HCPro's

Medicare Compliance Training Handbook

Billing for Ancillary Bedside Procedures

Denise Williams, RN, COC

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Table of Contents

About the Author

Denise Williams, RN, COC

Denise Williams, RN, COC, is the senior vice president of the revenue integrity division and compliance auditor at Revant Solutions, Inc., a company that specializes in revenue management services and outsourced coding services. In both clinical and financial divisions, she has extensive experience assisting providers with understanding and operationally implementing charging mechanisms that fit their established processes, while also assisting in process improvement. Her areas of expertise include documentation improvement to ensure that the legal record supports the services provided and reported to payers, understanding the implications of CMS' Outpatient Prospective Payment System (OPPS), and helping ensure that providers receive appropriate reimbursement for the services provided.

Williams has more than 30 years of healthcare experience and background in multiple areas of nursing. For the past 20 years, she has worked in the field of coding and reimbursement, including performing chart reviews, evaluation and management services, outpatient surgery, and emergency department and observation services. She is a nationally recognized speaker and educator on various coding and reimbursement topics, and is a recognized expert on CMS' OPPS, having been involved with the payment system since its initiation, first as a provider employee and later by educating providers and staff regarding the system methodology.

A published author, Williams has written several articles for the American Association of Professional Coders (AAPC) and is a contributing author to articles published in HCPro's *APC Insider* and *Briefings on APCs*. She has provided education and audited claims and documentation for hospitals in all areas of outpatient services, and she has helped hospital providers work with physicians and non-physician practitioners to ensure that their documentation supports the services they provide. She and her team of subject matter experts work with facility providers all over the United States.

Prior to working with Revant Solutions, Williams was senior vice president for revenue integrity services at Health Revenue Assurance Associates, Inc. (HRAA), and was the corporate chargemaster coordinator for two hospital systems, responsible for the coordination of as many as 16 facility chargemasters. She holds a nursing degree from Middle Tennessee State University.

Introduction

Charging for bedside procedures, especially those provided to inpatients, is a relatively new concept. The industry has long considered the room rate to be a sufficient "catch all" for any services provided to an inpatient. In reality, however, reporting all of these services under the room rate means losing data vital to evaluating the cost of an individual patient's care and appropriate reimbursement. There are other industry trends that support charging for bedside procedures, as well: increased transparency, consistency of charges across patient types and payer types, cost of services for comparison across providers, calculation of what patient care really costs, and scrutiny of the cost of services being provided by a facility, including whether the service line can continue to be supported.

Given that this practice has not been common until recently, hospitals often struggle to decide how to report bedside procedures performed on a nursing unit, even when the patient is an outpatient. Reporting the hours for observation services is relatively easy, but the process for reporting "bedside procedures" can be daunting from an operational perspective—especially when you try to separate those with inpatient admission status from those with outpatient status.

Billing for Ancillary Bedside Procedures is designed to help the reader understand the many steps involved in correctly billing for

ancillary bedside procedures and determining what types of services should be reported separately. This handbook offers strategies for negotiating the path while staying consistent with Medicare guidelines and working through the issues with non-Medicare payers.

We'll also discuss what documentation is required to support the bedside procedures (or any procedures performed) and, thus, to support the charge submitted to the payer. The examples of required documentation elements are just that—examples. Each electronic health record (EHR) has a specific methodology, and each practitioner has his or her own way of stating the facts and documenting the services. Thus, the examples should not be considered the only way to document a service. Other than the elements that are required, your actual documentation may look different.

See the end of this handbook for a sample policy for internal and external documentation to support the charging structure.

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
- 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."*

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.[1] 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.

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.
- **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.

- **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.

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

1. 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*

Hospitals are often concerned that charging separately for bedside procedures will be considered "double dipping"—perhaps rightfully so, because the rules can be complex. As a result, hospitals frequently miss payment for services that can be billed and reported separately by rolling them into charges for room-related or observation services. However, CMS allows facilities to line-report many items that are often thought of as outpatient nursing services (e.g., injections, transfusions, and certain supplies) for both inpatients and outpatients.

The ***Billing for Ancillary Bedside Procedures*** training handbook 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 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.

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