



## *April 2011 Edition*

April's edition of *Chargemaster Corner* discusses new and old issues impacting the facility's chargemaster and reimbursement opportunities.

This month's edition discusses nerve/pain management injections and blocks, commercial payment policies and the ever-continuing documentation dilemmas.

We hope you will enjoy the enclosed articles. Happy Easter and Happy Spring!!

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### **Guidance for Central Line and PICC Placement**

When using ultrasound guidance to place a central line or PICC, CPT 76937 *Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)* is reportable. CPT instructions as well as the above code description states that a permanent recording must be generated and included in the patient's medical chart, essentially supporting the use of ultrasound guidance.

Additionally, when fluoroscopy is utilized as the means to provide visualization when PICC or central lines are placed, CPT 77001 *Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)* is reported. Included in the fluoroscopy guidance we find the phrase "radiographic documentation of final catheter placement". A subsequent chest x-ray is not separately reportable when it is primarily used to "validate catheter location." The use of fluoroscopy + subsequent chest x-ray is essentially reporting two procedure charges providing the same information.

Reporting 76942 and 77001 seem fairly straight forward, generate no separate reimbursement, but can present charging challenges.

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A *Chargemaster Corner* subscriber recently shared the below information with Ingenix Consulting and we wanted to share it with our readers. Ingenix is finding more information disseminated from commercial payers providing guidelines on claims processing and reimbursement. The following policy will affect providers in Minnesota:

*Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) audit professional claims with comprehensive, sophisticated software containing clinical logic based upon medical practice and reimbursement standards, along with the knowledge and findings of medical experts. This includes national coding guidelines as well as industry standards, medical policy together with literature and academic affiliations.*

*Effective for claims received June 1, 2011 and after, Blue Cross will begin to apply the Correct Coding Initiative (CCI) edits in addition to the current auditing software.*

*Additionally, Blue Cross will no longer separately reimburse for venipuncture (36415, 36416) and/or handling fees (99000,99001). These codes will be denied as incidental, or included in, a primary service.*

"I have found many hospitals not applying CCI edits to all their claims," states Penny Allison, RN, BNS, Director of Chargemaster Consulting. "They will scrub only their Medicare claims applying CCI edits and appropriate modifiers, allowing all other claims to be submitted with all CPT codes generated by clinical departments. As the policy implemented by Blue Cross is adopted by more and more commercial payers around the country, this will undoubtedly provide billing and coding consistencies among all claims submitted for reimbursement.

"Venipunctures are still separately reimbursed by Medicare," comments John Arno, RT, (R), ARRT, CPC-A, MPA. "I've been waiting for the time when Medicare stops separately reimbursing the \$3.00. It is routine to most laboratory services. We've seen where commercial payers have or are adopting the payment policy Blue Cross and Blue Shield of Minnesota is."

As a side note, should a payer (including Medicare) check the patient's medical record to ascertain if a venipuncture was indeed performed, most would fail to find supportive documentation. Whether performed by laboratory phlebotomists, nursing staff or other professionals, unless there is documentation to support a venipuncture or capillary stick was performed, it would be hard to dispute the denial of this charge. While \$3.00 doesn't appear to be a lot of money, quantify the volume of outpatient venipunctures performed and it quickly adds up to a large amount of money. "It may be in the future where we will

see Medicare adopting industry standards and stop paying for venipunctures,” John continues. “But more importantly, the old statement we hate to hear seems appropriate in this instance, and that is “if it isn’t documented, it didn’t happen.” And it won’t receive payment.

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### Nerve Blocks Performed with Surgical Procedures

During recently performed chargemaster reviews, Ingenix identified gross and net reimbursement opportunities overlooked by the facility. These opportunities primarily were for the performance of nerve/pain injections performed by anesthesia services or physicians specializing in pain management.

The nerves that supply the sensation and movement control to the shoulder and arm pass out of the spinal cord in the neck forming a bundle of nerves called the brachial plexus. The information traveling in this bundle of nerves can be blocked using medicine similar to the Novocaine used by physicians and dentists. Blocking the brachial plexus prevents pain information from going to the brain and prevents the brain from sending movement signals to the arm. As with Novocaine, the block is temporary. By selecting different medicines, the physician or anesthesiologist can make the block last for longer or shorter periods of time. For shoulder surgery the goal is to have a block that comes on quickly (so that minimal general anesthesia is necessary for the operation), but lasts long enough for the patient to recover from the general anesthesia while experiencing minimal pain and nausea.

Interscalene block is the most proximal approach to the brachial plexus and is the most suitable block for procedures on the arm or shoulder. The block is a paravertebral approach at the level of the cervical roots in the neck and can provide both brachial and cervical nerve blocks.

CPT Assistant October 2001 states that the interscalene block can be reported “separately” from the surgical procedure and the charge for the delivery of anesthesia for the professional code. A CCI edit may occur but typically the 64415 procedure was performed in another area, e.g. pre-op area or even post-op.

Usually when done pre- or post- procedure it would be reported with a modifier -59 and, based on previously referenced *CPT Assistant*, would be totally appropriate. Joe Martinez, CPC, Senior Healthcare Consultant, states “From a charging perspective, these types of pain injections are usually separately reportable procedures from the surgical procedure. Charges for these injections should not be included in the operating room’s time-based charges. In addition, when charging for these types of nerve injections, the cost and charge for the needle and other trays and routine supplies would be included in the injection charge.”

CPT Assistant says:

It is appropriate to report pain management procedures, including the insertion of an epidural catheter or the performance of a nerve block, for postoperative analgesia separately from the administration of a general anesthetic.

When general anesthesia is administered and these injections are performed to provide postoperative analgesia, *they are separate and distinct services and are reported in addition to the anesthesia code*. Whether the block procedure (insertion of catheter; injection of narcotic or local anesthetic agent) occurs preoperatively, postoperatively, or during the procedure is immaterial.

If, on the other hand, the block procedure is used **primarily** for the anesthesia itself, the service should be reported using the anesthesia code alone. In a combined epidural/general anesthetic, the block cannot be reported separately.

**Reference:** CPT Assistant October 2001.

“While the above *CPT Assistant* references focus on the professional billing, they are also applicable as a guide for hospitals to follow,” Joe continues. “These injections often occur in the preoperative area but can also be routinely performed in the recovery room. When performed in these clinical areas, facilities should report a separate charge for the nerve injections while also reporting time charges for anesthesia and operating room services.”

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### CPT vs Medicare Guidelines for Monoclonal Chemotherapy Administration Services

CPT does not provide instructions regarding the appropriate reporting of drug administration services on a drug-by-drug basis. However, it does provide general guidance to help providers determine if the administration of a nonchemotherapeutic drug or a biologic agent may be appropriately reported using a chemotherapy administration code (96401–96549). Specifically, CPT describes the following characteristics of chemotherapy administration:

- The physician work and/or clinical staff monitoring that is required is well beyond that associated with the administration of other therapeutic drug agents that is reported with codes 96360–96379 because the incidence of adverse patient reactions is typically greater.
- The services are typically complex and require direct physician supervision for patient assessment, provision of consent, safety oversight, and intra-service supervision of staff.
- Advanced practice training and competency is typically required for staff that provide these services.

- Special considerations for preparation, dosage, or disposal are typically required.
- The services commonly entail significant patient risk and frequent monitoring as demonstrated by:
  - frequent changes in infusion rate
  - prolonged presence of the nurse administering the solution for frequent patient monitoring and infusion adjustments
  - frequent conferring with the physician

The CPT does not provide a list of specific monoclonal antibody agents or other biologic response modifiers that qualify for the use of the chemotherapy administration codes. However, based on CPT instructions, chemotherapy infusion and injection CPT codes could correctly be utilized for reporting for such drugs as Remicaide, Rituxan, Campath, Mylotarg and Herceptin.

Facilities are expected to select the appropriate drug administration code based on both the CPT guidelines that are summarized above as well as on any guidance or policies issued by specific payers. Payers exercise independent discretion when developing and setting drug administration coding policy, taking into account these same instructions.

### Medicare Guidance

Medicare policy regarding payment for chemotherapy administration and non-chemotherapy injections and infusions may be found in Chapter 12 of the Medicare Claims Processing Manual (Publication 100-04). Medicare recognizes same three categories of codes as detailed in CPT: 1) hydration; 2) therapeutic, prophylactic, and diagnostic injections and infusions (excluding chemotherapy); and 3) chemotherapy administration. Consistent with CPT, Medicare policy states that the chemotherapy administration codes apply to parenteral administration of: non-radionuclide anti-neoplastic drugs; anti-neoplastic agents provided for treatment of noncancer diagnoses (e.g., cyclophosphamide for auto-immune conditions); substances such as monoclonal antibody agents; and other biologic response modifiers. The manual instructions also indicate that the administration of anti-anemia drugs and anti-emetic drugs by injection or infusion for cancer patients is not considered chemotherapy administration. While Medicare provides specific examples, the manual instructions clearly indicate that the drugs cited are not intended to be a complete list of drugs that may be administered using the chemotherapy administration codes and local carriers may provide additional guidance regarding which drugs may be considered to be chemotherapy drugs under Medicare. There is no CMS mandate that all monoclonal antibodies are to be considered sufficiently complex to always justify use of chemotherapy administration codes. **Reference:** Claims Processing Manual, Chapter 12

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