HCPro's
Medicare Compliance
Training Series

Medicare Compliance Essentials Training Compendium

With contributions from:
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Debbie Mackaman, RHIA, CPCO, CCDS
Tanja Twist, MBA/HCM
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Table of Contents

About the Contributors v

Introduction vii

Billing for Ancillary Bedside Procedures Training 1

- What Is a Bedside Procedure? 3
- The Importance of Charging and Reporting Bedside Procedures 11
- Separate Reporting Versus Inclusion in the Room Rate 13
- How to Report the Services on a Claim 23
- The Payers Weigh In 27
- Sample Policy 33

Condition Codes 44 and W2 Training 35

- Introduction to Condition Codes W2 and 44 37
- Utilization Review and Condition Codes 44 and W2 43
- Condition Codes 44 and W2 Within the Revenue Cycle 51
- Sample Utilization Review Documentation Form and Sample Patient Notification Letter 57
- Steps for Using the Utilization Review Documentation Form 61
- Additional Resources 63

Patient Status Training Toolkit for Utilization Review 65

- Medicare Requirements for Observation 67
- Medicare Requirements for Inpatient Admission 73
- Utilization Review Requirements and Processes 83
- Notices for Care Not Covered by Medicare 89

Inpatient-Only Procedures 99

- Inpatient-Only Procedure Regulations 101
- The Effects on Reimbursement 109
- Creating Best Practices 117
- Draft Policy 125
- Departmental Checklist for Identifying Inpatient-Only Procedures 131
- Key Resources 133

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Observation Services Training **135**

Medicare Definition of Observation Services 137
Covered and Noncovered Observation 143
Observation Notices 151
Billing for Observation 157

Denials Management Training **163**

Understanding Denials 165
Capturing Your Denial Data 177
Managing Your Denials 181
Denial Prevention and Best Practices 185
Sample Appeal Letters/Templates 187
Helpful Websites 191
Denials Assessment Tool 193

Revenue Integrity Training **195**

Revenue Cycle Integrity: A System Enterprise 197
Other Roles and Responsibilities 217
Cross Functional Management of Revenue Cycle 221
Summary 225
Resources 227

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Introduction

The **Medicare Compliance Essentials Training Compendium** brings together seven of HCPro's most popular Medicare compliance training handbooks into a single collection, offering Medicare professionals a one-stop resource for regulatory and practical guidance.

Developed by industry-leading experts, this compendium simplifies Medicare compliance by providing a go-to source for training on critical billing and reimbursement issues, helping to ensure the delivery of a unified message throughout the organization.

When creating or updating a Medicare training program at your facility, refer to the guidelines in this text as you seek to break down complex regulations into simpler concepts that apply to both new and experienced staff members. The information included here can prove useful in drafting materials for on-boarding as well as providing refresher training for current staff. The handbooks provide easy-to-understand explanations of complex regulatory guidance with thorough references to the original sources for those who are seeking additional information. They also provide operational guidance and supplementary tools and resources, a variety of which can be found at the end of each chapter.

In addition to serving as an excellent resource on its own, this compendium includes unlimited downloadable copies of the following popular Medicare compliance training handbook titles for distribution amongst staff members at your facility:

- **Billing for Ancillary Bedside Procedures Training** will help staff understand CMS' guidelines and regulations and provide guidance for development of policies and procedures to ensure that bedside procedures are billed appropriately. The handbook includes a sample policy with explanations and step-by-step instructions, as well as a clear explanation of Medicare's complex rules governing separate charges for bedside procedures. This handbook educates its readers on when and how to bill separately for bedside procedures and is delivered in an easy-to-reference and distributable format.
- **Condition Codes 44 and W2 Training** helps staff understand when and how to use condition codes W2 and 44, as well as the effects they have on reimbursement and the revenue cycle. This handbook leads readers through the complex decision-making processes regarding the options for rebilling self-denied claims. Providing clear, concise interpretation of complicated regulatory guidance, the handbook presents the information in practical, easy-to-understand terms for a wide range of hospital professionals.
- **Inpatient-Only Procedures Training** analyzes the regulations and provides practical information,

strategies, and best practices for ensuring compliance and preventing denials and lost revenue. The downloadable handbook format will enable easy distribution of this critical education to the wide variety of departments and staff that require training on the topic.

- **Observation Services Training** goes past the definition of observation and discusses billing for observation, coverage of services, and counting of time. This handbook includes relevant information for physicians and is also useful for UR and case management, in addition to hospital staff members who need information about billing.
- **Denials Management Training** provides clear, concise explanations of the complex appeal guidelines for Medicare and other payers. This information is presented in an easy-to-understand handbook for distribution to staff members involved in preventing and handling appeals. This handbook will help you manage the denials management process by providing an overview of common denial types and appeal timelines and exploring best practices for improving the denials management process throughout the revenue cycle.
- **Revenue Integrity Training** will help get everyone, from billers to clinicians, on the same page improving systemic information flow and feedback loops. The revenue cycle in a hospital or health system is a continuum, and each department and role within the cycle has to work in unison to be successful. Due to the nature of today's healthcare environment, some staff may not even realize that they're part of the revenue cycle. If there's a weak link, the entire system can quickly be in trouble due to issues with compliance, reimbursement, and, ultimately, patient care.
- **Patient Status Training Toolkit for Utilization Review** is a quick-reference handbook that will serve as an everyday guide to utilization review (UR). The handbook is a practical guide that UR committee members can keep at their desk to refer to as they work through UR processes. It offers an overview of regulatory requirements for UR that can help guide committee members make sense of medical necessity, condition codes, and patient notices while reviewing cases.

Each of the seven handbooks included in this compendium is available for download in its original stand-alone format at *www.hcpro.com/downloads/12568*. This will enable you to provide staff with a takeaway following any training you may develop around the information included in this compendium.

Each handbook from the downloads page will help ensure staff have a comprehensive and reliable resource

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to which they can refer when questions arise after training. The downloadable handbooks include information about accessing additional resources specific to each topic.

Do you have a team that struggles with just one aspect of Medicare compliance included in this text, such as condition codes W2 and 44? No problem. Maximize efficiency and minimize potential information overload by sharing only the **Condition Codes 44 and W2 Training.** Perhaps a case management staff member has a firm grasp on the difference between covered and non-covered observation but has yet to master the difference between the Advance Beneficiary Notice and the Important Message from Medicare and when to deliver one notice over the other—this compilation has you covered. Simply print off a copy of the Observation Notices section of the **Observation Services Training** and encourage the staff member to keep a copy at his or her desk to refer to when tricky observation cases arise.

Let the **Medicare Compliance Essentials Training Compendium** be your trusted guide to providing critical training across your organization.

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Section 1

Billing for Ancillary Bedside Procedures Training

CHAPTER 1

What Is a Bedside Procedure?

Definition

The first question some might ask is, "What is a bedside procedure?" Although the answer is rather simple, it can be interpreted in different ways. Let's start with the basic definition: A bedside procedure is a procedure that is performed at the patient's bedside. It really is that simple.

However, there are a few other considerations. A procedure in this category typically has a Healthcare Common Procedure Coding System (HCPCS) code associated with it, and it is typically reported when performed in outpatient departments or in a treatment/procedure room.

Some of the most common examples of bedside procedures are:

- Thoracentesis
- Paracentesis
- Lumbar puncture
- Peripherally inserted central catheter (PICC) line insertion
- Insertion of a urinary catheter
- Cardioversion
- Incision and drainage procedures
- Negative pressure wound therapy
- Central line insertion and declotting procedures
- Pleurodesis
- Arthrocentesis and joint injections
- Echocardiograms

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- Biopsies (e.g., bone marrow biopsy)
- Cardiopulmonary resuscitation (CPR)
- Chest tube insertion
- Endotracheal intubation
- Blood transfusions
- Drug administration services

Documentation

Documentation is the key to supporting the HCPCS code and billing the charges for these procedures. Because documentation requirements are the same regardless of the patient's admission status, the documentation described here will support the service whether it is provided to an inpatient or an outpatient. There are some caveats that are unique to certain procedures, and these examples are noted as well.

Documentation basics

Documentation is a written notation that describes and records an event, happening, or conversation. It is a confirmation, certification, or corroboration that something occurred. In healthcare, it serves as the legal medical record of the reasons for and performance of procedures, tests, and services that are ordered for and provided to an individual patient, as well as the patient's response(s) to said treatment (including the refusal of it).

If a physician or non-physician provider (NPP) performs a procedure, he or she must document it. This documentation must include the date and time of the procedure, a procedure note that describes the procedure in detail, and the patient's response to the procedure. The procedure note can be handwritten or dictated, but the provider who performed the procedure must document it.

Physician or NPP procedure note
Dr. Smith performed a paracentesis at bedside on a patient. The documentation should look something like this: *"1/10/16—10 a.m.—Patient complaining of abdominal fullness and being uncomfortable. Ascites has recurred. Paracentesis performed after sterile prep and drape. A 22-gauge needle was inserted into the abdomen, and 1000 cc of yellowish fluid was removed. Patient tolerated the procedure without complaints. Dressing applied to the site."*

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In some cases, hospital staff provide bedside procedures. Documentation begins with a complete and valid order from a physician or an NPP (e.g., a nurse practitioner or a physician's assistant working within his or her scope of practice) who is licensed under state law to direct the care of a patient. The order may read "insert foley catheter to bedside drainage." The purpose of such a physician or NPP order for hospital staff to perform a procedure is to document that the physician or NPP has determined that the procedure is in the best interest of the patient, that it is medically necessary, and that he or she is directing the care of the individual. For Medicare patients, this order also documents that the service is being provided incident to a physician's service.

Note that physicians or NPPs will not necessarily provide orders for procedures that they themselves perform at the bedside because they are directing the patient's care and are licensed to perform the procedure themselves. However, they may do so if they are scheduling a treatment or procedure room or need certain trays or supplies to be provided.

To be complete and valid, the physician or NPP order must be dated, timed, legible, and authenticated by the physician or NPP. The order may start as a verbal or telephone order, but the physician or NPP must authenticate it within the time frame designated by the hospital's bylaws, policies, and procedures. For verbal and telephone orders, the authentication must be timed and dated. This is typically not an issue when the order is electronic and the authentication is applied via digital or electronic signature, as such orders are typically automatically dated and timed when the authentication is applied. However, for orders with a manual signature, the requirement still applies: The signature must be timed and dated for when it was applied.

The Centers for Medicare & Medicaid Services (CMS) devotes an entire section of the *Program Integrity Manual* to defining what constitutes a complete and valid authentication. Certain auditing arms of CMS (e.g., CERT, MAC) are instructed to treat the order as if it wasn't present in the documentation if it's not signed and authenticated.

In addition to generating a valid and complete order, the physician or NPP should also document the need for the procedure in his or her progress note or in the history and physical documentation. The hospital staff member who performs the procedure must document a procedure note in the record.

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Documentation and procedure notes
The order reads: *"Type, crossmatch, and infuse two units of PRBCs over two hours each"* and is signed and dated by Dr. Smith.
The documentation from Nurse Nancy states: *"2/1/16—1 p.m.—Started 18-gauge IV in left forearm. First unit of PRBCs started to infuse over two hours. Patient denies any discomfort at IV site. If she experiences any chills or discomfort at site, she will contact the nurse."*
Vital signs and documentation of checking blood product per hospital policy are provided on the appropriate form that accompanied the unit of blood.
"2/1/16—1:30 p.m.—PRBCs infusing without difficulty. Patient denies any complaints or discomfort at infusion site."
"2/1/16—3:30 p.m.—First unit PRBCs infused without incident. Second unit started. Reiterated instructions to patient for notifying nurse. Patient voices understanding."
"2/1/16—6 p.m.—Second unit of PRBCs infused without incident. IV flushed and capped."

Types and methods of documentation

The actual terms or methods used for documentation vary widely based on whether the documentation is handwritten, electronic, dictated, or template-driven, and there are inherent differences due to the different media available. Still, the content of the documentation is more important than the method of documentation, whether in the physician office setting or in the hospital setting.

The basic requirement of documentation is that it completely and accurately describes the reason or need for a service, as well as the specifics of the procedure/test/service provided. The documentation must show that the physician/NPP determined that a procedure/test/service was required for the individual patient. That is, the documentation must include a notation of what is needed, what is ordered, and why; this requirement applies whether the patient is treated in a physician's office or in a hospital setting.

Two examples of complete documentation appear earlier in this chapter: one for paracentesis and one for blood transfusion service. What follows are some best-practice documentation considerations for the specific bedside procedures listed. These examples may be used as a guide for the type of supporting documentation required for other bedside procedures. Although the exact procedures may be different, the individual components of the supporting documentation are the same (e.g., site, use of sterile precautions, patient response). Note that individual clinical situations may present additional documentation considerations.

Services typically provided by hospital staff upon physician order include the following:

- **PICC and other IV catheter insertions:** Use of sterile procedure precautions; preparation of site; location of insertion; blood return received; dressing applied; line flushed easily or resistance was felt. If resistance was met, note what steps were taken to resolve it.

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- **Insertion of a urinary catheter:** Sterile procedure prep; return of urine; appearance of urine; amount of fluid used to fill the balloon (for indwelling catheter); initial amount of urine returned; and any specimen collected.
- **Negative pressure wound therapy:** Detailed description of the wound assessment, including measurements and type of tissue; application of topical substances; application of the collection system (e.g., pads); instructions provided to the patient or clinical staff who will be maintaining the therapy; whether the therapy is provided by a disposable system or via durable medical equipment (DME).
- **Declotting central line procedures:** Steps taken to flush and aspirate the line; instillation of the declotting substance, including amount and type; time that the substance remained in the line; aspiration of the substance including any resistance encountered; amount and ease of obtaining blood return and flushing the line.
- **CPR:** A specific "code sheet" that includes the drugs administered, procedure(s) performed, and infusions provided is typically used during CPR. However, the presence of this sheet does not alter the requirement for the provider who performed the procedure (e.g., intubation, central line placement, arterial line placement) to provide documentation detailing the procedure performed. For the CPR event, only one line item that captures the cost of the entire procedure should be reported on the claim.
- **Drug administration services:** Substance(s) that was administered via infusion or intravenous push; the time that the infusion started and stopped; actual time that the IV push was administered; and condition of the IV site before, during, and after the infusion. If more than one IV site is being utilized, then the documentation must include what substance(s) is infusing via which line.

Services typically provided by physician/NPP but that involve hospital resources may include the following:

- **Drainage procedures (e.g., thoracentesis, paracentesis, lumbar puncture):** Laterality; needle insertion; type of guidance, if utilized; amount of fluid returned; appearance of the fluid; any drainage catheter left in.
- **Incision and drainage procedures:** Location and description of area prior to procedure (redness, temperature, any drainage, etc.); procedure for incision; appearance and type of drainage; packing or suturing performed; and type of dressing applied. If cultures or specimens are sent to the laboratory, an order is required to support the lab service.

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- **Pleurodesis and similar procedures such as fibrinolysis:** Agent being instilled, including amount and dilution; maneuvers performed to distribute the agent throughout the area (e.g., patient in Trendelenburg for 10 minutes; turned to left side for 5 minutes); aspiration (if any) of agent from the tube/catheter; and the total length of procedure.
- **Arthrocentesis and joint injections:** Sterile prep of area; type of guidance for needle placement (if utilized); needle insertion site; amount of fluid aspirated/drained and/or substances injected; any difficulty aspirating, draining fluid or injecting substances; dressing applied. If cultures or specimens are sent to the laboratory, an order is required to support the lab service.
- **Biopsies (e.g., bone marrow biopsy):** Sterile prep of area; laterality and location; type of needle, trocar, method utilized; amount or adequacy of specimen retrieved; single or multiple sites required; dressing applied. If cultures or specimens are sent to the laboratory, an order is required to support the lab service.
- **Chest tube insertion:** Sterile prep of area; laterality and location; type of needle and/or trocar utilized; type of guidance utilized, if any; amount of specimen retrieved; dressing applied. If cultures or specimens are sent to the laboratory, an order is required to support the lab service.
- **Endotracheal intubation:** This service is reportable only in emergency situations and not when the intubation is related to the provision of anesthesia for a surgical procedure. The documentation should include the circumstances of the emergency situation; type of blade utilized; size of endotracheal tube inserted; confirmation of placement of the tube; and use of ambu bag for oxygenation or placement on ventilator.

Regardless of the procedure, test, or service provided, the patient's response to the procedure should be clearly documented. In addition, all education provided, post-procedure assessments, and communication with other providers (e.g., call placed to physician) should also be documented.

Specific documentation considerations for inpatient procedures

The documentation requirements for a bedside procedure do not change based on whether the procedure is performed on an inpatient or an outpatient. In both cases, the documentation must support the procedure provided, and there must be a physician or NPP order when hospital staff provide the procedure. Some procedures may be considered to be "included in the room rate" and therefore have never been reported separately, but regardless of whether the services are charged as part of the room rate or are charged separately, documentation is still required to support the service was provided.

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Because of the documentation required to support the time and medical necessity of the service, drug administration services present a specific challenge in the inpatient setting. Drug administration services can last for several days in this setting. The challenge is twofold: Do you invest clinicians' time in documenting specifically enough to support charging the services by hours and by IV push, and do you make the time investment required for personnel to validate the services in order to enter the charges?

In an inpatient setting, documentation by the nursing staff typically includes the rate of infusion and the total amount of fluid that the patient received during a specific shift. The details are less clear when an IV is found to be infiltrated and has to be restarted, or when a patient pulls the IV out but no one knows exactly when he or she pulled the IV out. In these situations, the missing component is time. Because the reportable service is the time that the infusion is actually infusing, and any time related to the IV line being discontinued is not part of the infusion time, these situations can present a conundrum. Subsequent chapters will discuss ways to include this service.

Reference

Centers for Medicare & Medicaid Services (CMS). Chapter 3, Section 3.3.2.4. *Program Integrity Manual. www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf.*

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Developed by best-in-class industry-leading experts, this book and training package simplifies essential Medicare compliance training by offering a go-to source for training on critical billing, reimbursement, and compliance issues, helping to ensure compliance across the organization through the delivery of a unified message. The book and associated downloadable handbooks cover topics such as:

- Billing for ancillary bedside procedures
- Patient status training for utilization review
- Observation services
- Condition codes 44 and W2
- Inpatient-only procedures
- Denials management
- Revenue integrity

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