

CRIP Exam Study Manual Update for 2018

This document reflects updates made to the instructional content from the *Certified Revenue Integrity Professional (CRIP) Exam Study Manual 2017* to the 2018 version of the manual. This does not include updates to examples, Knowledge Checks and Answers, or the Glossary.

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Note: Unless otherwise stated, information in yellow below has been inserted and information struck through has been deleted.

Edit to page(s) 2-10: CPT/HCPCS

The CPT/HCPCS is divided into two current levels:

Level I CPT Codes

Level I is CPT codes. CPT codes are a system of descriptive terms and five-digit numeric codes that are used primarily to identify medical services and procedures furnished by physicians and other healthcare professionals. Level I codes do not include items or services that are regularly billed by suppliers other than physicians.

Level I CPT codes are divided into six sections:

1. Evaluation and Management
2. Anesthesia
3. Surgery
4. Radiology
5. Pathology and Laboratory
6. Medicine

Level II HCPCS Codes

Level II is HCPCS codes, a system of five-digit numeric codes with alphabetic prefixes A through V, assigned by CMS to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established for submitting claims for these items.

Here are some examples of the alphabetic prefixes found within the HCPCS manual:

- C – temporary hospital OPPS codes
- G – temporary procedures and professional services
- J – drugs administered other than an oral method or chemotherapy drugs
- P – pathology and laboratory
- V – vision and hearing services

Edit to page(s) 2-26 and 2-27: Advance Beneficiary Notice of Noncoverage (ABN)

Purpose and Proper Issuance of the Form

To avoid having to write off claims that Medicare deems not “reasonable and necessary,” **for outpatient services** providers can use the ABN. When a service does not meet or is not expected to meet medical necessity, the beneficiary is given an ABN *before* services are furnished that states that the provider believes that Medicare will not or probably will not cover the specified item. This supports Medicare’s rule that a beneficiary is not protected from financial liability of a noncovered service if that person had knowledge, or should have had knowledge, of the noncoverage. Thus, an ABN is also known as a notice of noncoverage.

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If the patient is going to have an extended course of treatment, a single ABN can be issued. The ABN must list all items and services plus the duration of the length for the expected treatment. The single ABN for extended treatment cannot extend past one year. If the treatment must extend past that time frame, a new ABN will need to be obtained.



NOTE: It is important to realize that a signed ABN is not an official denial of coverage by Medicare. The beneficiary and/or facility has the right to file an appeal if the payment is denied when a claim is submitted.

New topic on page(s) 2-28: Hospital Issued Notice of Noncoverage (HINN)

Hospitals use the HINN to inform beneficiaries that all or part of their Part A inpatient hospital care may not be covered by Medicare. Like the ABN, this notice will state why the facility thinks Medicare won't pay and what beneficiaries may have to pay if they choose to keep receiving the medical services.

Edit to page page(s): Laboratory Services, Types of Labs

- **Clinical laboratory** — A lab that offers services to review microbiology, chemistry, serology, immunoassay, cytology, pathology services, etc. A clinical lab must be certified to meet requirements of the Clinical Laboratory Improvement Act (CLIA) unless the lab is exempt. **CLIA regulations establish quality standards for laboratory testing performed on specimens from humans, such as blood, body fluid, and tissue, for the purpose of diagnosis, prevention, or treatment of disease or assessment of health.**

Edit to page(s) 3-5 and 3-7: Radiology Services, Mammography

There are ~~two~~ **several** types of mammograms: screening mammograms and diagnostic mammograms.

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A mammogram is a direct x-ray of the breast. Sometimes a computer-aided detection (CAD) is performed as well. The CAD procedure uses a laser beam to scan the mammography film from a film (analog) mammography and then converts it into digital data for the computer. It then analyzes the digital data for areas that may be suspicious for cancer. (The patient is not required to be present for the CAD process.)

Digital breast tomosynthesis is a new screening and diagnostic breast imaging tool that is used to improve the early detection of breast cancer. The three-dimensional part of this service is able to take multiple images in seconds.

Edit to page(s) 3-7: Radiology Services, Fluoroscopy

Fluoroscopy should only be reported when it is not included as an integral part of the primary procedure performed.



TIP: To determine when to bill separately for fluoroscopy, refer to the CPT/HCPCS descriptions in the yearly coding manuals. If the description includes any verbiage about fluoroscopy, then that code and charge should be encompassed in the procedure charge. If there is no reference to fluoroscopy in the code description, then fluoroscopy can be billed separately.

Edit to page(s) 3-8: Radiology Services, Nuclear Medicine

Hospitals are to submit the claim to the payer so that the services on the claim reflect the date that each particular service was provided. In other words, if a nuclear medicine procedure was provided on a different DOS from the radiolabeled product, the claim submitted will contain more than one DOS.



TIP: Be cautious when billing for radiopharmaceuticals given during nuclear medicine procedures. To remain compliant, it is important to pay close attention to descriptions. For example:

- For the agent Technetium Tc 99m, Medronate, (MDP), diagnostic, per study dose, up to 30 mCi's should be billed as one unit of service.
- For the agent Technetium Tc-99m-Per technetate, Diagnostic, per mCi, all units administered should be billed.

Edit to page(s) 3-9: Radiology Services, Positron Emission Tomography (PET) Scans

Prior to the performance of a PET scan, a tissue diagnosis is made. Following that diagnosis, PET scans can be used to assist with staging rather than a diagnosis.

Restaging applies to testing after a course of treatment is completed and is covered based on following:

- After the completion of treatment for the purpose of detecting residual disease
- For detecting suspected recurrence or metastasis
- To determine the extent of a known recurrence
- If it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is to determine the extent of a known recurrence or if the study information is considered insufficient

Edit to page(s) 3-12: Medical Nutritional Therapy (MNT), MNT Coverage Guidelines

Medicare covers three hours of MNT per calendar year, and one-on-one counseling for MNT during the first year and two hours of MNT in all subsequent years. Every calendar year the beneficiary must have a new referral for any additional follow-up hours. The referral can only be made by the treating physician and only when the beneficiary has been diagnosed with diabetes or renal disease.

Edit to page(s) 3-21: Screening Services, Pap Smear Screening

The following requirements must be met when screening services are done for Pap smears:

- The Pap smear was ordered and collected by a practitioner who is authorized under state law to perform the examination.
- The Medicare beneficiary has not had a screening Pap smear test during the preceding three two years.

Edit to page(s) 3-23: Screening Services, Colorectal Cancer Screening

The following services are considered colorectal cancer screening services according to CMS:

- A fecal-occult blood test (FOBT) – every year
- A flexible sigmoidoscopy – once every four years
- A colonoscopy – once every 10 years
- A barium enema (BA) – only done as an alternative to cover a screening flexible sigmoidoscopy

Edit to page(s) 3-23: Vaccines, Pneumococcal (Pneumonia) Vaccine

The pneumococcal vaccine is usually administered to beneficiaries only once in a lifetime.

Edit to page(s) 3-24: Vaccines, Hepatitis B Vaccine

The Hepatitis B vaccine and its administration costs are covered if ordered by a doctor. This vaccine is available to beneficiaries who are considered at high or intermediate risk of contracting Hepatitis B. Per CMS, Medicare beneficiaries who are currently positive for antibodies for Hepatitis B are not eligible for this benefit.

Edit to page(s) 3-34: National Drug Codes (NDCs)

CMS created NDCs to help identify drugs that could be reimbursed. The FDA is responsible for maintaining NDCs.

There are three components of each NDC:

1. The first component, assigned by the FDA, identifies the vendor who manufactured, packaged, and distributed the drug.
2. The second component, assigned by the manufacturer, identifies the product information such as the generic name, the dosage, and the strength.
3. The third component, also assigned by the manufacturer, indicates the size of the product.

The code that appears on the product package is usually 10 digits. There are three possible configurations for this code based on the number of digits allowed for each component described above: 4-4-2, 5-3-2, or 5-4-1.

10-Digit Code on Package	
Configuration	Example
4-4-2	9999-9999-99
5-3-2	99999-999-99
5-4-1	99999-9999-9

The 10-digit code on the package must be converted to 11 digits for billing. This is done by inserting a leading zero in one of the components to result in a 5-4-2 configuration. Regardless of the original 10-digit configuration, the 11-digit code for billing is always 5-4-2 and the zero is always inserted at the beginning of the group of numbers.

Although hyphens are shown in the table below to clarify the configurations, there are no hyphens in the code on the actual claim.

Conversion to 11-Digit Code for Billing		
Conversion	10-Digit Code on Package	11-Digit Code for Billing
4-4-2 to 5-4-2	9999-9999-99	09999-9999-99
5-3-2 to 5-4-2	99999-999-99	99999-0999-99
5-4-1 to 5-4-2	99999-9999-9	99999-9999-09

Edit to page(s) 4-4 and 4-5: Transplants, Kidney Transplants, Billing Process

If an interim bill is submitted, the standard acquisition charge should appear on the billing form for the period during which the transplant took place. This charge should be in addition to the hospital’s charges for services rendered directly to the Medicare recipient. Interim payment is made as a “pass through” item.

The MAC will deduct the kidney acquisition charges for PPS hospitals through the Pricer. The costs which are incurred by the approved kidney transplant hospital are not included in the kidney transplant prospective payment. Instead, they are paid on a reasonable cost basis.

The Medicare Code Editor (MCE) creates an edit for ICD-10-PCS procedure codes 0TY00Z0/0TY00Z1/00TY00Z2/0TY10Z0/0TY10Z1/ 0TY10Z2 55-69 - Kidney Transplant. If any of these this procedure codes is identified on the UB-04, the MAC will check the provider number on the claim to determine if the provider is an approved transplant center and then it will check the effective approval date. The MAC will also review to determine if the facility is certified for adults and/or pediatric transplants.

Edit to page(s) 4-6: Transplants, Heart Transplants, Billing Process

The MCE creates an edit for ICD-10-PCS procedure codes 02YA0Z0/02YA0Z1/02YA0Z2 37.51 Heart Transplantation. When this edit hits, the MAC will check the provider number to determine if the provider is an approved transplant center and will verify the effective approval date. The MAC will also determine if the facility is certified for adults and/or pediatrics.

Edit to page(s) 4-7: Transplants, Liver Transplants, Billing Process

The claim will also edit in the MCE if ICD-10-PCS a procedure codes 0FY00Z0/0FY00Z1/0FY00Z2 50.59 Liver Transplant is on the claim. If a procedure code of 0FY00Z0/0FY00Z1/0FY00Z2 of 50.51 Auxiliary Liver

Edit to page(s) 4-8: Transplants, Stem Cell Transplants

A stem cell transplant is a process in which stem cells are harvested from either a patient's (autologous) or donor's (allogeneic) bone marrow or by peripheral blood for intravenous infusion.

Edit to page(s) 4-8: Transplants, Stem Cell Transplants, Acquisition Charges

Acquisition charges for allogeneic stem cell transplants include, but are not limited to, the costs of the following services:

Edit to page(s) 4-10: Bariatric Surgery

- The patient must have a body mass index greater than or equal to 35.
- The patient must have at least one co-morbidity related to obesity.
- The patient must have been previously unsuccessful with medical treatment for obesity.

CMS has determined that covered procedures are reasonable and necessary only when performed at facilities that are

1. Certified by the American College of Surgeons as a Level 1 Bariatric Surgery Center or
2. Certified by the American Society for Bariatric Surgery Center of Excellence

Edit to page(s) 4-11: Inpatient-Only Procedures

A status indicator C means the procedure has been identified as inpatient-only. The Outpatient Code Editor (OCE) will edit any outpatient claim with a CPT code that is assigned a status indicator C. Under APCs, any procedure billed on an outpatient claim that is identified as inpatient-only is not assigned to an APC and, therefore, no payment will be made. If the procedure billed has been identified as inpatient-only, the outpatient claim must be billed to CMS or TRICARE for a denial. The inpatient-only procedure should not be removed from the claim.

For calendar year (CY) 2018, CMS is proposing to remove total knee arthroplasty from the IPO list. The CY 2018 OPPS/ASC proposed rule also seeks comment regarding whether partial and total hip arthroplasty should also be removed from the IPO list.

Edit to page(s) 4-23: Anesthesia

Revenue code 37X does not require a HCPCS code from CMS (although some payers, like TRICARE, do request a code on the claim). The reimbursement for the technical component of anesthesia services is considered packaged under OPPS or is included in the MS-DRG payment.

Edit to page(s) 5-6 and 5-7: Functional G-Codes

NOTE: The KX modifier which indicates that “requirements specified in the medical policy have been met” is not required on the claim line for nonpayable G-codes. However, it would still be required with the procedure code for medically necessary therapy services furnished once the patient’s annual cap has been reached.

For 2017 2018, the Medicare Part B outpatient therapy caps for Occupational Therapy as well as Physical Therapy and Speech were increased to \$1,980. With the addition of KX modifiers, therapy services cannot exceed \$3,700.

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Providers are required to report line item dates of service per revenue code line for all outpatient rehabilitation services.

Therapy services also require the use of three occurrence codes.

Required Occurrence Codes for Therapy Services			
Type	Onset of symptoms/illness	Date plan of care established or last reviewed	Date treatment started
Physical therapy	11	29	35
Occupational therapy	11	17	44

Speech therapy	11	30	45
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Edit to page(s) 5-12: Observation Services, Overview of Observation Services

Per CMS, observation services should not exceed a 48-hour period and but if medically necessary, Medicare will cover up to 72 hours. Observation services are:

Edit to page(s) 5-30: Condition Code 44

If a patient’s stay meets the condition code 44 guidelines, the entire episode of care should be billed as an outpatient as if the inpatient status had never occurred. If the condition code 44 requirements are not met, only the inpatient Part B charges can be billed. Medicare would require:

- A 110 no-pay claim
- A 121 claim for charges within the admit and discharge dates
- A 131 claim for any charges that were previously added to the inpatient claim because of the 72-hour rule