CRIP Exam Study Manual
Update for 2020

This document reflects updates made to the instructional content from the
Certified Revenue Integrity Professional (CRIP) Exam Study Manual 2019
to the 2020 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) 2-23: Modifier 59

There are four modifiers ~~Effective January 1, 2015, CMS established four new modifiers~~ which are considered subsets of modifier 59. These modifiers were created to assist in reducing errors associated with the overpayment of services. The four new modifiers are: ….

Edit to page(s) 2-27: Advance Beneficiary Notice of Noncoverage (ABN), Purpose and Proper Issuance of the Form

An ABN must be issued to a patient when it is expected that Medicare will deny payment for an item or service. Reasons why Medicare may deny the service include:

- Service does not ~~not does~~ meet medical necessity criteria.

Edit to page(s) 5-4: Coding Requirements for Therapy Services

NOTE: CR 11532 updates the annual per-beneficiary incurred expenses amounts now called the KX modifier thresholds and related policy for calendar year (CY) 2020. These amounts were previously associated with the financial limitation amounts that were more commonly referred to as "therapy caps" before the Bipartisan Budget Act of 2018 was signed into law repealing the application of the caps.

For CY 2020, the KX modifier threshold amounts are:

- $2,080 for PT and SLP services combined
- $2,080 for OT services

~~For calendar year (CY) 2019, the Medicare Part B outpatient therapy caps are:~~

- ~~$2,040 for PT and SLP services combined~~
- ~~$2,040 for OT services~~

The KX modifier, which indicates that "requirements specified in the medical policy have been met," is required with the procedure code for medically necessary therapy services furnished once the patient's KX modifier threshold amount ~~annual cap~~ has been reached.

Along with this KX modifier threshold, the ~~new~~ law retains the targeted medical review (MR) process (first established through Section 202 of the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA), but at a lower threshold amount of $3,000. For CY 2018 (and each calendar year until 2028 at which time it's indexed annually by the MEI), the MR threshold is $3,000 for PT and SLP services and $3,000 for OT services.

Edit to page(s) 5-6: Wound Care, Types of Wound Care Services

- **Selective Debridement** — Describes the type of treatment (such as a high pressure water jet which can be used with or without suction and debridement with the use of scissors, forceps, or a scalpel), the type of open wound, wound assessment, whirlpool, and instructions for continued care per session; also describes the total wound surface area for the first 20 square centimeters ~~sq cm's~~ or less

Edit to page(s) 5-41: Charges for Emergency Services

ACEP Guidelines for Type A Emergency Departments	
Level and CPT Code	E&M Assessments
Level VI CPT code 99291	Critical care services and intervention greater than 30 minutes for one-on-one care Criteria for critical care assignments can include the following symptoms: ▪ Acute renal failure ▪ Obstruction of airway ▪ Burns ▪ Cardiac arrest ▪ Coma ▪ Hemorrhage ▪ Ventilation of the patient ▪ CPR If a patient expires or is transferred out of the facility less than 30 minutes after the ER care is provided, the service should not be reported as critical care and should receive~~d~~ an E&M Level V charge instead.

Trivia: E&M Levels for Type A Emergency Departments

Q: If the start and stop times for an infusion are not documented in the medical record, should the level of care assigned be ~~by~~ Level III or Level IV?

A: The patient should be assigned a level of care IV. The documentation of the start and stop times is not required for the level of care determination.