



### January 2011 Edition

The holidays are behind us and the New Year already promises to be exciting. This month's edition of *Chargemaster Corner* will dive headfirst into some reporting challenges facing healthcare providers.

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#### CMS Updates Drug Screen Descriptor

This first week of January 2011 noted CMS' decision to change the description for HCPCS G0431. When the OPPS Final Rule was published, and the 2011 HCPCS files were released (long and short descriptor files), we noted the current description for G0431 to be: *Drug screen, qualitative, multiple drug classes by high complexity test method, (e.g. immunoassay, enzyme assay), per patient encounter*. It did appear that CMS erroneously removed all opportunity for facilities to report single drug class screens. On January 4<sup>th</sup>, CMS corrected this code's descriptor, including this revision in the "G-Code January 2011" file, located at CMS' HCPCS Quarterly Update website. Once again we have a HCPCS code by which we may report a single drug class, now reading: *Drug Screen single class, high complexity test, (e.g. immunoassay, enzyme assay), each specimen*. CMS noted the effective date for this descriptor change to be January 1, 2011.

By definition, the original HCPCS code published in the OPPS Final Rule indicated that G0431 would be reportable one time, based on the description "per patient encounter". As a result, the January 2011 MUE file was published and the MUE assigned to G0431 is found to be 1. Now the description has changed, we may have some claim processing issues should we report this specific HCPCS code with a unit greater than 1, as it's revised description now reads, "each specimen."

Providers should be watchful for guidance from their respective MACs on how this HCPCS code will be processed/paid as we continue through the first quarter.

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#### Drug Administration Clarified

CMS has never changed their stance from the original reporting instructions for infusions and injections. Providers were thrilled to see no CPT code changes were required, but more than confused when the AMA's 2011 CPT code book advised providers that when two IV pushes were administered, one before and the second

after midnight, two initial administration codes should be reported. (Page xii). In direct conflict with CMS' instructions, providers were wondering if Medicare would change their stance and issue revised reporting guidance.

CMS has, in fact, clarified drug administration services, issuing the following statement in Transmittal R2130CP, effective January 3, 2011:

*CMS revised Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 230.2, to clarify the correct coding of drug administration services. Drug administration services are to be reported with a line-item date of services on the day they are provided. In addition, beginning in CY 2007, hospitals should report only one initial drug administration service, including infusion services, per encounter for each distinct vascular access site, with other services through the same vascular access site being reported via the sequential, concurrent or additional hour codes. Although new CPT guidance has been issued for reporting initial drug administration services, Medicare contractors are to continue to follow the guidance given in this manual.*

Providers should, therefore, follow CMS' reporting guidelines, and ignore the statement noted above in the 2011 CPT codebook.

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#### CMS Did Not Clarify G0269

It was hoped CMS would issue a clarification on the confusing statement found on page 480 (2011 CPT *Professional Edition*), Cardiac Catheterization, stating, "Closure device placement at the vascular access site is inherent to the catheterization procedure and not separately reportable." Among several helpful resources often used to ascertain of procedures may be separately reported are the NCCI edits. When reviewing the January 2011 NCCI edit tables however, we fail to find any of the 2011 new CPT/HCPCS codes, since these edits are always one quarter behind. These new codes will be included in the April 2011 files

Do hospitals follow CPT codebook guidance in lieu of CMS' lack of reporting guidance? Be sure the claim reflects the facility's "costs" for inserting the vascular device, however, it will be a facility decision whether G0269 will appear separately on the claim with cardiac catheterization procedures. Until CMS issues their interpretation of this controversial statement, or until the April NCCI edits are published, it does appear the hospital could go either way. No such statement was issued when a closure device is placed during an interventional radiology procedure.

## Chargemaster Corner

### Reinstated Deleted Orthotic Supplies

CMS has reinstated codes:

L3660 *Shoulder orthosis, figure of eight design abduction restrainer, canvas and webbing, prefabricated, includes fitting and adjustment;*  
 L3670 *Shoulder orthosis, acromio/clavicular (canvas and webbing type), prefabricated, includes fitting and adjustment; and*  
 L3675 *Shoulder orthosis, vest type abduction restrainer, canvas webbing type or equal, prefabricated, includes fitting and adjustment*

Originally noted as “deleted” in Addendum B as well as the HCPCS files, CMS reversed their decision and noted the above HCPCS codes will be paid based on the DMEPOS fee schedule.

These HCPCS code changes as well as other code descriptor revisions may be found on CMS website:  
<http://www.cms.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage>

### MUE’s January 2011 Released

CMS issued the first MUE file for 2011, providing facilities and providers the guidance needed for the reportable MUEs for over 6,140 CPT and HCPCS codes. Some of the notable “new” changes are as follows:

Over 250 new CPT and HCPCS were released by the AMA and CMS, effective January 1, 2011. Seven of these new codes did end up on the MUE table as follows:

2011 CPT Code	Long Description 2011
43756	Duodenal intubation and aspiration, diagnostic, includes image guidance; single specimen (eg, bile study for crystals or afferent loop culture)
43757	Duodenal intubation and aspiration, diagnostic, includes image guidance; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube, includes drug administration
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence
90867	Therapeutic repetitive transcranial magnetic stimulation treatment; planning
90868	Therapeutic repetitive transcranial magnetic stimulation treatment; delivery and management, per session
91013	Esophageal motility (manometric study of the esophagus and/or gastroesophageal junction) study with interpretation and report; with stimulation or perfusion during 2-dimensional data study (eg, stimulant, acid or alkali perfusion) (List separately in addition to code for primary procedure)
96446	Chemotherapy administration into the peritoneal cavity via indwelling port or catheter

The above “new” codes added each contain an MUE of “1”.

Two new HCPCS codes are now found on January’s MUE table:

2011 CPT Code	Long Description 2011
G0431	Drug screen, qualitative; single drug class method (e.g., immunoassay, and enzyme assay), each drug class
L3677	Shoulder orthotic (SO), hard plastic, shoulder stabilizer, prefabricated, includes fitting and adjustment

As discussed above in the first article, with the recent description revision, the MUE of 1 is inappropriately assigned with HCPCS G0431. Providers should watch drug screen reporting and reimbursements very closely. HCPCS L3677 is assigned an MUE of 1, and this is the first time this DMEPOS item has been found included in the MUE table.

Other notable changes in January’s MUE table consist of increasing/decreasing the reportable MUE number:

CPT	Short Desc	Jan 2011 MUE	Oct 2010 MUE
90740	Hepb vacc pat 3 dose im	2	1
90747	Hepb vacc pat 4 dose im	2	1
G0010	Admin Hepatitis b vaccine	2	1
93922	Upr/l xtremity art 2 levels	1	2

We can discuss the MUE edit changes for those CPT and HCPCS procedures and supplies published. There are numerous other MUE edits for which CMS has elected to not publish. The provider blindly discovers those specific MUEs when claims are submitted and returned due to the MUE violation. Providers are always cautioned to keep abreast of the published MUE values assigned to procedures and services performed in the various ancillary departments. Accurate charging and correct reporting often do not coincide in the Medicare billing arena.

### AMA Issues CPT Corrections

The American Medical Association recently published the errata for both the 2011 CPT codebook as well as the 2011 *Insiders View*. For a closer look at these required changes to the printed publications, please see the following website:

<http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/errata.shtml>

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Corrections notable for the 2011 *Insider's View* are specific to the Table of Catheterization Codes, specifically the crosswalk for the 2011 CPT 93451. This table was essentially revised 1/5/2011 and cardiac cath labs and interventional radiology departments may be interested in this specific revision.

The AMA stated there are changes to a few vaccine CPT codes, not published in this year's CPT codebook. The H1N1 vaccine product codes 90663 and administration code 90470 developed for the 2009 Swine Flu Pandemic are no longer valid codes for reporting current flu vaccines. This change became effective in October 2010 when the CPT Editorial Panel approved the request to delete these codes. These changes will be published at the printing of the CPT 2012 codebook.

Therefore, CPT codes 90663 and 90470 are essentially deleted.

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### RACs to Expand And Include Medicaid Claims

As if things were not hectic enough already for most hospitals, in November 2010 the Department of Health and Human Services published the Proposed Rule for applying the RAC process to the Medicaid program. The RAC process has been part of the Medicare program since 2005, introduced first as a demonstration project from 2005-2008, and then extending to all states no later than January 1, 2010.

Proven to generate billions of dollars back from providers to the Medicare Trust Fund, the process requires providers to expend substantial amounts of increased administrative expenditures to accommodate these reviews.

While several States have conducted RAC type audits under their Medicaid programs, most have not. As part of the health reform legislation, Congress required all States to establish a Medicaid RAC program by December 31, 2010. (*See* §6411 of the Patient Protection and Affordable Care Act).

Other noteworthy provisions of the Proposed Rule include the following:

- Medicaid RACs will be required to employ trained medical professionals to review Medicaid claims;
- States "may consider" establishing requirements regarding the documentation of good cause to review Medicaid claims;
- Whenever a Medicaid RAC has reason to believe that fraud or criminal activity has occurred, it must report such activity to appropriate law enforcement officials.

Medicaid providers and suppliers should begin to prepare for yet another layer of auditing activity. The Medicaid RAC program is in addition to, and will supplement, existing routine State program integrity audits, Medicaid Integrity Contractor ("MIC") audits, and audits conducted by other State and Federal agencies. While "overlapping or multiple provider audits may be necessary, CMS hopes to minimize the likelihood of overlapping audits" by requiring Medicaid RACs to coordinate their efforts with other contractors

The Proposed Rule may be found at:

<http://edocket.access.gpo.gov/2010/pdf/2010-28390.pdf>

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