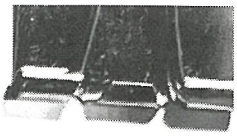


HCPCS Level II Coding Guidelines

AHA Coding Clinic for HCPCS is a resource newsletter that provides coding advice for the users of HCPCS Level II. This quarterly newsletter was first introduced in March 2001 and is published by the AHA's Central Office on HCPCS. The newsletter includes an "Ask the Editor" section providing actual examples, correct code assignment for new technologies, articles, and a bulletin of coding changes and corrections. Although this is not official coding guidance, it is expert. Unlike ICD-10-CM, ICD-10-PCS, and CPT, there are no official coding guidelines for HCPCS Level II other than coverage determinations issued by CMS and its MAC. It is important to keep in mind that coding does not dictate coverage of medical services or reimbursement policies.

Check Your Understanding 10.2

1. The code sets to be used for reporting healthcare services by public and private insurers were designated by what legislation?
2. Dr. Shah is a urologist that performs surgery at Community Hospital. He performs approximately 12 inpatient surgeries per month. His office staff generates claims for his surgeries. What procedure code set should his staff use to report inpatient surgeries on the provider (physician) claim?
3. What organization maintains the ICD-10-CM and ICD-10-PCS code sets?
4. What organization maintains the CPT code set?
5. Which code set includes detailed codes for chemotherapy drugs?

Start here.

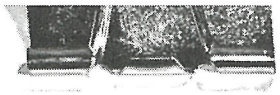
The Coding Process

When care is provided at a facility-based service area two claims for reimbursement are submitted to the payer. One claim is submitted for services and supplies provided by the facility. These charges detail the volume and intensity of resources used to treat the patient. The charges are submitted on the UB-04 or 837-I claim format for facilities. Claim formats are discussed in more detail in chapter 11, "Revenue Cycle Back-End Processes—Claims Production and Revenue Collection," when the claims generation process is explored. The second claim submitted to the payer is for the physician or other health professional services. This claim represents the complexity of the physician work provided during the encounter. Examples of physician work include performing an evaluation, providing a consultation or performing a surgery. These charges are submitted on the CMS 1500 or 837-P claim format for physicians and other health professionals. In the following section, we will discuss the coding process for each claim type.

Facility Coding

Facility coding is the process of determining the diagnosis and procedure codes that should be submitted on the facility claim (UB-04/837I). The facility claim is requesting reimbursement for the hospital or facility, not for the physician. Inpatient admissions and moderate-to-complex ambulatory surgery encounters require coding professionals to assign diagnoses and operating room procedures. Coding professionals read and closely examine the physician documentation to determine the correct diagnosis and procedure codes. This process is often referred to as **soft coding**. During soft coding, diagnoses and procedures are identified, coded, and then abstracted into the HIM coding system. This system works within the EHR to include the codes on the claim form prior to submission to the payer. It is important to remember that numerous services and procedures are hard coded via the CDM and not soft coded. For example, services like chest x-rays and laboratory tests are hard coded. A coding professional does not assign CPT procedure codes for these services. To complete the facility coding process, hard coded services and soft coded diagnoses and procedures are included on the claim format.

Facility coding professionals are trained in ICD-10-CM diagnosis coding, ICD-10-PCS inpatient procedure coding, and HCPCS coding, which is used for outpatient encounters. Facility coding professionals are experts in coding and billing guidance related to facility-based payment systems such as MS-DRGs and APCs, discussed in chapter 5, "Medicare Hospital Acute Inpatient Prospective Payment System," and chapter 7, "Medicare Hospital Outpatient Prospective Payment System," respectively. Most coding units have designated inpatient coding professionals and outpatient coding professionals. This allows the coding professionals to specialize in the code sets, conditions, and procedures that are most often encountered in their assigned role. This approach can improve quality and productivity because the coding professionals become experts in their clinical domains. However, one drawback is that the coding professionals may



lose some of their skill in coding other clinical areas or with other code sets, such as HCPCS. Example 10.2 illustrates the facility coding process.

Example 10.2

At a large metropolitan hospital, the coding team would consist of an inpatient coding team and an outpatient coding team. The inpatient coding team would have coding professionals that excel in ICD-10-CM and ICD-10-PCS coding. The team may even be divided by clinical areas. For example, there may be one or more coding professionals designated to code complex cardiovascular procedures such as heart transplants, implantation of heart assist systems, and coronary artery bypass procedures. Additionally, the team may have a coding professional designated to code deliveries and births. While an uncomplicated birth may be routine and familiar to most coders, complex pregnancies and births are difficult to code and may require a coding professional with extensive experience.

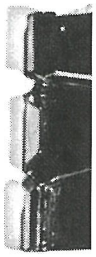
Professional Coding

Like facility coding, diagnosis and procedure codes are required for the professional claim (CMS 1500/837P). Professional coding is performed by coding professionals that specialize in HCPCS coding. As discussed earlier, HCPCS coding consists of CPT coding and HCPCS Level II coding. Remember that physicians and other clinicians report HCPCS codes for the services and procedures they perform regardless of the setting. They do not report ICD-10-PCS codes on professional bills.

Professional coders must be well versed in diagnosis coding. Although professional reimbursement rates are not dependent on diagnosis codes as illustrated in the resource-based relative value scale (RBRVS) section of this text, the diagnosis code(s) are required to determine medical necessity. When completing the professional claim, coding professionals must link the diagnosis code(s) to the associated HCPCS code in order to establish medical necessity. This linking is unique to professional coding. It is also a critical step to receive reimbursement.

Single Path Coding

Traditionally, facility coding and professional coding are separate functions. In most facilities, these functions have different reporting units and managers and may even use different platforms to capture diagnosis and procedure codes. However, there is a growing trend to explore single path coding. **Single path coding** is a process where one coding professional assigns the codes required for both facility and professional claims during the same coding session. Single path coding streamlines the coding processes because it eliminates two different coding teams looking at the same documentation. Instead, one team views the medical documentation one time to complete coding for both the facility and professional claims. Some benefits of single path coding include the following:



- Eliminate duplicate processes
- Optimize productivity
- Enhance coding accuracy
- Reduce or eliminate variances between professional and facility outpatient HCPCS codes (Goar 2018, 22)

Single path coding is especially effective in the outpatient setting, where the procedure coding set, HCPCS, is the same for facility and professional claims. This new approach also lends itself to improving coding performance for risk adjusted coding and hierarchy condition (HCC) coding. While risk adjusted coding models, such as the HCC model implemented by Medicare, are prevalent in the professional reimbursement methodologies, they are migrating toward facility value-based purchasing programs.

Single path coding is more challenging for the inpatient setting, where the coding professional must be well versed in ICD-10-PCS and HCPCS coding. To this point, expanding the coding professional's proficiency in multiple code sets is key. Coding managers should perform a gap analysis to determine which coding professionals need to improve skills in specific code sets.

Most departments moving toward single path coding are using a staged approach (Goar 2018, 22). Facilities may choose to start in one ancillary area, such as radiology. Once success is gained and the process refined, facilities may choose to move on to clinic areas such as pain management, and then finally on to same-day surgery. Since success is dependent on a good single path coding platform, cohesive teamwork, and well-cross-trained coding professionals, implementation throughout all coding processes could take a significant amount of time and resources. However, if gains in quality, productivity, and cost reduction are achieved,

single path coding could improve the facility's revenue integrity position.

Patient Connection

Nick is an analyst at Memorial Hospital. He is reviewing charge capture data for knee arthroplasty surgeries. He is focusing on admissions where the length of stay (LOS) was greater than the Medicare average LOS. He is examining the admission for patient Malakai. The surgeon for the case is Dr. Shah. Nick has created the following table for this admission based on his medical record review.

Patient Care Day	Charge Type	Documented in health record	Reported on claim	Missed charge
1	Operating room	√	√	
	Anesthesia	√	√	
	Pharmacy (pre- and postop meds)	√	√	
	Supply (implants used during surgery)	√	√	
	Recovery room	√		√
	Room rate	√	√	
2	Laboratory tests	√	√	
	Pharmacy (pain medication)	√	√	
	Supply (pressure stockings)	√	√	
	Physical therapy	√	√	
	Respiratory therapy	√		√
	Room rate	√	√	
3	Pharmacy (pain medication and laxative)	√	√	
	Physical therapy	√	√	
	Respiratory therapy	√		√
	Room rate	√	√	
4	Physical therapy	√	√	
	Occupational therapy	√	√	
	Respiratory therapy	√		√
	Room rate	√	√	
5	Laboratory test – culture	√		√
	Pharmacy (IV antibiotic)	√	√	
	Physical therapy	√	√	
	Occupational therapy	√	√	
	Respiratory therapy	√		√
	Room rate	√	√	
6	No charges (discharged in morning)	√		

Through analysis, Nick identified that several charges were missed during the charge capture process for this admission. Patient Malakai was moved to the recovery room after surgery, but the charge was not captured through the CPOE. Malakai was given respiratory therapy on days 2, 3, 4, and 5, but none of these charges were captured. Lastly, patient Malakai had a wound culture on day 5 that identified a surgical wound infection. This charge was not captured in the CPOE.

After reviewing over 50 patient records, Nick found several similar missed charges. His summary recommends the following next steps:

- Meet with the director of respiratory therapy to determine the root cause of the missed charges for the ancillary services
- Meet with the laboratory director to perform root cause analysis for missed culture charges
- Meet with the recovery room nurse manager to identify possible causes for missed charges in this area

Through this analysis, Nick identified $72,500 in missed charges, which translated to $20,375 in missed reimbursement.

Chapter 10 Review Quiz

1. How does CPOE reduce errors and improve patient safety?
2. Describe the barcoding process.
3. Identify and discuss a risk area that is of concern when the CDM is not properly maintained.
4. Why is the charge description construction an important CDM task?
5. How does CDM maintenance support the revenue integrity principle of compliance adherence and legitimate reimbursement?
6. Match each coding system on the left with its description of uses on the right.

ICD-10-CM and ICD-10-PCS	____	a. Medical and surgical supplies
HCPCS Level II	____	b. Physician inpatient or outpatient procedures
CPT	____	c. Diagnoses and inpatient procedures

7. Describe the difference between WHO versions of ICD and US versions of ICD (clinical modification).

(continued)

8. Match the governing bodies on the left with their associated code sets on the right.

CMS	____	a. ICD-10-PCS
NCHS	____	b. CPT
AMA	____	c. ICD-10-CM

9. Describe the differences between hard and soft coding.

10. How does single path coding support the revenue integrity principle of obtaining operational efficiency?

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