



THE RIGHT CARE FOR EVERY PERSON EVERYTIME

# Case Review Connection

The Medicare Quality Improvement Organization for Florida

Print this newsletter

## Case Review Connection

Case review would like to introduce our new quarterly newsletter - Case Review Connection. It will provide information on topics such as utilization review, HPMP, coding and quality of care issues. Initially, the newsletter will be sent to the QIO Liaison, but others who are interested in it may subscribe at the email listed below.

Our case review staff would like to get your input in the form of questions on any of the various topics. If you have a question, please e-mail it to [mmunsch@flqio.sdps.org](mailto:mmunsch@flqio.sdps.org). We hope you will find our newsletter to be helpful and informative to you in your job.

If you would like to subscribe to the newsletter, send an email to [casereview@flqio.sdps.org](mailto:casereview@flqio.sdps.org).

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## Coding Corner



Welcome to Coding Corner. The Coding Corner will serve as a forum for the coding staff here at FMQAI to address with the provider community coding, billing, and/or documentation issues identified during QIO reviews that have resulted in provider payment error. We encourage your input for future articles as well as feedback on any article/issues addressed here. Please submit your input/feedback to me at [lhilton@flqio.sdps.org](mailto:lhilton@flqio.sdps.org). Our first article will focus on coding of transcatheter embolization procedures.

Percutaneous Transcatheter Embolization is a precise occlusion of abnormal blood flow in a blood vessel as in AV malformations, aneurysm, or bleeding vessels, all of which may occur in a variety of body systems. This procedure may be performed either by use of various tiny instruments/adhesives (tiny tubes, wires, balloons, coils, glue and plastic particles) as either temporary or permanent embolic agents to occlude a blood vessel by the injection/infusion of liquid sclerosing agents or permanent particulate agents suspended in liquid directly into the damaged vessel.

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Prior to 10/01/02, all percutaneous transcatheter embolizations, regardless of the occlusive technique used, were indexed to ICD-9-CM procedure code 99.29, Injection/Infusion Therapeutic Substance NEC. Effective with patient discharges on or after 10/01/02, ICD-9-CM procedure code 39.79 was revised to separately identify endovascular (transcatheter using radiologic guidance) repairs or occlusions of vessels other than the head and neck vessels and ICD-9-CM procedure code 39.72 was developed to identify endovascular repair or occlusions of vessels of the head and neck. *Coding Clinic 4th Quarter 2002, p 103-105* “Transcather embolizations with the use of instruments (tiny tubes, wires, balloons, coils, glue, and plastic particles) were previously coded to 99.29. Currently, code 99.29 is assigned to describe embolization of artery by percutaneous transcatheter infusion. Embolizations by endovascular approach with tiny instruments or other occlusive substances are assigned codes 39.72 or 39.79 as appropriate.”

Incorrect procedure code assignment for the above described embolization techniques affects DRG assignment and can lead to either a significant overpayment or significant underpayment to the provider. ICD-9-CM procedure codes 39.72 and 39.79 both result in a surgical DRG assignment while ICD-9-CM procedure code 99.29 does not.

Please review the above referenced AHA Coding Clinic as well as the current ICD-9-CM indexing for percutaneous transcatheter embolization procedures to ensure the most appropriate procedure code and DRG assignments for any embolization cases your facility may perform.

## HPMP



Utilization reviews apply to all HPMP and higher weighted DRG reviews.

- If InterQual® criteria is used, it should be current with the discharge year. At this time, the 2006 version is in use. Please note in your Case Management files when the criteria year is changed to the current year so that it is documented for any possible retrospective reviews.
- CMS is still looking for a formal physician inpatient admission order. “Admit to inpatient status” must be documented in the physician’s orders, not just “Admit”.
- When hospitals are requesting a higher reimbursement on an initial DRG, be aware that the medical record will be reviewed for both medical necessity and quality of care issues.
- Patients must be informed of their observation status. Sample pamphlets explaining observation status to patients and physicians are available on our website [www.fmqai.com](http://www.fmqai.com). Select:
  - \* Professionals/Providers
  - \* HPMP
  - \*Project Resources
  - \* Observation Educational Pamphlet
  - \* Patient Information and Physician Information

InterQual® provides an Inpatient Only Procedures List for those organizations who do not have one of their own. McKesson states that CMS does have their own List (see page RRP-6) in the InterQual® 2006 Adult Acute Criteria Level of Care book. “For those organizations that need to follow the CMS Inpatient Only List, be sure to check the CMS website for the most up-to-date listing.” A link is provided from McKesson to the CMS website from [www.interqual.com](http://www.interqual.com)—enter the Clients Only section with the user ID and password provided from McKesson with your current contract, select Products, Level of Care, and under Acute, there is a bullet point for 2006 CMS Inpatient Only List. This is the link to the CMS website. Click here for the [CMS Inpatient Only List](#). Then click on Addendum E, click on accept and open the file.



## *New HINN*

As you were advised in MLN Matters and in other CMS communications, there is a new type of Hospital Issued Notice of Noncoverage available for use beginning in September. The circumstances governing the situations in which these HINNs are to be issued along with the complete information about how to fill in the HINN can be found at the following website: <http://www.hhs.gov/Transmittals/downloads/R982CP>

If you have any questions, please contact your fiscal intermediary at their toll-free number, which may be found at:  
<http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.pdf>

## *ADR*

Alternative dispute resolution (ADR) is an opportunity to resolve conflicts collaboratively with your patients. More than 80% of the Medicare beneficiary complaints are related to misunderstandings, communication, or the patient's perception of the effectiveness of their treatment or quality of care issues.



Beneficiaries frequently feel that no one has really listened to them; no one has time for them or that providers have not understood their medical problems. The focus of ADR is to bring together the Medicare beneficiary (or representative) and the health-care provider in order to collaboratively resolve the beneficiary's complaint.

ADR typically involves mediation, a form of conflict resolution, which brings two participants together in a process conducted by an impartial third party (the mediator). It is not a binding arbitration, confidentiality is maintained and protected by state and Federal law, and participation is voluntary.

ADR promotes two-way communication between the healthcare provider and their patients. By participating in ADR, you demonstrate your commitment to your patients and it can assist in continuing to foster understanding, share important information, develop insight, and improve relationships.



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