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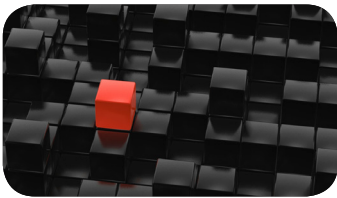
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## FEATURE ARTICLE

### RACs: What Do We Know Now?



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It has been two years since the Recovery Audit Contractor (RAC) demonstration program ended in March 2008, writes Brown. We have seen evaluation reports supporting the continued use of the RACs. We know Section 302 of the Tax Relief and Health Care Act of 2006 declared the RAC program as permanent. But what do providers need to know? And what's necessary for them to enhance quality improvement initiatives? Brown explains what providers need to know and what they need to do to embrace for the inevitable.

## DOC2DOC



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### How Practical are Nurse Practitioners?

Thinking of hiring a nurse practitioner (NP) for your busy practice? An NP can bring in about half of his or her salary, and physician practices usually make a profit from their NP employees, writes Denise Nash, MD. Having an NP in your practice may not be as easy as it seems. State laws on NP scope of practice vary widely, and may affect how you bill for their services. Types of services covered are limited to state law. And with these income opportunities come the responsibilities of compliance with payors' rules, advises Dr. Nash.

## TALKING POINTS



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### All Burned Out: Diagnosis Coding for Burns

When it comes to diagnosis coding for burns, several of the coding conventions in ICD-9-CM remain the same in ICD-10, but there are some changes. Coders could get burned if they're not aware of them, advises Darnacea Harris, MHA, RHIT, CCS.

## MODIFIERS CORNER



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### NCCI-associated Modifiers: Use to Prevent Denied Claims

The NCCI-associated modifiers are used to prevent the denial of a Column 2 code when reporting multiple procedures that trigger a CCI edit, reports Sandy Palmer, RHIT. They inform the payor that a valid reason exists for reporting both codes even though a CCI edit exists for the pair.

#### ALSO...

From getting the boot – in this case, the Unna Boot – to assigning Revenue Code 279 to implants of temporary items, we have your [FAQs](#).

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## RACs: What Do We Know Now?

IT has been two years since the Recovery Audit Contractor (RAC) demonstration program ended in March 2008. We have seen evaluation reports and RAC status documents supporting the continued use of the RACs. We know that Section 302 of the Tax Relief and Health Care Act of 2006 declared the RAC program as permanent. This permanency requires greater transparency. Therefore, providers need to know which RAC is assigned to cover their regions, the target areas under review, and take into consideration the identification of those reviews to develop or enhance quality improvement initiatives.

### Who Are The RACs

Contracts for the four RAC regions were awarded by CMS in October of 2009. Region A, covering the states Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island and Vermont, was awarded to Diversified Collection Services, Inc (DCS).

DCS is a subsidiary of Performant Financial Corporation and has experience performing recovery audit reviews. DCS will be subcontracting with PRG-Schultz, Inc. PRG-Schultz has worked with Medicare in the past and was part of the RAC demonstration in California. PRG-Schultz will conduct Part A and Part B audits in

MAC Jurisdiction 14 for home health/hospice audits in all states in Region A. In addition to PRG Shultz, DCS will also be subcontracting with iHealth Technologies and Strategic Health Solutions. However, DCS will remain totally responsible for the direct oversight of the subcontractors. DCS has the second highest contingency fee (12.45%) among all the RACs and, currently, the least amount of targeted areas identified on their Website ([www.dcsrac.com/issues.html](http://www.dcsrac.com/issues.html)).

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As with the other RACs, DCS will be posting the targeted areas of review after receiving approval from CMS. Although DCS did not publish its issues as quickly as some of the other RACs, it has identified automated review for overpayments on oxygen accessories, lower limb suction valve prosthesis, prosthetic additions and

Clinical Social Worker (CSW) services to name a few. It has also included some DRG Validation issues related to MS-DRGs for Tracheostomy, Ventilator Support and Pulmonary Edema & Respiratory Failure. Providers should carry out due diligence in reviewing the Medicare billing, reimbursement and coding guidelines applicable to the target areas.

The RAC contract for Region B was awarded to CGI Technologies and Solutions, Inc. Region B includes Michigan, Indiana, Minnesota, Illinois, Kentucky, Ohio and Wisconsin. CGI was founded in 1976. As with DCS, CGI will also subcontract with PRG Schultz for auditing support. PRG Schultz will audit Part A/B Medicare Administrative Contractor (MAC) claims in Minnesota and Wisconsin. It will also audit home health claims and durable medical equipment for Region B.

CGI has the highest contingency fee (12.50%) among the RACs and the CGI Website provides an extensive list of potentially high-risk targets ([www.racb.cgi.com](http://www.racb.cgi.com)). Providers in Region B should thoroughly review the posted issues, including 38 complex reviews involving DRG Validation.

Some of the issues include MS-DRGs for Tracheostomy, Ventilator, Septicemia, Major Chest Procedures, Renal Failure and more.

	REGION A	REGION B	REGION C	REGION D
STATES	Connecticut Delaware District of Columbia Massachusetts Maine Maryland New Hampshire New Jersey New York Pennsylvania Rhode Island Vermont	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi New Mexico North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas U. S. Virgin Islands Virginia West Virginia	Alaska Arizona California Hawaii Idaho Iowa Kansas Missouri Montana Nebraska Nevada North Dakota Oregon South Dakota Utah Washington Wyoming
RAC	<b>DIVERSIFIED COLLECTION SERVICES, INC. (DCS)</b>	<b>CGI TECHNOLOGIES AND SOLUTIONS, INC. (CGI)</b>	<b>CONNOLLY, INC.</b>	<b>HEALTHDATAINSIGHTS (HDI)</b>

The automated review list is not as lengthy as the complex review list. Only 12 issues have been identified for review and some will be related to hospital outpatient visits.

The designated RAC for Region C is Connolly, Inc. Region C includes Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, North Carolina, New Mexico, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia and the territories of Puerto Rico and the U.S. Virgin Islands.

Connolly was established in 1979 specifically for the purpose of recovery auditing. The company considers itself to be a pioneer in the technique of data mining, which is used today to identify overpayment and underpayments. In the past, the organization has reviewed and detected inappropriate Medicare payments to providers and was part of the RAC demonstration in New York and Massachusetts.

Connolly has subcontracted with Viant for assistance in the CMS reviews. Viant participated as a subcontractor to PRG Schultz in the demonstration program and will be providing Part A Complex Reviews.

Connolly's contingency fee is the lowest (9%) of all the RACs and it has posted to its Website ([www.connollyhealthcare.com/RAC](http://www.connollyhealthcare.com/RAC)) over 70 complex reviews for DRG Validation. The enormity of these statistics should not come as a surprise, considering that Connolly reviewed over \$150 billion in paid medical claims in 2008. It analyzed the root causes of the improper payments and provided CMS with attainable process improvement advice. The automated reviews they have posted only represent about 20 percent of all the issues identified.

By far, Connolly's focus area list appears to be the most intimidating in sheer numbers only. Connolly has historical knowledge and experience in the analysis of payment errors.

The fourth and last contractor to be awarded a CMS contract was HealthDataInsights, Inc (HDI). HDI covers Region D that includes Washington, Oregon, California, Alaska, Hawaii, Nevada, Idaho, Montana, Utah, Arizona, Wyoming, North Dakota, South Dakota, Nebraska, Kansas, Iowa and Missouri. HGI was the claim-level RAC in Florida and South Carolina for the demonstration program.

PRG will be the subcontractor for HDI and it will audit Part A/B Medicare Administrative Contractor claims for Idaho, Oregon and Washington. PRG will also audit the home health claims in this region.

HDI has the second lowest contingency fee (9.49%) and has identified a wide-range of issues on their Website ([www.racinfo.healthdatainsights.com](http://www.racinfo.healthdatainsights.com)). HDI has 48 DRG Validations and a mixture of hospice, MUEs, etc. The list duplicates a number of the issues identified in Region C. However, the non-DRG Validation reviews account for about 41 percent of all the issues posted for HDI, which is 21 percent more than those for Connolly.

RACs are not permitted to educate providers on Medicare policy. However, it is within their scope to educate providers on their business process and purpose. RACs are charged with identifying Medicare under- and overpayments and recouping overpayments. This is accomplished by way of a review process by which post payment claims are identified for incorrect coding, the presence of duplicate claims and claims reimbursed inaccurately due to outdated fee schedules. Moreover, these reviews are applicable to physicians, nursing homes,

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## Refer to other resources to identify areas for quality improvements such as the Program for Evaluation Payment Patterns Electronic Report (PEPPER), the Comprehensive Error Rate Testing program (CERT) and OIG audits.

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hospitals, home health agencies, skilled nursing facilities and medical suppliers.

### What Are The RACs Reviewing?

Reviews are identified based on the MS-DRG assigned to each case. The regions are using the same mix of MS-DRG selection, for the most part. Be sure to watch for updates in the medical necessity component of the reviews. Below are some examples of MS-DRGs that the RAC is reviewing.

#### Issue Name:

Percutaneous Cardiovascular Procedure with Drug Eluting Stent with MCC or 4+ Vessels/Stents: MS-DRG 246 (At this time, Medical Necessity excluded from review)

#### Description:

DRG Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate for MS-DRG 246, previously DRG 557 and 558, principal diagnosis, secondary diagnosis and procedures affecting or potentially affecting the DRG.

#### Provider Type Affected:

Inpatient Hospital

#### Issue Name:

Full Thickness Burn with Skin Graft or Inhalation Injury without CC/MCC: MS-DRG 929 (At this time Medical Necessity excluded from review)

#### Description:

DRG Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record. Reviewers will validate for MS-DRG 929, previously DRG 506 and 507, principal diagnosis, secondary diagnosis and procedures affecting or potentially affecting the DRG.

#### Provider Type Affected:

Inpatient Hospital

### What Should You Do Now?

Investigate all the issues that have been previously identified by the RACs. Refer to other resources to identify areas for quality improvements such as the Program for Evaluation Payment Patterns Electronic Report (PEPPER), the Comprehensive Error Rate Testing program (CERT) and OIG audits. Taken together, these reports should be considered as stepping stones to enhancing or developing your organization's quality initiatives.

In addition, Revenue Integrity departments should be aware of MS-DRG risk areas and monitor coding and billing activities to ensure compliance with federal and state regulatory agencies. The more comprehensive the internal initiatives, the better the outcome for your facility.

### CMS Announces A Series of Nationwide RAC 101 Calls

Presented by CMS, the RAC conference call will discuss the RAC operational process and offer opportunities for questions

regarding the RAC processes. Registration is not required for the calls. Go to [www.cms.gov/RAC/03\\_RecentUpdates.asp#TopOfPage](http://www.cms.gov/RAC/03_RecentUpdates.asp#TopOfPage) for session schedules.

### About the Author

Jennie Brown is a Senior Claims Capture Audit Integrity Analyst for MedAssets. She is a Registered Health Information Technician and a Certified Professional Coder with over 20 years experience in the healthcare environment. She has served as a Coder, Coding Consultant, Coding Supervisor, Compliance Auditor and HIMS Department Manager. She has been an instructor for Medical Office Skills Continuing Education (ICD-9-CM, CPT Coding, Anatomy Based Medical Terminology) and has presented seminars/webinars on Fraud and Abuse, RAC and Billing Compliance. ■

### REFERENCES

**The Centers for Medicare and Medicaid Services Recovery Audit Contractor**  
[www.cms.hhs.gov/RAC](http://www.cms.hhs.gov/RAC)

**CGI Group, Inc.**  
[www.racb.cgi.com](http://www.racb.cgi.com)

**Connolly Healthcare**  
[www.connollyhealthcare.com/RAC/Pages/cms\\_RAC\\_Program.aspx](http://www.connollyhealthcare.com/RAC/Pages/cms_RAC_Program.aspx)

**DCS Healthcare Services**  
[www.dcsrac.com](http://www.dcsrac.com)

**HealthDataInsights**  
<https://racinfo.healthdatainsights.com>



## How Practical are Nurse Practitioners?

**Are** you thinking of hiring a nurse practitioner (NP) for your busy practice? An NP can bring in about half of his or her salary, and physician practices usually make a profit from their NP employees particularly since the 1997 Balanced Budget Act (BBA) liberalized Medicare coverage of nurse practitioner (NP) services effective January 1, 1998.

Prior to the BBA, Medicare limited coverage by setting and place of service. For example, coverage was limited to rural areas or nursing facilities.

Having an NP in your practice, may not be as easy as it seems. Why, you may ask? Because state laws on the NP scope of practice vary widely, and may affect how you bill for their services. Types of services covered are limited to state law. And with these income opportunities come the responsibilities of compliance with payors' rules. Be aware that the government is stepping up efforts to audit billings, recover money and impose fines when mistakes are uncovered. Penalties for healthcare fraud and abuse can be severe.

You should also be aware of the buzz words: collaboration and "incident to," What are the differences?

### Collaboration

Collaboration is a process in which a NP works with one or more physicians to deliver healthcare services, with medical direction as required by the law of the state in which the services are furnished.

For example, the guidelines for NPs in Massachusetts require that all nurses practicing in the expanded role must practice in accordance with written guidelines. These are developed in collaboration with and mutually acceptable to:

1. The individual physician; or
2. The appropriate medical staff and nursing administrative staff of the institution employing the NP.

In all cases, the written guidelines must designate a physician who will provide medical direction as is customarily accepted in the specialty area. Guidelines may authorize the nurse's performance of any professional activities included within her or his area of practice. The guidelines shall:

- Specifically describe the nature and scope of the nurse's practice
- Describe the circumstances in which physician consultation or referral is required
- Describe the use of established procedures for the treatment of common medical conditions which the nurse may encounter
- Include provisions for managing emergencies (Board of Registration in Nursing (BORN) Rules and Regulations)
- Guidelines must be reviewed every two years with the supervising physician

In the absence of state law governing collaboration, it is to be evidenced by NPs documenting their scope of practice and indicating the relationship they have with physicians to deal with issues beyond their scope of practice. The collaborating

physician does not need to be present with the NP when the services are furnished or to make an independent evaluation of each patient who is seen by the NP.

### Incident to

"Incident to" a physician's professional services, means services are furnished as an integral (incidental) part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. Therefore, services must be performed under the physician's direct supervision. This means the physician must be present in the office suite and immediately available to furnish assistance and direction. In order for incidental services to be covered they must meet criteria:

- Integral (incidental) part of the physician's professional service
- Rendered without charge or included as part of the physician's bill
- The service is of the type that is furnished in physician's offices or clinics
- Furnished under the physicians direct supervision

### How does collaboration and "incident to" translate into reimbursement?

Since "incident to" is considered an incidental part of the physician's professional service, reimbursement would be at the allowable for the physician's fee schedule.

With collaboration, the payment for a NP would be 80 percent of the lesser of either the allowable charge or 85 percent of the physician's fee schedule amount. Payments

are allowed for “assistant at surgery” (‘AS’ modifier appended to surgical claim) as long as it is applicable under state licensure laws.

So which type of arrangement is right for your facility? The easiest to implement, if restricted by state law, is the collaboration model because it does not require the physician’s immediate presence in the office suite. However, the reimbursement is decreased. With “incident to” you will receive the full allowable but the requirements are stricter and remain on the OIG audit radar.

Below is a grid applicable to Physician Assistant (PA), Nurse Practitioner (NP),

Clinical Nurse Specialist (CNS) and Certified Nurse Midwives (CNM).

All of the below information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by CMS, are revised or implemented. For additional information please go to the CMS Internet Only Manual (IOM) Publication 100-2, Chapter 15 and Publication 100-4, Chapter 12 which can be found at [www.cms.hhs.gov/manuals](http://www.cms.hhs.gov/manuals).

**About the Author**

Denise M. Nash MD, CCS, CIM, is a senior financial consultant with MedAssets. Denise has more than 20 years experience in the healthcare industry. She has worked for

CMS in hospital auditing and has expertise in negotiation and implementation of risk contracting for managed care plans. She has worked with individuals as well as physician groups on utilization improvements to improve financial performance for the risk-based contracts. Denise has a solid understanding of key public and private payor policies, payment methodologies coding and coverage. She has worked with both hospitals and physician practices on the legal aspects of adding new services to the respective facilities. Denise is a consultant on compliance/HIPAA at physician practices, hospitals, and insurance plans and has worked for the OIG of NH for the Fraud and Abuse Division. ■

	PA	NP	CNS	CNM
QUALIFICATIONS	<p>Graduated from a physician assistant educational program that is accredited by the Accreditation Review Commission on Education for the Physician Assistant (its predecessor agencies, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the Committee on Allied Health Education and Accreditation (CAHEA)); or</p> <ul style="list-style-type: none"> <li>Passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants (NCCPA); and</li> <li>Be licensed by the State to practice as a physician assistant.</li> </ul>	<p>NPs who applied for a Medicare billing number for the first time from January 1, 2001, through December 31, 2002 must meet the requirements as follows:</p> <ul style="list-style-type: none"> <li>Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; and</li> <li>Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners.</li> </ul> <p>NPs who apply for a Medicare billing number for the first time on or after January 1, 2003, must meet the requirements as follows:</p> <ul style="list-style-type: none"> <li>Be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law;</li> <li>Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; and</li> <li>Possess a master’s degree in nursing.</li> </ul>	<ul style="list-style-type: none"> <li>Be a registered nurse who is currently licensed to practice in the State where he or she practices and be authorized to furnish the services of a clinical nurse specialist in accordance with State law;</li> <li>Have a master’s degree in a defined clinical area of nursing from an accredited educational institution; and</li> <li>Be certified as a clinical nurse specialist by a recognized national certifying body that has established standards for CNSs.</li> </ul>	<ul style="list-style-type: none"> <li>Be currently licensed to practice in the State as a registered professional nurse; and</li> </ul> <p>Meet one of the following requirements:</p> <ul style="list-style-type: none"> <li>Be legally authorized under State law or regulations to practice as a nurse- midwife and have completed a program of study and clinical experience for nurse-midwives, as specified by the State; or</li> <li>If the State does not specify a program of study and clinical experience that nurse-midwives must complete to practice in that State, the nurse-midwife must:</li> <li>Be currently certified as a nurse-midwife by the American College of Nurse-Midwives;</li> <li>Have satisfactorily completed a formal education program (of at least one academic year) that, upon completion, qualifies the nurse to take the certification examination offered by the American College of Nurse-Midwives; or</li> <li>Have successfully completed a formal education program for preparing registered nurses to furnish gynecological and obstetrical care to women during pregnancy, delivery, and the postpartum period, and care to normal newborns, and have practiced as a nurse-midwife for a total of 12 months during any 18-month period from August 8, 1976, to July 16, 1982.</li> </ul>

	PA	NP	CNS	CNM
COVERED SERVICES	<p>Coverage is limited to the services a PA is legally authorized to perform in accordance with State law (or State regulatory mechanism provided by State law). The services of a PA may be covered under Part B, if all of the following requirements are met:</p> <ul style="list-style-type: none"> <li>• They are the type that are considered physician’s services if furnished by a doctor of medicine or osteopathy (MD/DO);</li> <li>• They are performed by a person who meets all the PA qualifications;</li> <li>• They are performed under the general supervision of an MD/DO;</li> <li>• The PA is legally authorized to perform the services in the state in which they are performed; and</li> <li>• They are not otherwise precluded from coverage because of one of the statutory exclusions.</li> </ul>	<p>Coverage is limited to the services a NP is legally authorized to perform in accordance with State law (or State regulatory mechanism established by State law). The services of a NP may be covered under Part B if all of the following conditions are met:</p> <ul style="list-style-type: none"> <li>• They are the type that are considered physician’s services if furnished by a doctor of medicine or osteopathy (MD/DO);</li> <li>• They are performed by a person who meets the definition of a NP;</li> <li>• The NP is legally authorized to perform the services in the State in which they are performed;</li> <li>• They are performed in collaboration with a MD/DO, and</li> <li>• They are not otherwise precluded from coverage because of one of the statutory exclusions.</li> </ul>	<p>Coverage is limited to the services a CNS is legally authorized to perform in accordance with State law (or State regulatory mechanism provided by State law). The services of a CNS may be covered under Part B if all of the following conditions are met:</p> <ul style="list-style-type: none"> <li>• They are the types of services that are considered as physician’s services if furnished by an MD/DO;</li> <li>• They are furnished by a person who meets the CNS qualifications;</li> <li>• The CNS is legally authorized to furnish the services in the State in which they are performed;</li> <li>• They are furnished in collaboration with an MD/DO as required by State law; and</li> <li>• They are not otherwise excluded from coverage because of one of the statutory exclusions.</li> </ul>	<p>Coverage is available for services furnished by a CNM that he or she is legally authorized to perform in the State in which the services are furnished and that would otherwise be covered if furnished by a physician, including obstetrical and gynecological services.</p>
EXCLUDED SERVICES	<p>PA services may not be covered if they are otherwise excluded from coverage even though a PA may be authorized by State law to perform them.</p>	<p>NP services may not be covered if they are otherwise excluded from coverage even though a NP may be authorized by State law to perform them.</p>	<p>A CNS’s services are not covered if they are otherwise excluded from coverage even though a CNS may be authorized by State law to perform them.</p>	<p>The services of CNMs are not covered if they are otherwise excluded from Medicare coverage even though a CNM is authorized by State law to perform them. Coverage of service to the newborn continues only to the point that the newborn is or would normally be treated medically as a separate individual. Items and services furnished the newborn from that point are not covered on the basis of the mother’s eligibility.</p>
PHYSICIAN SUPERVISION	<p>The PA’s physician supervisor (or a physician designated by the supervising physician or employer as provided under State law or regulations) is primarily responsible for the overall direction and management of the PA’s professional activities and for assuring that the services provided are medically appropriate for the patient. The physician supervisor (or physician designee) need not be physically present with the PA when a service is being furnished to a patient and may be contacted by telephone, if necessary, unless State law or regulations require otherwise.</p>	<p>It is the responsibility of the supervising physician to direct and review the work, records, and practice of the NP on a continuous basis to ensure that appropriate directions are given and understood and that appropriate treatment is rendered consistent with applicable state law. Supervision includes, but is not limited to:</p> <ol style="list-style-type: none"> <li>1 the continuous availability of direct communication either in person or by electronic communications between the NP and supervising physician;</li> <li>2 the personal review of the NPP’s practice at regular intervals including an assessment of referrals made or consultations requested by the NP with other health professionals;</li> <li>3 regular chart review;</li> <li>4 the delineation of a plan for emergencies;</li> <li>5 the designation of an alternate physician in the absence of the supervisor; and</li> <li>6 review plan for narcotic/controlled substance prescribing and formulary compliance.</li> </ol>	<p>It is the responsibility of the supervising physician to direct and review the work, records, and practice of the NP on a continuous basis to ensure that appropriate directions are given and understood and that appropriate treatment is rendered consistent with applicable state law. Supervision includes, but is not limited to:</p> <ol style="list-style-type: none"> <li>1 the continuous availability of direct communication either in person or by electronic communications between the NP and supervising physician;</li> <li>2 the personal review of the NPP’s practice at regular intervals including an assessment of referrals made or consultations requested by the NP with other health professionals;</li> <li>3 regular chart review;</li> <li>4 the delineation of a plan for emergencies;</li> <li>5 the designation of an alternate physician in the absence of the supervisor; and</li> <li>6 review plan for narcotic/controlled substance prescribing and formulary compliance.</li> </ol>	<p>Most States have licensure and other requirements applicable to CNMs. For example, some require that the CNM have an arrangement with a physician for the referral of the patient in the event a problem develops that requires medical attention. Others may require that the CNM function under the general supervision of a physician. Although these and similar State requirements must be met in order for the CNM to provide Medicare covered care, they have no effect on the CNM’s right to personally bill for and receive direct Medicare payment. That is, billing does not have to flow through a physician or facility.</p>

## All Burned Out: Diagnosis Coding for Burns

**When** it comes to diagnosis coding for burns, several of the coding conventions in ICD-9-CM remain the same in ICD-10, but there are some changes. Coders themselves could get burned if they're not aware of them.

### What is a Burn?

A burn is a type of trauma that causes varying degrees of injury to the skin and underlying tissues. Along with dermal and epidermal tissue, muscle, bone, tendons, ligaments and blood vessels can be damaged as well. Burns are caused by heat, cold, electricity, chemicals, light, radiation, or friction. And burn symptoms can range from mild pain, such as redness and burning, to severe and excruciating pain as in the case of internal organs being charred.

### ICD-9-CM conventions

Coding burns in ICD-9-CM (diagnosis code categories 940-948) are classified according to depth, extent, and agent (E-code). Depth refers to the level of burn experienced. First degree burns are considered erythema, which is defined as redness and swelling affecting the outer layer of skin only.

Second degree burns involve blistering, redness, and swelling of both the outer and second layer of skin. Second-degree burns are also said to be partial thickness burns. Third degree burns are those that are full-thickness, and the most severe. These burns extend deeper into the tissues, and cause charred, blackened skin. The affected area

may be numb, and symptoms are much more severe.

Extent refers to the percentage of body surface that is burned. For example, a burn of the leg could cover 10 percent of the lower leg, or 50 percent of the lower leg. The agent, or E-code, is used to identify the external cause of the burn injury. ICD-9-CM Official guidelines for coding and reporting burns include specific instruction for:

- Sequencing of burns
- Burns of the same local site
- Non-healing burns
- Posttraumatic wound infection
- Assign separate codes for each burn site
- Encounters for treatment of late effects of burns

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**Burn codes – with the exception of sunburns – are used for thermal burns, originating from a heat source, such as a fire or hot appliance.**

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### ICD-10-CM conventions

For ICD-10-CM, there is a distinction between codes for burns and those for corrosions. Burn codes – with the exception of sunburns – are used for thermal burns, originating from a heat source, such as a fire or hot appliance. These codes are also used for injuries resulting from electrical shock and radiation exposure. Corrosion burns are defined as burn injuries due to chemicals. The coding guidelines are the same for both burns and corrosions.

As with ICD-9-CM, current burns (T20-T25) are classified according to depth, extent and agent (X-code). The definition of first, second, and third-degree burns are the same for both coding conventions. Burns of the eye and internal organs in ICD-10 (T26-T28), however, are classified by site, but not degree.

ICD-10-CM official guidelines for coding and reporting, effective October 1, 2009, lists specific guidelines for:

### Sequencing of burn and related condition codes

Sequence the first code that reflects the highest degree of burn when more than one burn is present.

### Burns of the same local site

Classify burns of the same local site (T-20-T-28), but of different degrees to the subcategory, identifying the highest degree recorded in the diagnosis.

### Non-healing Burns

Non-healing burns are codes as acute burns. Necrosis of burned skin should be coded as non-healed burn.

### Infected Burn

For any documented infected burn site, use an additional code for the infection.

### Assign separate codes for each burn site

Assign separate codes for each burn site. (Category T30, Burn and corrosion, body region unspecified is extremely vague and should rarely be used).

### Burns and corruptions classified according to extent of body surface involved

Assign coded from category T31, burns classified according to extent of body surface involved. Or category T32, corruptions classified according to extent of body surface involved, when the site of the burn is not specified or when there is a need for additional data.

### Encounters for treatment of late effects of burns (i.e., scars or joint contractures)

Should be coded with a burn or corrosion code with the 7th character "S" or sequel.

### Sequelae with late effect code and current burn

When appropriate both a code for a current burn or corrosion with 7th character extension "A" or "D" and a burn or corrosion code with extension "S" may be assigned on the same record (when both a current burn and sequelae of an old burn exist).

*NOTE: In ICD-10 most categories in chapter 19 (trauma) require 7th character extensions.*

*For burns, these extensions are A—initial encounter, D—subsequent encounter and S.*

### Use of an external cause code with burns and corruptions

An external cause code should be used with burns and corruptions to identify the source and intent of the burn as well as the place of occurrence.

### The more things change

What coders should keep in mind is that, although there are differences in the way codes are numbered, most of the guidelines for coding burn diagnoses are the same for both ICD-9-CM and ICD-10-CM. Gaining a good understanding of the guidelines now, will ease the transition to ICD-10 diagnosis coding later. Take some time to review the official guidelines for coding and reporting which can be found at

[ftp.cdc.gov/pub/Health\\_Statistics/NCHS/Publications/ICD10CM/2010](http://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2010) or

[www.cms.hhs.gov/ICD10/Downloads/7\\_Guidelines10cm2010.pdf](http://www.cms.hhs.gov/ICD10/Downloads/7_Guidelines10cm2010.pdf)

### About the Author

Darnacea Harris MHA, RHIT, CCS, is the Integrity Educator for MedAssets. Darnacea has more than 20 years experience in the healthcare industry and has previously has such positions as CCA Rules Manager, Assistant Director HIM, HIM Manager, Coding Manager, and Consultant. She has also held teaching positions at several colleges and universities where she taught coding, billing, HIM and supporting courses. ■

### REFERENCES

#### Centers for Medicare and Medicaid Services/ ICD10

[www.cms.hhs.gov/ICD10/Downloads/7\\_Guidelines10cm2010.pdf](http://www.cms.hhs.gov/ICD10/Downloads/7_Guidelines10cm2010.pdf)

#### Centers for Disease Control Health Statistics

[ftp.cdc.gov/pub/Health\\_Statistics/NCHS/Publications/ICD10CM/2010](http://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2010)

## MedAssets Coding & Compliance Presentations

MedAssets Coding and Compliance Presentations are free to MedAssets clients and employees. For online registration, please visit: <https://medassets.webex.com/medassets/onstage/g.php?p=23&t=m>

### ICD-10: IMPLICATIONS FOR CONTENT CONVERSION IN VENDOR PRODUCTS

THURSDAY, MAY 13, &  
TUESDAY, MAY 18  
2:00 – 3:00 PM EDT

Presented by Ardith Campbell, CPC, CPC-H, CCP

Objective: It is important for facilities to understand the implications of the October 2013 deadline for implementation of the Internal Classification of Diseases, 10th Revision (ICD-10) that will impact every aspect of the revenue cycle and more. We will assist facilities to understand the overall impact and provide implementation steps the facility may want to consider.

Background: The ICD-10 changes will affect many different areas, from patient registration to case management and beyond. Facilities will need to investigate any vendor products each department currently using ICD-9 and ready the system for conversion to ICD-10. Additionally, staff and provider training will be necessary to assist with a favorable transition.

### LABORATORY CODING AND BILLING UPDATES

TUESDAY, MAY, 4 &  
TUESDAY MAY, 25  
2:00 – 3:00 PM EST

Presented by Bev Hillinger

Objective: To discuss and clarify coding and billing issues related to CPT/HCPCS coding and modifiers for clinical laboratory services.

Background: CMS routinely adds/deletes and revises clinical laboratory CPT/HCPCS codes and updates billing guidance for laboratory services. Modifications made in recent years can be confusing to apply. Hospitals providing laboratory services require review and clarification of CMS instructions in order to appropriately charge for these services and receive correct reimbursement.

## F.A.Q.

### FREQUENTLY ASKED QUESTIONS

In this section, MedAssets has reviewed and analyzed the questions that are received via our compliance help desk. We offer some of the most frequently asked questions and the MedAssets response for your convenience.

**Q** When applying the Unna boot, Profore, or multi-layer compression (CPT 29580 & 29581) are the actual supplies separately chargeable? Or, are they included in the procedure?

#### MedAssets Response

CPT Code 29580, Application of Unna Boot, is used to report for strapping when a unna boot is applied to the leg or foot of a patient. The unna boot is typically used to treat or prevent venostasis dermatitis or ulcers of the lower leg or foot, but may also be used to control postoperative edema and as a supportive bandage. The viscopaste and coban combination dressing is not an Unna Boot dressing and CPT 29580 would not be reported.

To report 29580, a true Unna Boot dressing like the Tenderfoot Unna Boot, the GelCast Unna Boot or the Unna Flex Unna Boot needs to be applied to the wound. When the Unna Boot is reported with CPT 29580, the dressing is included as part of the procedure and the cost of the dressing is included in the procedure charge. There are times when an Unna Boot is applied and a procedure charge is not billed; such as in inpatient stays, or when the Unna Boot is used as a foot ulcer dressing and the foot is not "strapped." In the last instance, the Unna Boot may be charged as a supply, reported with a HCPCS code and revenue code 27X.

CPT 29581, Application of multi-layer venous wound compression system, below knee, should be reported when a multi-layer venous wound system is applied. According to the CPT Changes 2010, CPT 29581 was created to report treatment of chronic venous insufficiency with multi-layer compression. In addition, the CPT Changes 2010

provides the following clinical example and procedure description:

"Clinical Example: A 50-year-old female returns to the office for treatment of a medial calf ulcer. It measures 3x3 cm and demonstrates no signs of infection. She has palpable pedal pulses. Pigmented skin changes in the gaiter distribution of both lower extremities are consistent with chronic venous insufficiency. The wound is examined, cleaned and a multilayer venous ulcer compression dressing is applied.

Description of Procedure: The ulcer is cleansed and a primary wound dressing is then applied. With the foot in a dorsiflexed position, application of the compression bandage is initiated with a circular winding at the base of the toes. The second circular winding follows and covers the top of the foot and articulating aspect of the ankle joint. The next winding is applied and covers the back of the heel and the calf. Frequent checks are performed to ensure the foot is in a neutral position relative to the ankle. Each subsequent application is applied at the specific stretch needed for the desired compression."

Examples are Smith & Nephew's Profore and Proguide Multi-layer Compression Bandaging System, 3M Coban 2 layer Compression System and Systagenix's DYNA-FLEX™ Multi-layer Compression System. If the ViscoPaste and Coban 2 layer dressing can be properly documented as a multi-layer venous wound compression system, then the nurses can use 29581 for the application of this dressing.

#### RESOURCES

**2010 Final Rule**  
[edocket.access.gpo.gov/2009/pdf/E9-26499.pdf](http://edocket.access.gpo.gov/2009/pdf/E9-26499.pdf)

CMS Transmittal R1871CP

**Q** Should revenue code 279 be assigned to items that are implanted temporarily in a patient? If an item is implanted during a procedure then removed from body at the end of the procedure, can 278 be used? Is there a defined length of time that an item has to be implanted in the body for CMS to consider it an implant and be coded as a 278? Please provide any Medicare References that you can in your answer.

#### MedAssets Response

Revenue code 278 might be assigned to items that are implanted temporarily in a patient, depending on the actual use of the item. A discussion in the IPPS 2009 Final Rule provides clarification on how to determine if an item is a supply or an implant. CMS has stated that a device is not "a material or supply furnished incident to a service (for example, a surgical staple, a suture, customized surgical kit, or clip, other than a radiologic site marker)."

According to CMS the National Uniform Billing Committee (NUBC) definition of an implant should be used to determine which items would be designated as implants and reported in the implantable device cost center using NUBC revenue codes 275, 276, 278 and 624. This definition does not include a time frame on how long an item must remain in the body. The NUBC implant definition includes:

"That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing radioactive substance, a graft, or an insert. Also included are liquid

...continued on page 14



## NCCI-associated Modifiers: Use to Prevent Denied Claims

**Modifiers** are an important part of the coding and billing process for hospital outpatient reporting. One particular set of edits used with Medicare reporting is the National Correct Coding Initiative edits (NCCI) or the CCI edits. These edits were developed by the Centers for Medicare and Medicaid Services (CMS) to promote correct coding and prevent Medicare payment for code pairs representing services that should not be reported together.

The National Correct Coding Initiative Policy Manual contains three sets of modifiers – Anatomic, Global and Other. These may be utilized to bypass certain CCI edits. The manual refers to these as “NCCI-associated modifiers.” These modifiers may be used with code pairs that are listed with a modifier indicator of “1” in the Column 1/Column 2 Correct Coding Edit Table and Mutually Exclusive Edit Table. The other modifier indicators in the tables are “0=not allowed”

and “9=not applicable.” Column 1 codes are also referred to as “comprehensive codes” and column 2 codes are also referred to as “component codes.”

Table 1 shows a representation of three Column 1/Column 2 code pairs (from a total of 107 code pairs listed in the current CCI edit file) for the column 1 or comprehensive code CPT® 12031 – Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less.

A modifier should always be clinically appropriate for the procedure code it is used with and the circumstances for using the modifier should be documented in the patient record. For anatomical modifiers this could be as simple as documenting the anatomy and location where the procedure was performed such as a left wrist. The NCCI-associated modifiers are used to prevent the denial of a Column 2 code when reporting multiple

procedures that trigger a CCI edit. They inform the payor that a valid reason exists for reporting both codes even though a CCI edit exists for the pair.

### Anatomic Modifiers

The Anatomic set of NCCI-associated modifiers may be used with an appropriate procedure code to identify procedures performed on different anatomical sites or the contra-lateral side of the body on the same date of service. When reporting anatomical modifiers often both procedure codes in the pair will be appended with a unique modifier.

Reporting examples for anatomical modifiers:

- Coronary atherectomies performed on the right coronary and left anterior descending coronary arteries – 92995 RC, 92996 LD
- Phalangectomy performed on the right fifth toe and a hemiphalangectomy performed on the right fourth toe – 28150 T9, 28160 T8

Table 1

A	B	C	D	E	F
Column 1	Column 2		Effective Date	Deletion Date	Modifier
12031	36000		20021001	*	1
12031	36400		20090401	*	1
12031	36405		20090401	*	1

## Anatomic Modifiers

Modifiers	Description
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid
FA	Left hand, thumb
F1-F4	Left hand, second–fifth digits
F5	Right hand, thumb
F6-F9	Right hand, second–fifth digits
TA	Left foot, great toe
T1-T4	Left foot, second–fifth digits
T5	Right foot, great toe
T6-T9	Right foot, second–fifth digits
LT	Left side
RT	Right side
LC	Left circumflex coronary artery
LD	Left anterior descending coronary artery
RC	Right coronary artery

## Global Surgery Modifiers

The Global Surgery set of NCCI-associated modifiers may be used with an appropriate procedure or service code to communicate to the payor that the code pair represents procedures or services performed that were in some way separate.

Modifier 78 might be used when reporting a procedure that includes a return to the operating room to repair a post-op complication, whereas modifier 79 would be used when a physician performs two unrelated procedures on the same day.

Modifier 58 might be used when a diagnostic endoscopic procedure results in the decision to perform an open procedure. The CCI manual states that both procedure codes may be appended with modifier 58, as long as the endoscopic procedure was separately performed and was not a “scout” procedure used to “assess anatomic landmarks and/or extent of disease.”

## Global Surgery Modifiers

Modifiers	Description
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period
78	Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician During the Postoperative Period

## Other Modifiers: 27, 59, 91

The “Other” NCCI-associated modifiers can be used when reporting multiple outpatient clinic visits or ER visits on the same date (27), distinct services (59) or laboratory tests that must be repeated to obtain multiple results (91).

Modifier 59 can be used to indicate that a procedure represents an incision, lesion, injury or encounter that was performed separately from a comprehensive procedure. However, if another NCCI-associated modifier, such as one of the anatomic modifiers, is more descriptive and appropriate for the procedure, then that modifier would be reported instead of modifier 59.

Do not use modifier 59 when reporting component services (Column 2 codes) that are performed as an integral part of the comprehensive procedure (Column 1 code).

## Other Modifiers: 27, 59, 91

Modifiers	Description
27	Multiple Outpatient Hospital E/M Encounters on the Same Date
59	Distinct Procedural Service
91	Repeat Clinical Diagnostic Laboratory Test

Additional points to remember when using modifiers with CCI edits:

- The NCCI edits are updated quarterly
- The hospital version is one calendar quarter behind the carrier or physician version
- The global period under the OPSS consists of one day for facility reporting
- When using one modifier to bypass a CCI edit, append the modifier to the Column 2 or component procedure code

## Summary

Careful and compliant use of the NCCI-associated modifiers can prevent wrongful denials of claims for multiple outpatient procedures performed on the same day or during the same encounter when submitted to Medicare.

## About the Author

Sandy Palmer, RHIT, is a Coding and CDM Analyst for MedAssets, Integrity Services. Her expertise includes inpatient and outpatient facility coding with a specific emphasis on the Outpatient Prospective Payment System (OPPS). She has more than 12 years experience in Health Information Management and is currently responsible for researching and responding to complex facility coding inquiries as well as database maintenance and management. ■

## REFERENCES

**NCCI Edits - Hospital Outpatient PPS**  
[www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS](http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS)

**NCCI Policy Manual for Medicare Services, Version 15.3 - Effective October 1, 2009**  
[www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/NCCI\\_Policy\\_Manual.zip](http://www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/NCCI_Policy_Manual.zip)

## NCCI FAQs

[questions.cms.hhs.gov/app/answers/list](http://questions.cms.hhs.gov/app/answers/list)

# Trade Shows & Events

## NDC – National Distribution & Contracting, Inc. International Expo

May 2-4 • Nashville, TN • Booth: 524  
[www.ndcexhibition.com](http://www.ndcexhibition.com)

## Metropolitan Chicago Healthcare Council (MCHC) Webinar

May 6-9 a.m. CST  
[www.mchc.com](http://www.mchc.com)

### *The Transformational Supply Chain*

Presented by Jeremy Belinski, Vice President, Strategic Development, Aspen Healthcare Metrics, a MedAssets company

## DST/CSC HUG

May 10-13 • Tucson, AZ • Booth: TBD  
[www.hugconferences.com](http://www.hugconferences.com)

## HFMA Region 1 Ninth Annual Healthcare Conference

May 13-14 • Uncasville, CT • Booth: TBD  
[www.chfma.org/site/epage/26376\\_473.htm](http://www.chfma.org/site/epage/26376_473.htm)

### *Revenue Integrity Tactics That Shut Down Cash Leakage – Provider Case Studies*

Presented by Debbie Messina, Director, Business Operations, Stamford Hospital;

Denny Roberge, Revenue Operations Manager, Concord Hospital; Abe Berman, Manager, Revenue Cycle Performance, Fletcher Allen Health Care; and Kate Banks, President, Customer Revenue Strategy and Improvement, MedAssets

## ASCs 2010

May 19-22 • Anaheim, CA • Booth: 248  
[www.ascassociation.org/ascs2010](http://www.ascassociation.org/ascs2010)

## Greater San Antonio AHRMM Chapter Educational Seminar

May 20 • San Antonio, TX  
[www.gsahrm.org/id34.html](http://www.gsahrm.org/id34.html)

### *Leveraging the Expertise in Group Purchasing Organizations*

Presented by Gina Thomas, RN, MBA, CMRP, Regional Vice President, MedAssets

## Kentucky Hospital Association (KHA) 81st Annual Convention

May 24-26 • Lexington, KY  
[www.kyha.com](http://www.kyha.com)

### *How to Have a Margin Discussion With Your Doctors*

Presented by Nick Sears, M.D., Chief Medical Officer, MedAssets

## ASCP's 32<sup>nd</sup> Midyear Conference & Expo

May 26-28 • Phoenix, AZ • Booth: 404  
[web.ascp.com/education/meetings/2010/Midyear/Index.cfm](http://web.ascp.com/education/meetings/2010/Midyear/Index.cfm)

## E-Health Conference

May 31-June 1 • British Columbia, Canada  
 Booth: TBD  
[www.e-healthconference.com](http://www.e-healthconference.com)

## 2010 Catholic Health Assembly

June 13-15 • Denver, CO • Booth: 16  
[www.chausa.org/assembly](http://www.chausa.org/assembly)

## HFMA's 2010 ANI: The Healthcare Finance Conference

June 20-23 • Nashville, TN • Booth: 611  
[www.hfma.org](http://www.hfma.org)

### *"Phoebe Putney Memorial Hospital: Finding Lost Revenue Through Accurate Claims"*

Presented by Wendy Allen, Director, Revenue Management, Phoebe Putney Memorial Hospital and Rebecca Haworth, Vice President, Charge Capture Audit, MedAssets

## FREQUENTLY ASKED QUESTIONS

...continued from [page 11](#)

and solid plastic materials used to augment tissues or to fill in area traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, diagnostic purposes."

Most catheters are considered implants, which may be reported under revenue code 278. However, when these items are used as routine supplies they would not be reported separately. CMS Transmittal R1702CP includes the following example where it is suggested the charges for a Foley catheter be included with the procedure charge:

"...if hospital outpatient staff perform a surgical procedure on a patient in which temporary bladder catheterization is necessary and use a catheter described by HCPCS code A4338 (Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each), the hospital should not report A4338 because the catheter was used as a supply and would be paid through OPSS payment for the surgical procedure. The hospital should include the charge associated with the urinary catheter on the claim."

MedAssets recommends incorporating the cost of routine supplies into the procedure charge, but it is ultimately the facility's decision on how to handle these supplies.

Hospitals should create their own internal policies on how to address routine and non-routine supplies and implants in their facilities. Additional guidance on supplies and revenue code reporting may be obtained from your FI or MAC.

## RESOURCES

**CMS Transmittal R1702CP, the April 2009 OPSS Update is available in KnowledgeBase | Federal Guidelines. Review item #2 "Further Clarification Related to Billing for Medical and Surgical Supplies."**

[www.cms.hhs.gov/Transmittals/Downloads/R1702CP.pdf](http://www.cms.hhs.gov/Transmittals/Downloads/R1702CP.pdf)

**The 2009 Inpatient Final Rule may be reviewed in KnowledgeBase | Federal Register. Use the drop down to select the date of "08/08" and keywords such as IPPS, NUBC and implant to review the discussion.**

[edocket.access.gpo.gov/2008/pdf/E8-17914.pdf](http://edocket.access.gpo.gov/2008/pdf/E8-17914.pdf)

# CCFN CROSSWORD APRIL 2010

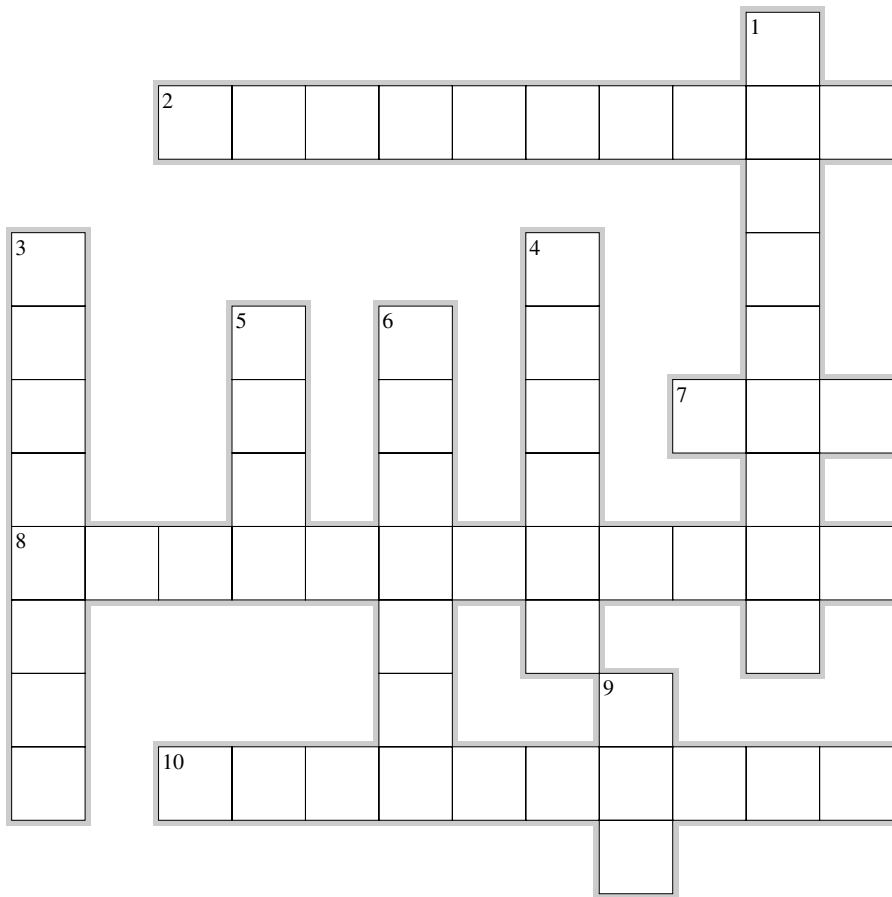
By Nikita Ashford, MBA/HCM, CPC-H, CPhT

## Across

- 2. This technique was pioneered by RAC Connolly which is used today for the identification of overpayments and underpayments. (2 words)
- 7. Providers in Region B are encouraged to review high risk issues which include 38 complex reviews involving \_\_\_\_ validation.
- 8. Diversified Collection Services, Inc. has identified automated review for \_\_\_\_ on oxygen accessories, lower limb suction valve prosthesis, prosthetic additions and Clinical Social Worker (CSW) services.
- 10. Region A RACs will conduct Part A and Part B audits in MAC Jurisdiction 14 focusing on \_\_\_\_ audits. (2 words)

## Down

- 1. HealthDataInsights, Inc., Region D's RAC is recognized as the leader in healthcare claims \_\_\_\_ which involves fraud and abuse.
- 3. This RAC has subcontracted with Viant to provide assistance with CMS reviews.
- 4. One purpose of the RACs is to identify Medicare underpayments and overpayments by reviewing \_\_\_\_ post payment.
- 5. The number of regions the recovery audit contractors service.
- 6. Region B's subcontractor PRG Schultz will provide audits on home health claims and \_\_\_\_ medical equipment.
- 9. Recovery Audit Contractor acronym.



**ANSWERS**  
 ACROSS 2. DATA MINING 7. DRG 8. OVERPAYMENTS 10. HOME HEALTH  
 DOWN 1. INTEGRITY 3. CONNOLLY 4. CLAIMS 5. FOUR 6. DURABLE 9. RAC

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CCFN provides a discussion of coding practices for educational purposes only. MedAssets has made every effort to ensure the accuracy of the contents herein. Official coding guidelines are maintained by the Central Office on ICD-9-CM of the American Hospital Association.



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