB, the Department, through the Centers for Medicare & Medicaid Services (CMS), published a notice in the **Federal Register** on December 30, 2004 (69 FR 78442) establishing a general 3-year timeline for publishing Medicare final rules after the publication of a proposed or interim final rule.

II. Notification of Continuation

Section 1861(e)(1) through (9), section 1861(m), section 1861(mm), section 1861(o), section 1891, and section 1820(e) of the Act list the requirements that hospitals, home health agencies (HHAs), and critical access hospitals (CAHs) must meet to be eligible for Medicare and Medicaid participation. The Medicare Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) set forth the federal health and safety standards that providers and suppliers must meet to participate in the Medicare and Medicaid programs. The purposes of these conditions are to protect patient health and safety and to ensure that quality care is furnished to all patients in Medicare and Medicaid-participating facilities. The statute also specifies that the Secretary may establish other requirements as necessary in the interest of the health and safety of patients.

On November 3, 2015, we published a proposed rule in the **Federal Register** titled, "Medicare and Medicaid Program; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies" (80 FR 68126) that would update the discharge planning requirements for hospitals, CAHs, and HHAs. We also proposed to implement the discharge planning requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014 (Pub. L. 113–185), that requires hospitals, including, but not limited to, short-term acute care hospitals, CAHs and certain post-acute care (PAC) providers, including long term care hospitals, inpatient rehabilitation facilities, HHAs, and skilled nursing facilities, to take into account quality measures and resource use measures to assist patients and their families during the discharge planning process in order to encourage patients and their families to become active participants in the planning of their transition to the PAC setting (or between PAC settings). In response to the proposed rule, we received 299 public comments. Commenters included individuals, health care professionals and corporations, national associations and coalitions, state health departments, patient advocacy organizations, and individual facilities that would be impacted by the rule. The commenters presented procedural and cost information related to their specific circumstances, and the information presented requires additional analysis.

This document announces an extension of the timeline for publication of the final rule based on the following exceptional circumstances, which we believe, justify such an extension. Based on both public comments received and stakeholder feedback, we have determined that there are significant policy issues that need to be resolved in order to address all of the issues raised by public comments to the proposed rule and to ensure appropriate coordination with other government agencies. Specifically, the development of the final rule requires collaboration with the Department of Health and Human Services' Office of the National Coordinator for Health Information Technology.

We, therefore, are not able to meet the 3-year timeline for publication of the final rule and are instead extending the timeline for publication of the final rule.

Our decision to extend the timeline for issuing a final rule that would update the CoPs should not be viewed as a diminution of the Department's commitment to timely and effective rulemaking in this area. We are committed to publishing a final rule that provides clear health and safety standards for hospitals, HHAs, and CAHs. At this time, we believe we can best achieve this balance by issuing this notification of continuation.

This document extends the timeline for publication of the final rule until November 3, 2019.

III. Collection of Information

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

FIGURE 1–3 Example of page from *Federal Register*.

Items 1 through 8 are always placed before the Final Rule, which is the official statement of the entire rule.

EXERCISE 1-2 Federal Register

Answer the following questions:

1 Which edition of the *Federal Register* is of special interest to hospital facilities? _____

2 Which edition of the *Federal Register* is of special interest to outpatient facilities? _____

Using Fig. 1-3, answer the following questions:

3 What is the issuing office?

_____
_____

4 What is the effective date?

_____
_____

5 What is the Action?

_____
_____

6 According to the "For Further Information Contact" section, who is the person you would contact about this publication?

_____
_____

(Answers are located in Appendix B)

Outpatient resource-based relative value scale (RBRVS)

Physician payment reform was implemented to:

1. Decrease Medicare expenditures
2. Redistribute physicians' payments more equitably
3. Ensure quality health care at a reasonable rate

Before January 1, 1992, payment under Medicare Part B for physicians' services was based on a reasonable charge that, under the Social Security Act, could not exceed the lowest of (1) the physician's actual charge for the service, (2) the physician's customary charge for the service, or (3) the prevailing charges of physicians for similar services in the locality.

The act also required that the local prevailing charge for a physician's service not exceed the level in effect for that service in the locality for the fiscal year ending on June 30, 1973. Some provision was made for changes in the level on the basis of economic changes. When there were economic changes in the country, the Medicare Economic Index (MEI) reflected these changes. Until 1992, the MEI tied increases in the Medicare prevailing charges to increases in the costs of physicians' practice and general wage rates throughout the economy as compared with the index base year. The MEI was first published in the *Federal Register* on June 16, 1975, and has been recalculated annually since then.

Congress mandated the MEI as part of the 1972 Amendment to the Social Security Act. The 1972 Amendment to the Act did not specify the particular type of index to be used; however, the present form of the MEI follows the recommendations outlined by the Senate Finance Committee in its report accompanying the legislation. The MEI attempts to present an equitable measure for changes in the costs of physicians' time and operating expenses.

A major change took place in Medicare in 1989 with the enactment of the Omnibus Budget Reconciliation Act of 1989 (OBRA), Public Law 101-239. Section 6102 of PL 101-239 amended Title XVIII of the Social Security Act by adding Section 1848, Payment for Physician Services. The new section contained three major elements:

1. Establishment of standard rates of increase of expenditures for physicians' services
2. Replacement of the reasonable charge payment mechanism by a fee schedule for physicians' services

3. Replacement of the maximum actual allowable charge (MAAC), which limits the total amount non-QIO physicians could charge

Revisions were made and a new Omnibus Budget Reconciliation Act of 1990 was passed. OBRA 1990 contained several modifications and clarifications of the provisions establishing the physician fee schedule. This final rule required that before January 1 of each year, beginning with 1992, the Secretary establish, by regulation, fee schedules that determine payment amounts for all physicians' services furnished in all fee schedule areas for the year.

The physician fee schedule is updated each year and is composed of three basic elements:

1. The relative value units (RVUs) for each service
2. A geographic adjustment factor to adjust for regional variations in the cost of operating a health care facility
3. A national conversion factor

The Physician Fee Schedule (PFS) is located at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html.

The CMS Physician Fee Schedule Search can be accessed at www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx.

Medicare volume performance standards have been developed to be used as a tool to monitor annual increases in Part B expenditures for physicians' services and, when appropriate, to adjust payment levels to reflect the success or failure in meeting the performance standards. Various financial protections have been designed and instituted on behalf of the Medicare beneficiary.

Relative value unit

Nationally, unit values are assigned for each service and are determined on the basis of the resources necessary to the physician's performance of the service. By analyzing a service, a Harvard team was able to identify its separate parts and assign each part a relative value unit (RVU). These parts or components are as follows:

1. **Work.** The work component is identified as the amount of time, the intensity of effort, and the technical expertise required for the physician to provide the service.
2. **Overhead.** The overhead component or **practice expense** is identified as the allocation of costs associated with the physician's practice (e.g., rent, staffing, supplies) that must be expended in order to provide a service.
3. **Malpractice.** The malpractice component is identified as the cost of the medical malpractice insurance coverage/risk associated with providing the service.

The sum of the units established for each component of the service equals the total RVUs of a service.

A relative value was established for a midlevel, established-patient office visit (99213) and all other services are valued at, above, or below this service relative to the work, overhead, and malpractice expenses associated with the service.

Geographic practice cost index

The Urban Institute developed scales that measure cost differences in various areas. The Geographic Practice Cost Indices (GPCIs) have been established for each of the prevailing charge localities. An entire state may be considered a locality for purposes of physician payment reform. The GPCIs reflect the relative costs of practice in a given locality compared with the national average. A separate GPCI has been established and is applied to each component of a service.

Conversion factor

The conversion factor (CF) is a national dollar amount that is applied to all services paid on the basis of the Medicare Fee Schedule. Congress provided a CF to be used to convert RVUs to dollars. Updated annually on the basis of the data sources, the CF indicates:

- Percent changes to the Medicare Economic Index (MEI)
- Percent changes in physician expenditures
- Relationship of expenditures to volume performance standards
- Change in access and quality

The CF varies according to the type of service provided (e.g., medical, surgical, nonsurgical).

Medicare volume performance standards

The Medicare Volume Performance Standards (MVPS) are best thought of as an object. "It" represents the government's estimate of how much growth is appropriate for nationwide physician expenditures paid by the Part B Medicare program. The purpose of MVPS is to guide Congress in its consideration of the appropriate annual payment update.

The Secretary of Health and Human Services must make MVPS recommendations to Congress by April 15 for the upcoming fiscal year, and by May 15, the Physician Payment Review Commission (PPRC) must make its recommendations for the fiscal year. Congress has until October 15 to establish the MVPS by either accepting or modifying the two proposed MVPS recommendations.

If Congress does not react by October 15, the MVPS rate is established by using a default mechanism. If the default mechanism is used, the Secretary is then required to publish a notice in the *Federal Register* that provides the formula for deriving the MVPS.

Variations in health care usage by Medicare patients occur every year. Because Medicare strives for a balanced budget, if CMS agrees to pay for additional services not previously paid for or increases the weights of CPT codes, thus increasing reimbursement, then discounts are taken across the board so that more money than authorized is not spent and the budget remains balanced.

Beneficiary protection

Several provisions in the Physician Payment Reform were designed to protect Medicare beneficiaries.

1. As of September 1, 1990, all providers must file claims for their Medicare patients (free of charge). In addition, claims must be submitted according to timely filing guidelines. As of January 1, 2010, the Patient Protection and Affordable Care Act requires physicians and suppliers to submit claims within 12 months of the service date. Assigned claims submitted more than 12 months after the date of service will be denied payment.
2. The Omnibus Budget Reconciliation Act of 1989 requires participating physicians to accept the amount paid for eligible Medicaid services (mandatory assignment) as payment in full.
3. Effective January 1, 1991, the Maximum Actual Allowable Charge (MAAC) limitations that applied to nonparticipating physician charges were replaced by new limits called limiting charges. The provisions of the new limitations state that

nonparticipating physicians and suppliers cannot charge more than the stated limiting charge.

Limiting charge

In 1991 and 1992, the limiting charge was specific to each physician. Beginning in 1993, the limiting charge for a service has been the same for all physicians within a locality, regardless of specialty.

The limiting charge applies to every service listed in the Medicare Physicians' Fee Schedule that is performed by a nonparticipating physician. This includes global, professional, and technical services performed by a physician. When a nonphysician provider (e.g., portable x-ray supplier, laboratory technician) performs the technical component of a service that is on the fee schedule, the limiting charge does not apply. CPT codes are assigned many different prices. The amount is determined by multiplying the RVU weight by the geographic index and the conversion factor for the fee schedule amount. If a physician is participating, he or she receives the fee schedule amount. If the physician is not participating, the fee schedule amount or the allowable payment is slightly less than the participating physician's payment. The limiting charge is a percentage over the allowable (e.g., 115% times the allowable amount). The limiting charge is important because that is the maximum amount a Medicare patient can be billed for a service. For covered services, Medicare usually pays 80% of the allowable amount for participating physicians. The beneficiary is then balance-billed, which means that the patient is billed the difference between what Medicare pays and the limiting charge.

Example

Limiting charge is	$115	(Maximum charge)
Allowable is	$100	
Medicare pays	$80	(Medicare pays 80%)
Patient is billed	$35	($20, 20% of $100, and $15, the remainder of the limiting charge maximum)

Physicians may round the limiting charge to the nearest dollar if they do this consistently for all services.

Uniformity provision

Equitable use of the Medicare fee schedule requires a payment system with uniform policies and procedures. Because the relative value of the work component of a service is the same nationwide (except for a

geographic practice cost adjustment), it is important that when physicians across the country are paid for a service, they be paid the same amount, or "package." For example, the preoperative and postoperative periods included in the payment must be the same. To prevent variation in interpretation, standard definitions of services are required.

Adjustments

Whenever an adjustment of the full fee schedule amount is made to a service, the limiting charge for that service must also be adjusted. These adjustments are identified on the physician disclosure, which is provided to all physicians during the participating enrollment period each year.

Adjustments to the limiting charge must be manually calculated before submitting claims for all services in which a fee schedule limitation applies.

Payments to nonparticipating physicians do not exceed 95% of the physician fee schedule for a service.

Site-of-service limitations

Services that are performed primarily in office settings are subject to a payment discount if they are performed in an outpatient hospital department. There is a national list of procedures that are performed 50% of the time in the office setting. These procedures are subject to site-of-service limitations for which a discount is taken on any service that is performed in a setting other than a clinic setting. For instance, an arthrocentesis is normally performed in the office. If a physician provides this service in a hospital outpatient setting, the limiting charge will be less than that for the office setting. This is because the hospital will also be billing Medicare for the use of the room and the supplies. Medicare has a built-in practice expense, or overhead, for the clinic setting (the RVU weight for practice expense), and Medicare doesn't want to pay twice for the overhead; therefore, part of the overhead is reduced from the physician's payment to offset the hospital payment. For these procedures, the practice expense RVU is reduced by 50%. Payment is the lower of the actual charge or the reduced fee schedule amount.

There are many rules and regulations when reporting Medicare services, and these rules and regulations become "adjustments" to the final payments providers receive. As an example, review the following rules regarding the assignment of just a few modifiers.

Surgical modifier circumstances

Multiple surgeries

General.

If a surgeon performs more than one procedure on the same patient on the same day, discounts are made on all subsequent procedures, excluding add-on codes. Medicare will pay 100% of the fee for the highest value procedure, 50% for the second most expensive procedure, and 50% for the third, fourth, and fifth procedures. Each procedure after the fifth procedure requires documentation and special review to determine the payment amount. Discounting is why the order of the codes and the use of modifiers are so important! These discount amounts are subject to review every year by the CMS.

Third-party payers often follow different discount limits rules from those of Medicare. It is necessary to keep abreast of payer discounting rules.

Endoscopic procedures.

In the case of multiple endoscopic procedures, in the same indented category of the CPT, Medicare allows the full value of the highest valued endoscopy, plus the difference between the next highest endoscopy and the highest valued endoscopy. As in all other reimbursement issues, some non-Medicare carriers follow this pricing method, whereas others follow their own multiple-procedure discounting policies.

Dermatologic surgery.

For certain dermatology services, there are CPT codes that indicate that multiple surgical procedures have been performed. When a CPT code description states “additional,” the general multiple-procedure rules do not apply. For example, code 11001, which is an indented code under 11000, states “each additional” in the code description, and the general multiple-procedure rules do not apply because of this statement in the code description.

Providers furnishing part of the global fee package.

Under the fee schedule, Medicare pays the same amount for surgical services furnished by several physicians as it pays if only one physician furnished all of the services in the global package.

Medicare pays each physician for his or her part of the global surgical services. The policy is written with the assumption that the surgeon

always furnishes the usual and necessary preoperative and intraoperative services and also, with a few exceptions, in-hospital postoperative services. In most cases, the surgeon also furnishes the postoperative office services necessary to ensure normal recovery from the surgery. Recognizing that there are cases in which the surgeon turns over the out-of-hospital recovery care to another physician, Medicare has determined percentages of payment if the postoperative care is furnished by someone other than the surgeon. These are weighted percentages based on the percentage of total global surgical work.

For example:

■ Preoperative care	15%
■ Intraoperative service	70%
■ Postoperative care	15%

Again, become familiar with individual third-party payer policies, because some may not split their global payments in this manner.

Physicians who assist at surgery.

Physicians assisting the primary physician in a procedure receive a set percentage of the total fee for the service. Medicare sets the payment level for assistants-at-surgery at 16% of the fee schedule amount for the global surgical service. Non-Medicare payers may set this percentage at 20% or more. CPT modifiers -80 (Assistant Surgeon), -81 (Minimum Assistant Surgeon), and -82 (Assistant Surgeon, when qualified resident surgeon not available) and HCPCS modifier -AS (Assistant at Surgery) would be appended to the code to indicate the type of assistant.

Two surgeons and surgical team.

When two primary surgeons (usually of different specialties) perform a procedure, each is paid an equal percentage of the global fee. For co-surgeons, Medicare pays 125% of the global fee, dividing the payment equally between the two surgeons (each will receive the lesser of the actual charge or 62.5% of the global fee). No payment is made for an assistant-at-surgery when co-surgeons perform the procedure.

For team surgery, a medical director determines the payment amounts on an individual basis. Modifiers -62 (Two Surgeons) or -66 (Surgical Team) would be appended to the procedure code.

Purchased diagnostic services.

For physicians who bill for a diagnostic test performed by an outside supplier, the fee schedule amount is limited to the lower of the billing

physician's fee schedule amount or the price paid for the service.

Reoperations.

The amount paid by Medicare for a return to the operating room for treatment of a complication is limited to the intraoperative portion of the code that best describes the treatment of the complications.

When an unlisted procedure is reported because no other code exists to describe the treatment, payment is usually based on a maximum of 50% of the value of the intraoperative services originally performed.

Modifiers -78 (Return to Operating/Procedure Room for a Related Procedure During the Postoperative Period) or -79 (Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period) would be appended to the code to more specifically identify that the service was a reoperation.

Third-party payers have their own guidelines. Many do not apply discounts for these subsequent surgical procedures.

CMS publishes the RVUs on their website (www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html). In your job in the medical office, you may be responsible for downloading the new RVUs when they are posted, usually in October of each year. So, it is a good idea to know where to locate this information!

EXERCISE 1-3 RBRVS

Fill in the blanks with the correct words:

1 What does RBRVS stand for?

_____
_____

2 The Medicare Economic Index is published in what publication?

_____
_____

3 In 1989, a major change took place in Medicare with the enactment of

_____
_____.

(Answers are located in Appendix B)

Medicare fraud

Fraud defined

The Medicare program is subject to fraud, as is any third-party payer program. But because Medicare is the largest third-party payer, it has the most comprehensive anti-fraud program. You must understand the specifics of this program because you will be submitting Medicare claims. CMS is responsible for establishing the regulations that monitor the Medicare program for fraud. CMS publishes fraud guidelines for professionals (www.cms.gov/FraudAbuseforProfs/) that contain links to the latest fraud and abuse information.

Fraud is the intentional deception or misrepresentation that an individual knows to be false or does not believe to be true and makes it knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. Fraud involves both deliberate intention to deceive and an expectation of an unauthorized benefit. By this definition, it is fraud if a claim is filed for a service rendered to a Medicare patient when that service was not actually provided. How could this type of fraud happen? The fact is that most Medicare patients sign a standing approval, which assigns benefits to the provider and is kept on file in the medical office. Having a standing approval is convenient for the patient and for the coding staff. After the patient has received a service, the Medicare claim is filed automatically, without the patient's actual signature. But a standing approval also makes it easy for unscrupulous persons to submit charges for services never provided. This circumstance also makes it possible for extra services to be submitted in addition to services that were provided (upcoding). Suppose, for example, a patient came in for an office visit and a claim was submitted for an in-office surgical procedure that was not performed. That's also fraud.

CAUTION

The most common kind of fraud arises from a false statement or misrepresentation made, or caused to be made, that results in additional payment by the Medicare program.

Who are the violators?

The violator may be a physician or other practitioner, a hospital or other institutional provider, a clinical laboratory or other supplier, an employee of any provider, a billing service, a beneficiary, a Medicare employee, or any person in a position to file a claim for Medicare

benefits. You will be the person filing Medicare claims so you have to be careful about the claims you submit. It is important to validate that the service was provided by consulting the medical record or the physician.

Medicare Learning Network (MLN), the CMS educational Center on the Web, contains publications and Web-Based Training (WBT) courses on fraud and abuse (www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html). Upon creating a training account, you'll be able to access a list of courses, and one of them is "Medicare Fraud and Abuse."

Fraud schemes range from those committed by individuals acting alone to broad-based activities perpetrated by institutions or groups of individuals, sometimes employing sophisticated telemarketing and other promotional techniques to lure consumers into serving as unwitting tools in the schemes. Seldom do such perpetrators target just one insurer; nor do they focus exclusively on either the public or the private sector. Rather, most are found to be defrauding several private- and public-sector victims such as Medicare simultaneously.

What forms does fraud take?

The most common forms of Medicare fraud are:

- Billing for services not furnished
- Misrepresenting a diagnosis to justify a payment
- Soliciting, offering, or receiving a kickback
- Unbundling, or "exploding," charges
- Falsifying certificates of medical necessity, plans of treatment, and medical records to justify payment
- Billing for additional services not furnished as billed-up coding
- Routine waiver of copayment

Who says what is fraudulent?

CMS administers the Medicare program. CMS's responsibilities include managing claims payment, overseeing fiscal audit and/or overpayment prevention and recovery, and developing and monitoring the payment safeguards necessary to detect and respond to payment errors or abusive patterns of service delivery. Within CMS's Bureau of Program Operations is the Office of Benefits Integrity (OBI), which oversees Medicare's payment safeguard program related to fraud, audit, medical review, the collection of overpayments, and the imposition of civil monetary penalties (CMPs) for certain violations of Medicare law.

The Office of the Inspector General (OIG), Department of Health and Human Services, is responsible for developing a work plan that outlines

the ways in which the Medicare program is monitored to identify fraud and abuse. The plan is updated monthly on the OIG HHS website (https://oig.hhs.gov/reports-and-publications/workplan/index.asp) and provides the current evaluation methods and approaches that will be taken to monitor the Medicare program. For example, this excerpt from the January 2019 Work Plan update identifies a specific area that was expected to be monitored in 2019:

TOOLBOX 1-1

Susan recently graduated as a medical coder and has been employed at Island Clinic for three months. While coding last Monday, she encountered a superbill for a Medicare patient for an office visit for $62, but there was no supporting documentation in the patient's medical record. Susan questioned the physician, and he said that he just forgot to do the paperwork and asked her to send the claim to Medicare with a promise to complete the paperwork later.

Questions

Susan should do which of the following:

a. Complete the claim and send it in, and write a reminder to the physician to complete the documentation.
b. Wait until the physician completes the documentation.
c. Inform the physician that she cannot submit a claim without appropriate documentation in the medical record.

Answers are located in Appendix B.

Medicare outpatient outlier payments for claims with credits for replaced medical devices

CMS requires hospitals to submit a zero or token charge when they receive a full credit for a replacement device, but CMS does not specify how charges should be reduced for partial credits. CMS makes an additional payment (an outpatient outlier payment) for hospital outpatient services when a hospital's charges, adjusted to cost, exceed a fixed multiple of the normal Medicare payment. 42 CFR § 419.43(d). Prior OIG reviews focused on finding unreported credits for medical devices and recommended that CMS recoup Medicare funds for the overstated ambulatory payment classification payment only. This audit focuses on overstated Medicare charges on outpatient claims that contain both an outlier payment and a reported medical device credit.

We will determine whether Medicare payments for replaced medical devices and their respective outlier payments were made in accordance with Medicare requirements. (Report Number: W-00-19-35819; expected issue date: FY 2019)[10]

The OIG charges the MACs with doing the actual monitoring. The OIG Work Plan sets the broad boundaries for monitoring the Medicare program for fraud and abuse.

CHECK THIS OUT The site https://oig.hhs.gov/reports-and-publications/workplan/index.asp contains the latest OIG work plan as well as archived work plans.

Specific regulations are in the IOMs

CMS establishes the specific regulations in the *Internet-Only Manuals (IOMs)* for the providers and carriers to follow. You will deal with regulations as you report Medicare services in order to know what is allowable and what fraud and abuse are.

CHECK THIS OUT The IOMs are located at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html and publication 100-08, Medicare Program Integrity Manual presents principles and values to protect the Medicare program from fraud and abuse.

Attempts to defraud the Medicare program may take a variety of forms. The following are some more examples of how fraud may be perpetrated:

- Billing for services or supplies not provided;
- Deliberately applying for duplicate payment (e.g., billing both Medicare and the beneficiary for the same service or billing both Medicare and another insurer in an attempt to get paid twice);
- Soliciting, offering, or receiving a kickback, bribe, or rebate (e.g., paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment);
- Unbundling or "exploding" charges (e.g., the billing of a multichannel set of lab tests to appear as if the individual tests had been performed);
- Completing Certificates of Medical Necessity (CMN) for patients not personally and professionally known by the