



## January 2012 Edition

Welcome to the first newsletter of 2012!! First of all, *Chargemaster Corner* would like to take this opportunity to wish everyone a Happy New Year, and welcome the many new subscribers who have joined our family of readers. We are excited to add the many e-mail addresses to our distribution list and thank everyone for the positive comments and interest in our free monthly newsletter. It is hoped the articles included in January's edition of *Chargemaster Corner* are helpful to your facility as you continue the quest to reflect coding and charge data for services and procedures compliantly and accurately.

This edition contains the following articles:

- New Screening and Counseling HCPCS Codes
- Correction for Intraocular Lens
- Molecular Pathology Test Reporting
- Three-Day Payment Window for Outpatient Services
- Implementing new Modifier –PD
- Medically Unlikely Edit Update for 2012

### New Screening and Counseling HCPCS Codes

Even though the 2012 OPPTS Final Rule introduced new CPT/HCPCS codes, status indicators, and APC assignments, Medicare created a few unexpected but welcomed surprises in the middle of November by the issuance of several transmittals specific to coverage updates for several screening and counseling services. Additionally, Transmittal 2376, "January 2012 Update of the Hospital Outpatient Prospective Payment System (OPPTS)" summarized the billing guidelines and requirements for receiving payment for these services. CMS is committed to promoting the appropriate use of Medicare preventive benefits. Medicare now covers a broad range of services to prevent disease, detect disease early when it is most treatable and curable, and manage disease so that complications can be avoided.

CMS recognizes the crucial role that health care providers play in providing and educating Medicare beneficiaries about potentially life-saving preventive services and screenings. While Medicare now pays for more preventive

benefits, many Medicare beneficiaries do not fully realize that using preventive services and screenings can help them live longer, healthier lives.

Patients opting for "original Medicare" will have more preventative services covered this year. Medicare now covers screening and behavioral counseling to reduce alcohol misuse, depression screening as well as screening for sexually transmitted infections. Additional HCPCS for other behavioral counseling sessions have been created, all reportable from the facility's chargemaster.

CMS will begin covering screening and counseling services for alcohol misuse, effective October 14, 2011. HCPCS G0442, *Annual alcohol misuse screening, 15 minutes* (Status Indicator S) is covered by Medicare for one alcohol misuse screening per year. Counseling may be covered if the screening result is positive, reportable with new HCPCS G0443, *Brief face-to-face behavioral counseling, for alcohol misuse, 15 minutes*. People who screen positive can get up to 4 brief face-to-face counseling sessions per year. A qualified primary care doctor or other primary care provider must provide the counseling with documentation requirements detailed in Chapter 1, Section 210 of Pub 100-03, *Medicare National Coverage Determinations Manual* as well as Chapter 18, Section 180, Pub 100-04, *Medicare Claims Processing Manual*.

HCPCS G0444, *Annual Depression Screening, 15 minutes*, is covered by Medicare to help with conditions such as depression or anxiety. Coverage includes services generally provided in an outpatient setting (such as a doctor's or other health care provider's office or hospital outpatient department), including visits with a psychiatrist or other doctor, clinical psychologist, nurse practitioner, physician's assistant, clinical nurse specialist, or clinical social worker; certain treatment for substance abuse; and lab tests. It is noted that emergency departments, inpatient hospital settings, ambulatory surgical centers, independent diagnostic testing facilities, skilled nursing facilities, inpatient rehabilitation facilities, and hospice are not considered primary care settings and HCPCS G0444 will not be covered in these clinical settings. Medicare covers one depression screening per year, beginning for claims with dates of service on and after October 14, 2011. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.

Screening laboratory tests using FDA approved/cleared laboratory tests (in compliance with CLIA regulations) for sexually transmitted infections will be covered by Medicare, on and after November 8, 2011. Screening for chlamydia, gonorrhea, syphilis and hepatitis B, when ordered by the primary care provider, will be covered by Medicare, reportable with the respective laboratory CPT codes. HCPCS G0445, *High intensity behavioral counseling to*

*prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes* is utilized when reporting face-to-face counseling sessions, up to two individual sessions annually to prevent sexually transmitted infections for all sexually active adolescents and adults at risk. To be eligible for coverage and reimbursement, the counseling must be provided by a Medicare eligible primary care provider in a primary care setting. As discussed previously, a primary care setting is integrated and accountable for addressing a large majority of personal health care needs. HCPCS G0445 is separately payable, assigned to APC 0432, Status Indicator S.

Another new preventative service now covered will hopefully help to prevent cardiovascular disease and obesity. Screenings for cardiovascular disease and obesity have been added to the preventive services available at no out-of-pocket cost to patients with Medicare. The new benefit covers one doctor visit each year to determine the best way a patient can ward off cardiovascular disease. A physician may screen the patient for hypertension and discuss how changes in their diet can lower the risk of heart disease or a stroke. The free screening for obesity includes regular counseling sessions at the doctor's office if the patient has a body mass index of 30 or higher. A patient who loses at least six pounds during the first six months qualifies for six more months of counseling.

HCPCS G0446, *Intensive behavioral therapy to reduce cardiovascular disease risk, individual, face-to-face, annual, 15 minutes* as well as HCPCS G0447, *Face-to-face behavioral counseling for obesity, 15 minutes* are reportable for services on and after November 8, 2011 and November 29, 2011 respectively.

The above new HCPCS codes join the other codes for preventative services Medicare now covers: Welcome to Medicare Exam, Annual Wellness Visit, Breast Cancer Screenings, Heart Disease Screening, Osteoporosis Screening, Diabetes Screening, Colon Cancer Screenings, Vaccinations, Smoking Cessation, Cervical Cancer Screenings, Prostate Cancer Screenings, Medical Nutritional Therapy, Glaucoma Screening and Prostate Cancer Screening.

Unless specifically stated by CMS in their coverage policies, the facility may elect to report the above new preventative services using one of the many "clinic" revenue codes, e.g. 051X, or treatment room, 076X.

As a result of the Affordable Care Act, Medicare now covers many of these services without cost to patients, including the new Annual Wellness Visit that was created under the Affordable Care Act. (Refer to the Preventive

Services Quick Reference Chart in the Downloads section below for more information.)

[https://www.cms.gov/MLNProducts/downloads/MPS\\_QuickReferenceChart\\_1.pdf](https://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf)

An added "free" resource that maybe extremely useful for billing and coding as well as chargemaster staff are the Medicare Preventative Services Series on CMS Website. These web-based training courses are provided in a 3-part series (updated as of August 2011) and are also AAPC approved for continuing education hours. To obtain a course overview of this Web-based coding series as well as the other 13 on-line free courses on CMS website, please use the link below:

<http://www.cms.gov/MLNEdWebGuide> and select the "Web-Based Training (WBT) Courses" link.

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### Correction for Intraocular Telescopic Lens

Transmittal 2376, December 29, 2011, Effective January 3, 2012 issued a corrective reporting requirement for providers billing the lens implant C1840 (*Lens, intraocular (telescopic)*). In 2011 Transmittal 2296, CMS directed providers to report this new lens with CPT 66982 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage* or CPT 66984 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)*. CMS issued a correction for providers to report C1840 with new HCPCS C9732, *Insertion of ocular telescope prosthesis including removal of crystalline lens*. The new IOL is billed and paid as a pass-through device only when billed with C9732, effective January 1, 2012. Providers are advised to ignore previous instructions published in the October 2011 OPSS Update, Transmittal 2296. HCPCS C1840 is reported with Revenue Code 0276, Intraocular Lens.

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### Laboratory Molecular Pathology Procedure Reporting

The laboratory industry and hospital chargemaster coordinators are struggling with the challenge of implementing the new molecular pathology CPT codes. CMS announced that the new CPT codes, specific for molecular pathology created by the American Medical Association (AMA), could not be utilized for payment by Medicare in 2012. The 2012 Final OPSS Rule initially noted that CMS assigned status indicator "B" (Codes that

are not recognized by OPSS when submitted on an outpatient hospital Part B bill type (12x and 13x),” to the more than 100 new CPT codes. However, the January 2012 Addendum B contains the reassignment of status indicator “B” to status indicator “E”, (Codes which are not recognized by Medicare for outpatient claims but for which an alternate code for the same item or service may be available, not paid by Medicare when submitted on outpatient claims (any outpatient bill type)).

Medicare essentially has no claims data on which to rely when assigning reimbursement amounts for these new molecular pathology CPT codes. They are asking hospitals and providers to do this work for them. Transmittal R2365CP, December 9, 2011, “Calendar Year (CY) 2012 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment” was the first communication issued by CMS which provided billing requirements. In simplistic terms, the hospital/provider should continue reporting panel/explode or “stacked” test codes as they did in CY2011 for these molecular procedure tests. Adding to these panel/explode/stacked series of CPT codes, the hospital/provider must also include the corresponding new 2012 Molecular Pathology CPT code with a \$0.00 charge. This will demonstrate to Medicare the individual tests comprising these new molecular procedure codes as well as the overall “charge” for the reported codes. This sounds rather simple, but it is not.

Reference laboratories around the country perform these stacked panel codes differently, including more/fewer testings with varying costs. A cystic fibrosis panel performed by one reference laboratory in the northeast may have be comprised of 10 separate CPT codes, while a reference laboratory in the western region of the country may report the panel with 8 different CPT codes. This may yield inconsistent claims data as Medicare begins the analysis for pricing these new molecular pathology procedure test codes.

It may be too early to predict the hospital/provider will have claim reporting issues, simply by including a CPT code that has an “E” status indicator on a claim containing \$0.00; however, billing and reimbursement staff should pay close attention to denials and payments as claims containing these new “stacked” code series begin to be billed.

Reference laboratories may begin to provide hospitals/providers with the new 2012 molecular pathology CPT codes only, particularly since they are part of the AMA 2012 CPT code set. Closely working with the facility’s reference laboratory may be necessary for the first few months, to establish the correct code assignments for the “stacked” or explode panels currently utilized. Another question to be pursued is whether private insurance

companies will continue to accept and reimburse based on current 2011 CPT code panels, or will they require facilities to report the molecular pathology testings using the 2012 new CPT codes? Will hospitals/providers have to accommodate Medicare’s reporting requirements while considering the “other payers” billing and reimbursement rules for services on and after January 1, 2012.

Transmittal 2376, “January 2012 Update of the Hospital Outpatient Prospective Payment System (OPSS)” (December 29, 2011) provided no additional helpful guidance in Paragraph 15, Molecular Pathology Procedure Codes. Hospital’s chargemaster and laboratory staff will undoubtedly continue with a very close relationship to coordinate the reporting of these new tests. CMS does have relative value unit (RVU) information created for each of these new molecular pathology codes but has decided not to publish the information. It is assumed that hospitals/providers’ claim data will be used as validation, confirmation or support of any proposed reimbursements by CMS. Only after sufficient claims data has been received and analysis completed, will hospitals and providers be privy to reimbursements for these new codes.

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### **Three-Day Payment Window for Hospital Outpatient Services, and new Modifier –PD**

The Three-Day Payment Window requires the admitting hospital to include preadmission services (diagnostic and non-diagnostic) provided within three days prior to and including the date of the patient’s admission with those services provided after admission. This includes any services provided by “an entity wholly owned or wholly operated” by the admitting hospital; that is, any outpatient department or clinic for which the hospital has exclusive responsibility for conducting and overseeing the entity’s routine operations. This includes a hospital-owned or operated physician practice as well as a freestanding clinic.

For outpatient services furnished on or after June 25, 2010, the **technical** portion of all nondiagnostic and diagnostic services (ambulance and maintenance renal dialysis are excluded) provided on the day of inpatient admission or during the 3 calendar days (or 1 calendar day) immediately preceding the date of the inpatient admission must be billed with the inpatient admission. Transmittal 2373, December 21, 2011. The **professional** component, however, will be paid by Medicare with payment rates that include a professional and technical split and at the facility rate for services that do not have a professional and technical split.

The three-day payment window policy requires a hospital to include the technical portion of any outpatient diagnostic services and admission-related nondiagnostic services provided during the preadmission payment window with the

other charges generated for the inpatient claim (MPFS Final Rule). Because the three-day inpatient payment window policy does not include professional services, the clinic's CMS-1500 claim form should only contain charges for the **professional** component.

Facilities have expressed concerns of implementation challenges as they incorporate the three-day payment window policies into their billing practices and requested CMS postpone this requirement for at least a year. Billing and accounting systems between the clinic and hospital are often not coordinated and the facilities may require internal procedures and system upgrades to accommodate this requirement. CMS agreed to delay this requirement until July 1, 2012. However, for those facilities which can meet this billing requirement, modifier PD (Diagnostic or related nondiagnostic item or service provided in a wholly owned or wholly operated entity to a patient who is admitted as an inpatient within 3 days, or 1 day) will be appended to each CPT code reported on the CMS-1500. Here are some billing examples provided by Medicare in the MPFS 2012:

*A hospital owns a physician clinic or a physician practice that performs preadmission testing for the hospital. Policy: A hospital-owned or hospital operated physician clinic or practice is subject to the payment window provision. The technical portion of preadmission diagnostic services performed by the physician clinic or practice must be included in the inpatient bill and may not be billed separately. A physician's professional service is not subject to the window.*

Free standing clinics performing diagnostic laboratory or radiology procedures will be impacted even more, as the costs of diagnostic services are impacted because of the three-day payment window policy. If laboratory services were performed on Monday which included blood glucose and urinalysis, these charges would need to be included on the inpatient claim if the patient was admitted for a related medical condition. For radiology services, modifier PD will be reported on the CPT code and CMS will reduce those services that have a PC/TC component, reducing payment to the PC only. The charges associated for the TC is to be reported on the hospital claim. The PD modifier will signal claims processing systems to provide payment only for the PC for CPT/HCPCS codes with a TC/PC split at the facility rate when they are provided in the 3-day (1-day) payment window.

For patients admitted as an inpatient, any **professional** component submitted by the clinic on a CMS-1500 claim form which are related to the inpatient admission, will be billed with modifier –PD appended to each claim line.

CMS has stated they will hold the hospital accountable for notifying the wholly owned or wholly operated physician

practice of related inpatient admissions for patients who have received services within the three-day payment window, prior to the inpatient stay. The hospital and clinic will undoubtedly need to develop a process to transfer charges and develop a process for handling this process. The clinic will need to begin reporting modifier PD on the CMS-1500 billing document as soon as possible. Payments will be reduced beginning July 1, 2012.

Facilities impacted by this new directive will need to review policies and procedures, computer interfaces, communication mechanisms, billing processes as well as responsibility for assignment of modifier –PD. For facilities operating multiple clinics which are wholly owned or operated by the hospital, the challenges increase with each clinic. Rural health clinics (RHCs) and Federally Qualified Health Center (FQHCs) are exempt from this CMS directive, primarily because these types of clinics bill and are paid for services included in their all-inclusive rate.

### Medically Unlikely Edit Updates for 2012

Medicare updates the Medically Unlikely Edit (MUE) table each quarter. Review of the January 2012 MUE table has identified approximately 1,009 surgical CPT codes which have had a reduction of MUE assignment. In October 2011 these CPT codes contained an MUE value of 2, January 2012 the same CPT codes were noted to have an MUE value of 1.

Other interesting changes were noted for four injection and infusion CPT codes as noted below:

CPT	Description	MUE January 2012	MUE October 2011
96360	Hydration iv infusion init	1	2
96374	Ther/proph/diag inj iv	1	2
96409	Chemo iv push sngl drug	1	2
96413	Chemo iv infusion 1 hr	1	2

Based on Medicare's direction, if services exceeded the listed MUE value and documentation supported, modifiers may be utilized to report services beyond this MUE value.

Other notable MUE value changes reside with medical device reporting:

CPT	Description	MUE January 2012	MUE October 2011
C1722	AICD, single chamber	1	2
C1767	Generator, neuro non-recharg	2	3
C1772	Infusion pump, programmable	1	2
C1785	Pmkr, dual, rate-resp	1	2
C1813	Prosthesis, penile, inflatab	1	2
C1820	Generator neuro rechg bat sy	2	3

Facilities are encouraged to review the MUE values on a quarterly basis and include HIM coders, billing staff and department directors on distribution of any notable revisions.

We hope you enjoy receiving the *Chargemaster Corner* from OptumInsight. Each month OptumInsight will circulate this newsletter via e-mail to those interested parties who have provided contact information either via e-mail request or who have completed an informational form when attending a number of educational seminars conducted nationwide. Please share this e-mail with your co-workers and encourage them to contact OptumInsight via [Chargemaster.corner@gmail.com](mailto:Chargemaster.corner@gmail.com). Contact information will not be shared with any other organization and used *only* for means of distributing this monthly newsletter. For direct contact concerning receipt of this newsletter, please e-mail your comments to the above noted e-mail address. Thank you for your interest in this monthly chargemaster newsletter and hope you find it helpful.

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Also please remember OptumInsight can assist you in the preparation of ICD-10-CM/ICD-10-PCS. Whether doing a gap analysis, assessing financial risk, chart audits or coder and physician education, OptumInsight is prepared to meet your needs.

Have you looked on-line for free resources to use when preparing for ICD-10-CM and ICD-10-PCS? OptumInsight’s website has “ICD-10 Coder’s Corner” and provides an overview to the ICD-10 coding system and gives focused spotlight discussions for both ICD-10-CM and ICD-10-PCS. There are even coding scenarios to test your coder’s knowledge. The link for “Coding Resources” contains a list of valuable and official resource website links for guidance and additional information.

Please take time to review the resources found on this site, and bookmark the page as updates and new coding scenarios are posted. You may find the site at: <http://www.optuminsightcoding.com/NonProd/2952/>

Under “Coding Central” you will also find an archive for previous *Chargemaster Corner* articles as well.