Coding for Hospital Outpatient Services

Catrena Smith
CPC, CCS, CCS-P, PCS

Disclaimer
Objectives

- Define “facility” services
- Explain Facility coding vs. Physician coding
- Explain the Hospital Outpatient Prospective Payment System
- Identify several procedures performed in the hospital outpatient clinic setting and their corresponding coding and documentation requirements

APCs

- Ambulatory Payment Classification - grouping that categorizes outpatient visits
Bundling

• Procedure(s) or service(s) that are integral to the major procedure

• They are not separately reimbursed

Emergency Services

• The absence of immediate medical attention could reasonably be expected to result in:
  – Placing the patient’s health in serious jeopardy;
  – Serious impairment to bodily functions; or
  – Serious dysfunction of any bodily organ or part
Medically Necessary

• Service that is reasonably calculated to:
  – Prevent
  – Diagnose
  – Cure
  – Alleviate or prevent worsening

Outpatient

• A patient receiving services in other than an inpatient hospital setting
Status Indicator (SI)

- Outpatient Code Editor

- Assigned to each procedure/service

Facility Services

- Global coding
  - Technical component
  - Professional component

- Claim forms (or electronic equivalent)
  - CMS 1450
    - institutional claim
  - CMS 1500
    - professional claim
Types of Encounters

• Radiology
• Pathology/Laboratory
• Emergency Department
• Urgent Care
• Outpatient Clinics
• Recurring accounts

Types of Encounters

• Short Stay
• Outpatient Observation
• Outpatient Surgery
Charge Description Master (CDM)

- Includes a list of:
  - CDM Numbers
  - Description
  - Services
  - Procedures
  - Supplies
  - Drugs/biologicals
  - Radiopharmaceuticals
  - Revenue codes
  - GL number

Charge Description Master (CDM)

- CDM Number/Charge Code
  - Charge Description
  - CPT® or HCPCS code(s)
  - Revenue Codes
  - Charge amount
  - Identifies the department
  - May contain modifiers
  - GL number/GL key
Charge Description Master (CDM)

• Helps ensure billing accuracy
  – Decreases the likelihood that required elements are missed

• Aids in timely filing

Charge Description Master (CDM)

• Clinical or clerical staff enters charges

• Charges may be tied to electronic medical record documentation
Revenue Codes

• Four digits
• Assigned with procedure codes
• Must be included on the claim form
  – Typically handled by the billing department or chargemaster

Revenue Codes

• Can describe where treatment was received
• Can describe type of item received
### Revenue Codes

<table>
<thead>
<tr>
<th>Revenue center ID</th>
<th>Revenue Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0351</td>
<td>CT Scan: Head</td>
</tr>
<tr>
<td>0352</td>
<td>CT Scan: Body</td>
</tr>
<tr>
<td>0359</td>
<td>CT Scan: Other CT scans</td>
</tr>
<tr>
<td>0360</td>
<td>Operating Room Services</td>
</tr>
<tr>
<td>0361</td>
<td>Operating Room Services: Minor surgery</td>
</tr>
<tr>
<td>0362</td>
<td>Operating Room Services: Organ transplant, not kidney</td>
</tr>
<tr>
<td>0367</td>
<td>Operating Room Services: Kidney transplant</td>
</tr>
<tr>
<td>0300</td>
<td>Laboratory - Clinical Diagnostic</td>
</tr>
<tr>
<td>0301</td>
<td>Laboratory - Clinical Diagnostic: Chemistry</td>
</tr>
<tr>
<td>0302</td>
<td>Laboratory - Clinical Diagnostic: Immunology</td>
</tr>
<tr>
<td>0304</td>
<td>Laboratory - Clinical Diagnostic: Nonroutine dialysis</td>
</tr>
<tr>
<td>0306</td>
<td>Laboratory - Clinical Diagnostic: Bacteriology/microbiology</td>
</tr>
<tr>
<td>0307</td>
<td>Laboratory - Clinical Diagnostic: Urology</td>
</tr>
<tr>
<td>0421</td>
<td>Physical Therapy: Visit charge</td>
</tr>
<tr>
<td>0422</td>
<td>Physical Therapy: Hourly charge</td>
</tr>
<tr>
<td>0423</td>
<td>Physical Therapy: Group rate</td>
</tr>
<tr>
<td>0424</td>
<td>Physical Therapy: Evaluation/re-evaluation</td>
</tr>
<tr>
<td>0429</td>
<td>Physical Therapy: Other physical therapy</td>
</tr>
<tr>
<td>0450</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>0451</td>
<td>Emergency Room: EM/EMTALA</td>
</tr>
<tr>
<td>0452</td>
<td>Emergency Room: ERL Beyond EMTALA</td>
</tr>
<tr>
<td>0456</td>
<td>Emergency Room: Urgent care</td>
</tr>
<tr>
<td>0730</td>
<td>EKG/ECG</td>
</tr>
<tr>
<td>0731</td>
<td>EKG/ECG: Holter monitor</td>
</tr>
</tbody>
</table>

### Hospital Outpatient Prospective Payment System (HOPPS)

- Billing for facility services
- Supervision

https://www.cms.gov/HospitalOutpatientPPS/05_OPPSGuidance.asp#TopOfPage
SUPERVISION

- THERAPEUTIC SERVICES: Direct Supervision

- DIAGNOSTIC SERVICES: Follow existing requirements in the Medicare Physician Fee Schedule (MPFS) Relative Value File

TYPES OF SUPERVISION

- General - procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure
TYPES OF SUPERVISION

• Direct - the physician or non-physician practitioner is immediately available to furnish assistance and direction throughout the performance of the procedure, but it does not mean that the supervising individual needs to be present in the room when the procedure is performed.

TYPES OF SUPERVISION

• Personal - a physician must be in attendance in the same room during the performance of the procedure.
Reason for Visit

- AHA Coding Clinic, Second Qtr. 2000, "ICD-9-CM diagnosis code describing the patient's diagnosis or reason for visit at the time of outpatient registration on unscheduled outpatient visits to a health care facility"

- Often also used on outpatient claims for scheduled visits

Diagnostic Radiology Services

- Chargemaster
  - Hard coded modifiers
  - Soft coded modifiers

- Diagnosis coding
  - Reason for visit
  - Findings on exam
Modifiers in Radiology

• Hard coded
  – Automatically built into the charge number and included in the charge description

Modifiers in Radiology

• Soft Coded
  – Added on the back-end after the charge has been entered
  – Coding Department
    • May append during the coding process
  – Billing Department
    • May have modifier(s) added if missed during the coding process or when there is no coder for the account type
Modifiers in Radiology

• Anatomical Modifiers
  – **50** (Bilateral procedure)
  – **RT** (right side)
  – **LT** (left side)
  – **FA, F1, F2, F3, F4** (fingers on left hand)
  – **F5, F6, F7, F8, F9** (fingers on right hand)
  – **TA, T1, T2, T3, T4** (toes on left foot)
  – **T5, T6, T7, T8, T9** (toes on right foot)

Modifiers in Radiology

• **Repeat procedure/service**
  – **76** (Repeat procedure by same physician or other qualified health care professional)

  – **77** (Repeat procedure by another physician or other qualified health care professional)

  – **SAME CALENDAR DATE**
Modifiers in Radiology

• Distinct procedural service
  – 59
  – Modifier of last resort

Modifiers in Radiology

• Payment modifiers should always be listed first
  – i.e., Modifier -76 would be reported before modifier -RT
Modifiers in Radiology

• Example:
  – 2 view X-ray of the right lower leg completed prior to reduction of tib/fib fracture.

  – Post reduction 2 view X-ray of right lower leg done on same calendar date

Modifiers in Radiology

– 2 view X-ray of the right lower leg completed prior to reduction of tib/fib fracture.
  • Radiologic exam; tibia and fibula, 2 views (73590-RT)

– Post reduction X-ray of right leg done on same calendar date
  • Radiologic exam; tibia and fibula, 2 views (73590-76-RT)
Radiology Case Study 1

Dr. Hall orders a complete abdominal ultrasound. Ordering diagnosis: pelvic pain (ICD-9 code 625.9)

Ultrasound is completed and permanent images maintained. (CPT® code 76700)

Final impression: complex ovarian cyst and uterine fibroids (ICD-9 codes 620.2 and 218.9)

Case Study 1: Key points

- Ultrasound procedure code is likely chargemaster driven
  - Coder review?

- Reason for visit is the reason for the study known at the time of outpatient registration
  - Pelvic Pain

- Final diagnoses are the reason chiefly responsible for the services provided
  - Complex Ovarian Cyst
  - Uterine Fibroids
Radiology Case Study 2

Dr. Singh orders a bone density study of the hip
Ordering diagnoses: 1. Screening for osteoporosis 2. Menopause, asymptomatic
Bone density study is done and permanent images maintained
Final diagnoses: Normal bone density scan

ICD-9 codes: V82.81 and V49.81
CPT® code: 77080

Case Study 2: Key Points

• Bone density scan procedure code is likely chargemaster driven
  — Coder review is recommended

• Reason for visit is the reason for the study known at the time of outpatient registration
  — Up to three may be coded.
  — 1. Screening for osteoporosis
  — 2. Asymptomatic postmenopausal status

• First-listed diagnosis is the reason chiefly responsible for the services provided.
  — 1. Screening for osteoporosis
  — 2. Asymptomatic postmenopausal status
Dr. Cason orders a renal ultrasound (not a transplanted kidney) and a complete duplex scan of arterial inflow and venous outflow.

**76775**: Ultrasound, retroperitoneal (eg renal, aorta, nodes), real time with image documentation; limited

**93975**: Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study

Coder receives an edit that 76775 is a component of 93976 but can be reported with a modifier. What next?

- Review potential modifiers
- Distinct procedure service?
Pathology and Laboratory Services

- Orders received from within facility (i.e. hospital outpatient clinics)

Pathology and Laboratory Services

- Orders received from outside the facility (i.e. private physician’s office)
Pathology and Laboratory Services

• Orders must contain the diagnosis
  – Admitting/Registration department
  – Staff education
  – Physician office education

Pathology and Laboratory Services

• Provided by a pathologist

• Provided by technician under the supervision of a physician
Pathology and Laboratory Services

• Common documentation pitfall
  – Venipuncture

Pathology and Laboratory Services

• Common modifiers
  - 91 (Repeat clinical diagnostic lab test)

  - 59 (Distinct procedural service)
Path/Lab Case Study 1

- Patient presents to the ED with chest pain. Troponin is ordered and is elevated. Per physician’s order, two additional Troponin levels are ordered at specified intervals. Assign codes for lab service only.

- Modifier -59??
- Modifier -91??

Path/Lab Case Study 1

Patient presents to the ED with chest pain. Troponin level is ordered and is elevated. Per physician’s order, two additional Troponin levels are ordered and drawn at specified intervals. Assign codes for lab service only.

- 84484, 84484-91, 84484-91

- Modifier -59 not appropriate as another modifier adequately addresses the edit
Path/Lab Case Study 2

- Patient presents to the hospital for labs prior to her scheduled hospital outpatient clinic visit. A Comprehensive Metabolic Panel (CMP) was previously ordered and is drawn (80053). The patient proceeds to the outpatient clinic. While there, the physician reviews the CMP results and notes elevated potassium level. The physician orders a repeat of potassium level only (84132). The technician draws the blood and sends for testing in the hospitals lab. All services take place on the same calendar date.

Path/Lab Case Study 2: Key notes

**Comprehensive metabolic panel includes:**
- Albumin (82040)
- Bilirubin, total (82247)
- Calcium, total (82310)
- Carbon dioxide (bicarbonate) (82374)
- Chloride (82435)
- Creatinine (82565)
- Glucose (82947)
- Phosphatase, alkaline (84075)
  **Potassium (84132)**
- Protein, total (84155)
- Sodium (84295)
- Transferase, alanine amino (ALT) (SGPT) (84460)
- Transferase, aspartate amino (AST) (SGOT) (84450)
- Urea Nitrogen (BUN) (84520)
Path/Lab Case Study 2: Key notes

1. CMP: 80053
2. Potassium: 84132-59
3. Venipuncture: 36415

Modifier -59 is supported because a test that is also a component of the panel was performed additionally and meets the definition of a distinct procedural service.

Modifier -59 is appended to the lesser code, not the panel

Modifier -91 is not appropriate since the entire panel was not repeated.

Evaluation and Management Coding

• No national guidelines exist

• Do not follow CMS 1995 or 1997 E/M Documentation guidelines for hospital coding
Evaluation and Management

• Must be documented and medically necessary
• Internal E/M guidelines
• System reasonably relates the intensity of hospital resources to the different HCPCS codes
• Guidelines must be provided upon request

Evaluation and Management

• Hospital internal guidelines

• Full range of E/M codes (99201-99205) (99211-99215) (99281-99285) (99291) should be used
Evaluation and Management

• Facility resources NOT physician documentation

• A hospital E/M is not always appropriate and should not be automatically assigned simply because the patient was seen that day

Evaluation and Management

• Don’t double-dip
  – Lab
  – X-ray
  – Infusion/Injection services
Evaluation and Management

• Modifier -25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service)

Evaluation and Management

• Modifier -27 (Multiple Outpatient Hospital E/M Encounters on the Same Date)
Emergency Department

• Typically mixture of CDM driven and coder assigned procedures
  – Facility guidelines

Emergency Department

• Review documentation to ensure all applicable procedures have been coded and necessary modifiers appended
Emergency Department

• Area of caution
  – Infusions and Injections
    • Initial vs. Subsequent
    • Time

ED: Infusions/Injections Hierarchy

Chemotherapy

   ↓

Diagnostic, prophylactic, and therapeutic

   ↓

Hydration

   ↓

Infusions

   ↓

Pushes

   ↓

Injections
Emergency Department

- Areas of caution
  - Laceration Repair
    - Anatomic Location
    - Type of Repair
    - Size of repair

Emergency Department: Laceration Repair Classifications

*Simple repair* is used when the wound is superficial; e.g., involving primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and requires simple one layer closure. This includes local anesthesia and chemical or electrocauterization of wounds not closed.
Emergency Department: Laceration Repair Classifications

**Intermediate repair** includes the repair of wounds that, in addition to the above, require layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure. Single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair.

**Complex repair** includes the repair of wounds requiring more than layered closure, viz., scar revision, debridement (eg, traumatic lacerations or avulsions), extensive undermining, stents or retention sutures. Necessary preparation includes creation of a limited defect for repairs or the debridement of complicated lacerations or avulsions. Complex repair does not include excision of benign (11400-11446) or malignant (11600-11646) lesions, excisional preparation of a wound bed (15002-15005) or debridement of an open fracture or open dislocation.
Emergency Department: Laceration Repair Classifications

• Repaired wounds should be measured and recorded in centimeters

• Multiple wounds
  – Same classification and same anatomic grouping, add lengths together
  – Different classification, code separately
  – Different anatomical grouping, code separately

Emergency Department: Laceration Repair Classifications

• When more than one classification of wounds is repaired:
  – List the more complicated as the primary procedure.
  – List the less complicated as the secondary procedure
    • Append modifier -59
Emergency Department: Laceration Repair Classifications

• Debridement is considered a separate procedure only when:
  – Gross contamination requires prolonged cleansing;
  – Appreciable amounts of devitalized or contaminated tissue are removed; or
  – When debridement is carried out separately without immediate primary closure

Emergency Department: Laceration Repair Classifications

• Extensive debridement of soft tissue and/or bone, not associated with open fracture(s) and/or dislocations resulting from penetrating and/or blunt trauma: See 11042 - 11047
Emergency Department: Laceration Repair Classifications

• Extensive debridement of subcutaneous tissue, muscle fascia, muscle, and/or bone associated with open fracture(s) and/or dislocation(s): See 11010-11012

Emergency Department: Laceration Repair Classifications

• Involvement of nerves, blood vessels, and tendons are reported under those appropriate systems.
  – Complex repair may be coded separately
    • Modifier -59
Emergency Department

• Areas of caution
  – Electrocardiograms
    • Coding for technical component (93005)
  – Do not assign 93000 if the EKG will be read by the physician and the professional component reported on a separate claim

Outpatient Clinics

• Evaluation and Management
  – Same standards as outlined previously
  – Different clinics within the same facility can have different criteria
Outpatient Clinics

• Modifiers
  – Modifiers -25 or -27 when necessary
  – May be hard coded or soft coded

Outpatient Clinics

• Areas of caution
  – Biopsies
    • Per Lesion not Per specimen
    • Chargemaster challenges
Outpatient Clinics

• Areas of caution
  – Destruction of lesions
    • Location
    • Type of Lesion
    • Number Treated
    • Chargemaster challenges

Outpatient Clinics

• Areas of caution
  – Injections/Infusions
    • Follow Hierarchy mentioned previously
    • Time must be documented
    • Chargemaster challenges
Outpatient Clinics

• Areas of caution
  – Vaccinations
    • Vaccine Administration
      – Payer Policy
    • Vaccine Product
    • Supporting diagnosis code

Golden Rule

• If it wasn’t documented, it wasn’t done
QUESTIONS

References

• CMS Q&A response: Common Questions about Supervision Requirements for Medicare Payment of Hospital Outpatient Services, April 23, 2010

• 2012 CPT® Professional Edition

• Medicare Claims Processing Manual, Chapter 25
Catrena L Smith, CPC, CCS, CCS-P, PCS
904-777-9515: Phone
888-827-4065: Fax
csmith@aqcconsulting.com: Email