AHIMA Distance Education

# *Facility Coding for ED Services*

## Audio Seminar / Webinar

***November 6, 2008***

***Practical Tools for Seminar Learning***

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## Faculty

### Darice Grzybowski, MA, RHIA, FAHIMA

Darice Grzybowski, MA, RHIA, FAHIMA, is president of HIMentors, a consulting firm specializing in helping hospitals plan and implement electronic health records management solutions and provide operational and best practice assessments and coaching. Ms. Grzybowski previously worked for over 25 years in hospital administration and consulting. She is also on staff as an adjunct assistant professor at several universities.

Contact info: HIMentorsLLC@aol.com

### Tedi G. Lojewski, RHIA, CCS

Tedi G. Lojewski, RHIA, CCS, is coding compliance senior manager for CHAN Healthcare Auditors in St. Louis, MO, where she is responsible for supervising coding compliance audits and providing internal technical coding review for coding compliance staff. Ms. Lojewski has over 30 years experience in HIM, including HIM and coding management, and consultant in a variety of healthcare settings. She is also the coding roundtable coordinator for the Colorado Health Information Management Association.

Contact info: tlojewski@chanllc.com

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- ED Documentation and Management Issues
- ED Coding Specifics
  - Developing ED Guidelines
  - Challenging Coding & Documentation Areas with Case Scenarios (Modifier -25, Critical Care, Drug Administration)
  - ICD-9-CM and Medical Necessity

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## *Polling Question #1*

- Attendee job role?
  - *1 Coder
  - *2 Clinician (nurse, physician, other)
  - *3 Other HIM professional
  - *4 Other

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## *Understanding the Demographics*

- **Who we are?**
- **Where we work?**
- **The Bias of Education & Experience**
- **Change is the Dynamic that Unites Us**

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## *Polling Question #2*

- **Attendee work environment?**
  - ***1 Hospital Based Emergency Dept.**
  - ***2 Urgent Care, Clinic or Standalone ED**
  - ***3 Emergency Billing/Coding Company**
  - ***4 Other**

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## *ED Documentation Issues*

- **Paper, Hybrid and Automated Documents**
- **To Dictate or Not to Dictate**
- **Documentation Accountability**
- **Forms Approval**

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## *ED Documentation Issues*

- **Return Visits**
- **Release of Information – Emergency vs. Routine**
- **Observation Orders**
- **Computer Assisted Coding or Speech Recognition? (technology advancement)**

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## *Polling Question #3*

- **What type of ED documentation does your facility use?**
  - ***1 All paper/handwritten forms**
  - ***2 Hybrid – Combination paper and electronic (including some dictated/automated documentation)**
  - ***3 100% automated/electronic**

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## *ED Coding & Reimbursement*

- **Coding Practice – Revenue Impact**
  - **Charge Capture**
  - **E & M**
  - **Observation**
  - **Late Documentation Completion**
  - **Present on Admission (POA)**

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## *HIM Management Issues in the ED*

- **Statistical review:**
  - **% Admits**
  - **% Observation**
  - **% Return to EMD**
  - **Diagnosis/Procedure trends**
- **Attending physician definition**
- **Follow up lab results**
- **Duplicate number prevention**
- **Confidentiality**

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## *ED Coding Productivity*

- **Who Does the Coding? Credentialed or not?**
- **Abstracted data? Trauma Registry?**
- **Charts per hour/minutes per chart?**
- **Electronic Document Management issues: Scanning?**
- **Physician Practices?**

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## *Polling Question #4*

- **Who performs your ED service coding?**
  - ***1 HIM Department Coders**
  - ***2 EMD Staff**
  - ***3 An outside service**

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## *Best Practices in ED Coding*

- **HIM managed**
- **<24 hour TAT**
- **Complete, CONCISE, current**
- **Electronic (non-dictated)**
- **Controlled observation admit process**
- **Use of encoder and other technology tools**

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## *ED Coding Specifics*

- **Developing ED Facility Level Guidelines**
- **Challenging Coding & Documentation Areas**
- **ICD-9-CM Coding and Medical Necessity Issues**

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## *Polling Question #5*

- **How many years have you been involved with ED Coding?**
  - ***1 Less than 1 year**
  - ***2 2-5 years**
  - ***3 Greater than 5 years**

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## *Developing ED Guidelines – What Does CMS Say?*

- **Hospitals must report ED visits using CPT® -4 E/M codes 99281 – 99285, critical care code 99291**
- **CPT® E/M levels describe physician services**
- **CPT® E/M level descriptions do not adequately describe ED services provided by hospitals**
- **Hospitals must develop their own internal guidelines for reporting ED E/M services**
- **Hospital guidelines must be based on HOSPITAL resources**
- **Hospital level assignment will not necessarily equate to the level reported by the physician**

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## *Developing ED Guidelines – Basic Models*

- **Staff Intervention Models**
  - **AHA/AHIMA Draft Guidelines**
  - **ACEP Guidelines**
- **Time-based Models**
  - **Based on hospital staff face-to-face time**
- **Point Systems**
  - **Time, complexity, and type of staff**
- **Patient Severity Models**
  - **Diagnoses, medical decision making, presenting complaint**

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## *Developing ED Guidelines – Guiding Principles*

1. **Must follow the intent of the CPT® code descriptor**
   - **Designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code**
2. **Must be based on hospital resources, not physician resources**
   - **CMS recognizes that these may be different**
3. **Must be clear**
   - **Facilitate accurate payments**
   - **Usable for compliance purposes and audits**
4. **Must meet HIPAA requirements**

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## *Developing ED Guidelines – Guiding Principles*

5. **No additional documentation requirements beyond what is clinically necessary for patient care**
6. **Must not facilitate upcoding or gaming**
7. **Must be written down, well documented, identify the basis for the selection of a specific code**
8. **Must be applied consistently across patients**

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## *Developing ED Guidelines – Guiding Principles*

9. **Must not change with great frequency**
10. **Must be readily available for MAC/FI review**
11. **Must be verifiable by other hospital staff as well as outside reviewers**

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## *Polling Question #6*

- **What model ED guidelines have you implemented in your facility?**
  - ***1 AHA/AHIMA or modification**
  - ***2 ACEP or modification**
  - ***3 Point system**
  - ***4 Face-to-face time-based model**
  - ***5 Severity-based model**
  - ***6 Other**
  - ***7 Have not implemented**

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## *Developing ED Guidelines – Separately Payable Services*

- **The level of service should not include resource consumption that is otherwise separately payable**
  - **CMS concerns regarding ACEP model**
  - **"Double dipping"**
- **Separately payable services may act as a "proxy" to measure other hospital resources not associated with separately payable services**
- **Hospital must be able to clearly articulate why these services reflect a proxy for additional hospital resource consumption**

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## *Developing ED Guidelines – OPPS 2009 Final Rule*

- **Claims data analysis indicates normal & stable distribution of visit levels**
- **Hospitals are general billing in an appropriate and consistent manner**
- **Continue to use internal hospital guidelines**
- **Goal to ensure that OPPS national or hospital-specific visit guidelines are**
  - **Consistent and accurate**
  - **Resource-based**

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## *Type B Emergency Departments*

- **2007 – Type B Level II HCPCS codes established (G0380 – G0384)**
- **Dedicated EDs that incur EMTALA obligations but do not meet Type A ED definition – i.e., not open 24 hours a day**
- **Data collected resulted in creation of 4 new APCs for 2009**
- **Review FAQ on CMS website**

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## *Challenging CPT® Areas – Modifier -25 Focus*

- **Significant, separately identifiable evaluation and management service**
  - **Above and beyond the other service provided**
  - **Beyond the usual preop/postop care**
  - **Different diagnoses are not required**
  - **Key components of history, examination, and medical decision making must be met**

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## *Challenging CPT® Areas – Modifier -25 Focus*

- **DOJ activity with Medicaid claims**
- **What is separately identifiable in the ED? Has CMS interpretation changed?**
- **Previous OPPS precedent: A-00-40, A-01-80**

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## *Challenging CPT® Areas – Modifier -25 Focus*

- **CMS Transmittals A-00-40 & A-01-81**
  - **Service must meet the definition of "significant, separately identifiable E/M service" as defined by CPT®**
  - **ALWAYS append to ED E/M when provided on the same date as a diagnostic and/or therapeutic medical/surgical procedure**
  - **DO append even if E/M services provided by different professional in facility setting (OPPS)**
  - **DO append when E/M services lead to a decision to perform diagnostic or therapeutic medical/surgical procedure**
  - **DO NOT append if only taking patient's BP, temperature, asking how the patient feels, obtaining written consent - included in procedure, NOT separately identifiable E/M**

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## *Challenging CPT® Areas – Critical Care and OPPS*

- **2008 OPPS Final Rule - 99291**
  - **Minimum of 30 minutes**
  - **Critically ill or critically injured**
  - **Face-to-face staff time**
  - **Multiple staff service provided simultaneously only reported once**
  - **Follow all rules related to CPT®**
  - **Services inclusive in code 99291 cannot be separately billed**
  - **Subtract any time separately reportable**
    - **CPR**
    - **Drug administration**

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## *Challenging CPT® Areas – Critical Care and OPPS*

- **CPT® Rules: Services inclusive in code 99291 cannot be reported separately**
  - **the interpretation of cardiac output measurements (93561, 93562)**
  - **pulse oximetry (94760, 94761, 94762)**
  - **chest x-rays (71010, 71015, 71020)**
  - **blood gases**
  - **information data stored in computers (99090)**
  - **gastric intubation (43752, 91105)**
  - **transcutaneous pacing (92953)**
  - **ventilator management (94002, 94003, 94660, 94662)**
  - **vascular access procedures (36000, 36410, 36415, 36591, 36592, 36600)**

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## *Challenging CPT® Areas – Critical Care and OPPS*

- **Trauma Response Associated with Critical Care**
  - **G0390**
  - **Must be reported with 99291 for higher APC payment**

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## *Challenging CPT® Areas – Critical Care and OPPS*

- **Cardiopulmonary Resuscitation (CPT 92950) found in cardiac arrest only includes the actual bagging of the patient and external cardiac massage**
- **Drugs given during cardiac resuscitation should not be coded separately (see NCCI Policy Manual Chapter XI)**

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## *Challenging CPT® Areas – Critical Care and OPPS*

- **Endotracheal Intubation (CPT® 31500) is an emergency procedure done to establish an airway**
- **Rapid Sequence Intubation (RSI) includes total body paralysis in order to control the scene, paralyze the vocal cords (muscle relaxation) and protect the airway from aspiration. For RSI – IVP drugs are used and should be coded in addition to CPT®**

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## *Challenging CPT® Areas – Critical Care Case Scenario*

- **The History:**

  **Patient arrives to the ED in cardiac arrest. CPR is begun immediately upon arrival, resulting in successful resuscitation of the patient. Patient is stabilized and transferred to a regional cardiac center for further care.**

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## *Challenging CPT® Areas – Critical Care Case Scenario*

- **The Documentation:**
  - **Good forms management providing for separate documentation of critical care time on a critical care flow sheet**
  - **CPR provided by 4 ED staff upon arrival from 1223 to 1246**
  - **Documented continuous monitoring by nursing, one-on-one interventions including lab draws, O2 monitoring, blood gases, airway, pain assessments, vitals from 1246 to 1314**

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## *Challenging CPT® Areas – Critical Care Case Scenario*

- **The Code Assignment:**
  - **Meets definition of critical care**
  - **Total critical care time provided 51 minutes**
  - **Subtract 23 minutes of CPR time**
  - **28 minutes of remaining critical care**
  - **No CPT® code assignment for critical care less than 30 minutes – assign E/M code (e.g., 99285)**

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## *Challenging CPT® Areas – Drug Administration*

- **Coding guidelines for IV infusion, IV injection (IV push) are complex**
- **Must follow AMA CPT® coding guidelines**
- **Documentation of start and stop times, mode/route of administration, location of line and line flushes**

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## *Challenging CPT® Areas – Drug Administration*

- **Primary/Initial Service: hierarchy**
  - **Chemotherapy infusion**
  - **Chemotherapy injection (push)**
  - **Therapeutic/prophylactic/diagnostic infusion**
  - **Therapeutic/prophylactic/diagnostic injection (push)**
  - **Hydration**
- **Only one initial code for each IV line for each episode of care**

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## *Challenging CPT® Areas – Drug Administration*

- **Additional Sequential Service**
  - **Administered in sequence (one after the other)**
  - **Line flush may or may not occur between drugs**
  - **Secondary or subsequent service to the initial service**
  - **Report once per sequential infusion of same "infusate mix"**

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## *Challenging CPT® Areas – Drug Administration*

- **Concurrent Infusion**
  - **Multiple drugs running at the same time through the same line, different bags**
  - **Billable only once per encounter regardless of the number of drugs infused**

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## *Challenging CPT® Areas – Drug Administration*

- **SQ/IM Injection/Vaccine**
  - **Does not affect distinction between primary and secondary**
  - **Report as many times as ordered and administered**

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## *Challenging CPT® Areas – Drug Administration*

- **Hydration**
  - **Do not report hydration less than 30 minutes**
  - **Do not report hydration used only to facilitate administration of another drug**
  - **Do not report KVO, line flush, heplock**
  - **Must be an order for the solution**
  - **CPT® defined solutions – normal saline, lactated ringers, D5W, premixed electrolytes**

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## *Challenging CPT® Areas – Drug Administration*

- **Start and stop times are essential**
- **Calculation nuances for hydration versus infusion**
- **Initial Hydration time must be 31 minutes**

**"31 minutes to 1 hour"**

**= 31 – 90 minutes**

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## *Challenging CPT® Areas – Drug Administration*

- **Initial Infusion must be greater than 15 minutes**

**"up to 1 hour"**
**= 16 – 90 minutes**

- **Each additional hour (hydration or infusion) – may report multiple units**

**"more than 30 minutes beyond 1 hour increments"**
**= 91 – 150 (1 additional hour)**
**= 151 – 210 (2 additional hours)**
**etc.**

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## *Challenging CPT® Areas – Drug Administration Case Scenario*

- **The History:**

  **ED patient presents to a small community hospital with multiple medical problems, including possible CVA, pneumonia, sepsis and septic shock, skin ulcer, R foot. After stabilization, patient is transferred to regional medical center for further specialty care.**

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## *Challenging CPT® Areas – Drug Administration Case Scenario*

**Medication Record:**

| Order | Start | Fluid Vol Hung | IV Rate | Stop |
|---|---|---|---|---|
| 8L NS 500 ml IV bolus then 100 ml/hr | 1525 | NS 1000 ml | 999 ml | 1558 |
| Rocephin 1 gram IV | 1625 | NS 50 ml | 125 ml | 1715 |
| Zithromax 500 mg IV | 1715 | NS 250 ml | 100 ml | 1830 |
| NS 100 ml/hr | 1558 | NS 500 ml | 100 ml | Continues c transfer |
| NS 1 liter IV bolus | | | | |
| Dopamine gtt | 1700 | D5W 250 ml | titrate | Continues c transfer |
| Vancomycin | 1930 | NS 250 ml | 250 | Continues c transfer |

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## *Challenging CPT® Areas – Drug Administration Case Scenario*

**Additional Nursing Notes:**

**1430 #18 IV placed L hand**

**1520 – B/P 71/51 HR 96, reported to PA.**

**NS 500 ml bolus began, sterile dressing applied to R lower extremity**

**1630 – SC #20 to L FA**

**1645 Dopamine 5meq kg/min**

**1715 Dopamine (down arrow) 2.5 meq kg/min**

**1558 saline bolus complete. IV @100 ml/hr**

**1815 NS 500 ml bolus began**

**2000 EMS here to transfer pt via stretcher. Vancomycin infusing without difficulty.**

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## *Challenging CPT® Areas – Drug Administration Case Scenario*

- **Good medication form – includes start and stop times, fluids hung, IV rate, IV volume infused, and initials of provider**
- **Medication record does not specify location of IV line**
- **From nurses notes we know IV place in left hand at 1430**
- **From nurses notes we know a second line was started in the left forearm at 1630**
- **Dopamine start time documented at 1645 per nursing notes, start time 1700 per medication record – conflicting**

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## *Challenging CPT® Areas – Drug Administration Case Scenario*

- **We know that clinically, Dopamine drip and antibiotic would not be infused in the same line**
- **If coder is to accurately assign drug administration codes, must make assumptions or clarify documentation, and coders cannot assume!**
- **Illegibility and wide use of abbreviations**
- **Patient transferred at 2000**

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## *Challenging CPT® Areas – Drug Administration Case Scenario*

**(assumes clarification of documentation of multiple lines)**

**Therapeutic infusions – Line 1:**

**Rocephin 1625–1715 (50 min) = 90765 (initial service, up to 1 hr)**
**Zithromax 1715-1830 (75 min) = 90767 (sequential, up to 1 hr)**
**Vancomycin 1930-2000 (30 min) = 90767 (sequential, up to 1 hr)**

**Therapeutic infusions – Line 2:**

**Dopamine drip in D5W 1700-2000 (180 min) = 90765-59; 90766 x2**
**(initial service, separate line, separate drug)**

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## *Challenging CPT® Areas – Drug Administration Case Scenario*

**Hydration infusions:**

- **NS bolus then 100ml/hr 1525-1558; NS 100 ml/hr 1558-2000**
- **Must carve out 1625-1830 and 1930-2000 for drug delivery**
- **Leaving 1525-1625 (60 minutes) and 1830-1930 (60 minutes) = 90761 (secondary/subsequent service, 120 minutes)**

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## *ICD-9-CM and Medical Necessity*

- **LCDs and NCDs**
- **2009 OIG Work Plan: X-rays in the ED**
- **Official Guidelines for Coding and Reporting**

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## *ICD-9-CM and Medical Necessity – Commonly Missed Diagnoses*

- **Signs and symptoms when appropriate**
- **Chronic diseases when treated or managed**
- **V codes for other factors influencing health status**

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## *ICD-9-CM and Medical Necessity – First-Listed Diagnosis*

- **List first the code for the diagnosis, condition, problem, or other reason shown to be chiefly responsible for the services provided**
- **Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established**

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## *ICD-9-CM and Medical Necessity – First-Listed Diagnosis*

- **Do not code diagnoses documented as "probable", "suspected", "questionable", "rule out", or "working diagnosis" or other similar terms indicating uncertainty**
- **Code the condition to the highest degree of certainty, such as symptoms, signs, abnormal test results, or other reason for the visit**

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## *ICD-9-CM and Medical Necessity – Additional Diagnoses*

- **Code all documented conditions that coexist and require or affect patient care treatment or management**
- **Chronic diseases may be coded and reported as many times as the patient receives treatment and care for the condition**

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## *ICD-9-CM and Medical Necessity – Additional Diagnoses*

- **For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnoses documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.**

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## *ICD-9-CM and Medical Necessity – Additional Diagnoses*

- **V58.6x Long-term (current) drug use**
  - **Continuous use of a prescribed drug for long-term therapy or prophylaxis**
  - **Do not assign for medication administered for a brief period to treat an acute illness/injury (e.g., course of antibiotics to treat acute bronchitis)**

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## *ICD-9-CM and Medical Necessity – New Code*

**V45.88 S/P administration of tPA (rt-PA) in a different facility within the last 24 hours prior to admission to the current facility**

- **Assign as secondary diagnosis only**
- **Applies even if patient is still receiving the tPA**
- **Only applicable to the receiving facility record**

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## *Resource/Reference List*

- **"Medicare Program: Proposed Changes to the Hospital Outpatient Prospective Payment System and CY 2009 Payment Rates", FR Vol. 73, No. 139, July 18, 2008**

  **http://edocket.access.gpo.gov/2008/pdf/E8-15539.pdf**

- **CY 2009 Outpatient Prospective Payment System Final Rule – (pre-publication to Federal Register)**

  **http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CMS-1404-FC.pdf**

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## *Resource/Reference List*

- **CMS, "OPPS Guidance on Visit Codes"**
  **www.cms.hhs.gov/HospitalOutpatientPPS/downloads/OPPS_Q&A.pdf**
- **CMS, "January 2008 Update of the Hospital Outpatient Prospective Payment System (OPPS)", Transmittal 1417, January 18, 2008**
  **www.cms.hhs.gov/transmittals/downloads/R1417CP.pdf**

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## *Resource/Reference List*

- **CMS, "Draft Visit Guidelines for Hospital Outpatient Care", June 1, 2006**
  **www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CMS1506P_Draft_AHA_AHIMA_Guidelines.pdf**
- **CMS, "Use of Modifier -25 and Modifier -27 in the Hospital Outpatient Prospective Payment System (OPPS)", Transmittal A-01-80, June 29, 2001**
  **www.cms.hhs.gov/Transmittals/downloads/A0180.pdf**
- **CMS, "Further Information on the Use of Modifier -25 in Reporting Hospital Outpatient Services", Transmittal A-00-40, July 20, 2000**
  **www.cms.hhs.gov/Transmittals/downloads/A0040.pdf**

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## *Resource/Reference List*

- **"Update on Hospital Clinic and Emergency Department Visit Coding", AHA Coding Clinic for HCPCS Vol 7, No 4 (4th Q 2007)**
- **ACEP ED Facility Level Coding Guidelines**
  **http://www.acep.org/practres.aspx?id=30428**
- **AMA, CPT® Assistant – 2007 issues on drug administration (May, June, September); Q&A section (Nov/Dec)**

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## *Resource/Reference List*

- **OIG Work Plan Fiscal Year 2009**
  **www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf**
- **ICD-9-CM Official Guidelines for Coding and Reporting, Effective October 1, 2008**
  **www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf**
- **Coding Assessment and Training Solutions Emergency Room Coding in Hospitals**
  **http://campus.ahima.org/campus/course_info/CATS/CATS_info.html**

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## *Audio Seminar Discussion*

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## *Upcoming Seminars/Webinars*

***Coding Clinic*** **Update**
**November 20, 2008**

**2009 CPT® Update**
**December 4, 2008**

**Coding Septicema, SIRS, and Sepsis**
**December 11, 2008**

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# Appendix

# Appendix

## Resource / Reference List


http://edocket.access.gpo.gov/2008/pdf/E8-15539.pdf

http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CMS-1404-FC.pdf

www.cms.hhs.gov/HospitalOutpatientPPS/downloads/OPPS_Q&A.pdf

www.cms.hhs.gov/transmittals/downloads/R1417CP.pdf

www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/CMS1506P_Draft_AHA_AHIMA_Guidelines.pdf

www.cms.hhs.gov/Transmittals/downloads/A0180.pdf

www.cms.hhs.gov/Transmittals/downloads/A0040.pdf

http://www.acep.org/practres.aspx?id=30428

www.oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf

www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/icdguide08.pdf

http://campus.ahima.org/campus/course_info/CATS/CATS_info.html

**Drug Administration Code 2008 to 2009 Crosswalk**

| 2008 HCPCS Code | Short Descriptor | SI | APC | Relative Weight | Payment Rate | 2009 HCPCS Code | Short Descriptor | SI | APC | Relative Weight | Payment Rate |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 90760 | Hydration iv infusion, init | S | 0440 | 1.7998 | 114.64 | 96360 | Hydration iv infusion, init | S | 0438 | 1.1152 | 73.67 |
| 90761 | Hydrate iv infusion, add-on | S | 0437 | 0.3945 | 25.13 | 96361 | Hydrate iv infusion, add-on | S | 0436 | 0.3768 | 24.89 |
| 90765 | Ther/proph/diag iv inf, init | S | 0440 | 1.7998 | 114.64 | 96365 | Ther/proph/diag iv inf, init | S | 0439 | 1.947 | 128.62 |
| 90766 | Ther/proph/dg iv inf, add-on | S | 0437 | 0.3945 | 25.13 | 96366 | Ther/proph/dg iv inf, add-on | S | 0436 | 0.3768 | 24.89 |
| 90767 | Tx/proph/dg addl seq iv inf | S | 0437 | 0.3945 | 25.13 | 96367 | Tx/proph/dg addl seq iv inf | S | 0437 | 0.5469 | 36.13 |
| 90768 | Ther/diag concurrent inf | N | | | | 96368 | Ther/diag concurrent inf | N | | | |
| 90769 | Sc ther infusion, up to 1 hr | S | 0440 | 1.7998 | 114.64 | 96369 | Sc ther infusion, up to 1 hr | S | 0438 | 1.1152 | 73.67 |
| 90770 | Sc ther infusion, addl hr | S | 0437 | 0.3945 | 25.13 | 96370 | Sc ther infusion, addl hr | S | 0437 | 0.5469 | 36.13 |
| 90771 | Sc ther infusion, reset pump | S | 0438 | 0.8041 | 51.22 | 96371 | Sc ther infusion, reset pump | S | 0436 | 0.3768 | 24.89 |
| 90772 | Ther/proph/diag inj, sc/im | S | 0437 | 0.3945 | 25.13 | 96372 | Ther/proph/diag inj, sc/im | S | 0436 | 0.3768 | 24.89 |
| 90773 | Ther/proph/diag inj, ia | S | 0438 | 0.8041 | 51.22 | 96373 | Ther/proph/diag inj, ia | S | 0437 | 0.5469 | 36.13 |
| 90774 | Ther/proph/diag inj, iv push | S | 0438 | 0.8041 | 51.22 | 96374 | Ther/proph/diag inj, iv push | S | 0437 | 0.5469 | 36.13 |
| 90775 | Tx/pro/dx inj new drug addon | S | 0438 | 0.8041 | 51.22 | 96375 | Tx/pro/dx inj new drug addon | S | 0437 | 0.5469 | 36.13 |
| 90776 | Tx/pro/dx inj same drug adon | N | | | | 96376 | Tx/pro/dx inj same drug adon | N | | | |
| 90779 | Ther/prop/diag inj/inf proc | S | 0436 | 0.2545 | 16.21 | 96379 | Ther/prop/diag inj/inf proc | S | 0436 | 0.3768 | 24.89 |

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