June 2011 Edition

By now, you may have heard that Ingenix has a new name. Ingenix Inc., the health information technology subsidiary of UnitedHealth Group, changed its name to Optum, starting June 6th. This change reflects the increasing coordination and cooperation between the three leaders in healthcare who work to bring about significant and positive changes in the health system: OptumHealth ™, which will retain its name, **OptumInsight** ™, formerly **Ingenix**, and OptumRx ™, formerly Prescription Solutions. Together these companies serve more than 60 million people, more than 30,000 employees and reported in 2010 consolidated sales of USD 25 billion, which has as Optum entire company the size of a Fortune 100 company.

Please be aware, the company has a new name, but we have the same dedicated and expert consultants to assist clients in billing and coding issues encountered. OptumInsight has grown…..stay tuned to new developments and new product offerings to help the provider/facility in this ever-changing healthcare arena.

Third Quarter Chargemaster Updates

The July 2011 required revisions impacting the facility's chargemaster are detailed in Transmittal 2234, issued May 27, 2011. Various clinical areas and departments are affected by these new codes and changes, and OptumInsight will provide discussion and insight on these new procedures to assist the facility in their readiness for July 1, 2011.

Observation – What's New

Medicare has stated in the past that observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is part of the procedure (e.g., colonoscopy, chemotherapy). Medicare is seeking to provide clarification for providers by revising their billing instructions to state "*In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time."* John Arno, RT, (R), ARRT, CPC-A, MPA explains Medicare's new guideline as follows: "If a patient is in observation for 20 hours and during that time undergoes a colonoscopy and has a CT of the abdomen performed, the hospital should subtract from the total observation hours the time for both the colonoscopy and CT exam. Medicare is opening the door a little by allowing the hospital to determine the most appropriate method to account for this time, based on their own internal guidelines or processes." John continues, "Documentation in the medical record should support the patient's need for observation, but certainly while the patient is having the colonoscopy procedure (2 hours) and the CT Scan (1 hour) the patient is not being officially "observed" by nursing staff (hourly charges reported with RC 0762). Medicare thereby states the facility may add the time for observation care pre-colonoscopy procedure and CT scan with the time post-colonoscopy procedure and CT scan resulting in the net billable observation time. Another option is to account for the average time for the colonoscopy and CT scan and deduct the procedure time from the total observation time."

Hospitals may have performed time studies for diagnostic and therapeutic radiology procedures (CT, MRI, Ultrasound, and etc.) and have developed a time schedule which provides the "average" time it takes to perform these specific procedures. Additionally, any procedure that may be performed away from the patient's observation bed would theoretically need to have the time deducted from the total observation time. These could include stress tests, cardiac echocardiography, GI procedures, day surgeries, cardiology procedures as well as radiology interventional procedures. Therapeutic infusions and injections are typically provided by the same nursing staff observing the patient. Charging for nursing time by reporting both observation time and Infusion time could be viewed as double charging, but at this CMS has not provided a clear stated interpretation of which pharmaceutical product would require nursing time beyond the typical nursing evaluations/observation.

"To summarize Medicare's new directives, hospital A and hospital B may each have different ways to account for their observation services. The hospital may determine the most appropriate way to account for this time." John adds a final thought. "If the facility develops a time-grid containing the "average length of time" for the above stated diagnostic procedures performed in the respective clinical areas, this should be incorporated into the facility's "observation policy" or "charge-capture policy". Should a RAC audit interpret the facility's observation time somewhat differently than what they find documented, the "observation policy" will support the facility's observation hours reported."

New Category III CPT Codes

Several new surgical CPT codes are available for reporting 7/1/11. Introduced on the AMA's website the end of last year, Category III codes are updated bi-annual on this specific website. Not printed in the *CPT (Current Procedural Terminology)* book until the following calendar year, providers have to be aware of these new codes available January 1 and July 1 of each calendar year. Let's

discuss a few of these codes. For a complete list of all new Category III codes, please go to: http://www.ama-assn.org/ama1/pub/upload/mm/362/cptcat3codes.pdf

CPT	Description	Rev Code	S.I.
0262T	Implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach	036X, 048X,	C
0263T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure including unilateral or bilateral bone marrow harvest	036X, 076X, 0402	S
0264T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; complete procedure excluding bone marrow harvest	036X, 076X, 0402	S
0265T	Intramuscular autologous bone marrow cell therapy, with preparation of harvested cells, multiple injections, one leg, including ultrasound guidance, if performed; unilateral or bilateral bone marrow harvest only for intramuscular autologous bone marrow cell therapy	036X, 076X, 0402	S
0266T	Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)	036X	C
0267T	Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	036X, 048X, 076X	T
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-opoerative interrogation, programming, and repositioning, when performed)	036X, 048X, 076X	S
0269T	Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed)	036X, 048X, 076X	T
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed)	036X, 048X, 076X	T
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed)	036X, 048X, 076X	T
0272T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (eg, battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day);	036X, 048X, 076X	S
0273T	…..with programming	036X, 048X, 076X	S

CPT	Description	Rev Code	S.I.
0274T	Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic	036X, 048X, 076X	T
0275T	……….lumbar	036X, 048X, 076X	T

Two of the new CPT codes above are designated as "Inpatient-only" CPT code, noted with Status Indicator C. The Revenue Codes noted above are simply included recommended revenue codes. As the facility adds the above procedures into the clinical department's chargemaster, the revenue code should be replicated with those currently utilized. The last CPT code CPT 0275T replaces deleted CPT code C9729.

Transmittal 2234 and New HCPCS Codes

New HCPCS codes are introduced for reporting services on or after July 1, 2011 which will generate additional net reimbursement from Medicare. "This is always exciting news for those hospitals which have these pharmaceutical products in their chargemaster and facility formulary," Joe Martinez, CPC, Senior Healthcare Consultant. "At the date of this newsletter, CMS has not published the third quarter payment rates contained in Addendum B. But we can determine which drugs will be separately paid." Joe remarked, "There are 7 new HCPCS that we should be aware of, and are detailed below:

HCPCS	Description	SI	Treatment for:
C9283*	Injection, acetaminophen, 10 mg	G	Pain/Anesthesia
C9284*	Injection, ipilimumab, 1 mg	G	Approved by FDA for treatment of Melanoma
C9285*	Lidocaine 70 mg/tetracaine 70 mg, per patch	G	Pain/Anesthesia
J1572	Injection, immune globulin, (flebogamma/flebogamma dif), intravenous, non-lyophilized (e.g. liquid), 500 mg	G	Immune deficiencies
Q2042	Injection, hydroxyprogesterone caproate, 1 mg	K	Weekly injections to prevent pre-term delivery
Q2044*	Injection, belimumab, 10 mg	G	Approved by FDA for treatment of Lupus

HCPCS J1572 is not a new code but has changed status indicator from K to G, effective July 1, 2011. The other HCPCS codes are brand new codes, all reportable with revenue code 0636, Codes Requiring Detailed Coding. If the facility's chargemaster has these pharmaceutical products listed with C9399, Unclassified drug or biological, the chargemaster should be revised to reflect the above HCPCS.

A new biological skin product is billable and payable, along with a new radiopharmaceutical product:

HCPCS	Description	SI	Treatment for:
C9365*	Oasis Ultra Tri-Layer Matrix, per square centimeter	G	OASIS® Ultra Tri-Layer Matrix, derived from three layers of porcine small intestinal submucosa (SIS). Used to incorporate increased structure into difficult-to-heal and chronic wounds.
C9406*	Iodine I-123 ioflupane, diagnostic, per study dose, up to 5 millicuries	G	Radiopharmaceutical

Other required changes for the facility's chargemaster require HCPCS updates for two deleted codes, replacements provided in Transmittal 2234:

HCPCS	Description	SI	Action:
C9273	Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion	D	Deleted 7/1/11
Q2043	Sipuleucel-r, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other prepatory procedures, per infusion	G	Replacement
J7184	Injection, von Willebrand factor complex (human), Wilate, per 100 IU VWF:RCo	D	Deleted 7/1/11
Q2041	Injection, von willebrand factor complex (human), Wilate, 1 i.u. vsf:rco	G	Coagulation Factor

The language in the long descriptor of HCPCS code Q2043 states "all other preparatory procedures" which refers to the entire process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, sending the immune cells to the facility that prepares the immunotherapy product, and then transporting the immune cells back to the site of service to be administered to the patient.

Medicare introduced two new "C" codes for bronchial RFA procedures.

HCPCS	Description	SI	Rev Codes	Reimburse-ment
C9730	Bronchoscopic bronchial thermoplasty with imaging guidance (if performed), radiofrequency ablation of airway smooth muscle, 1 lobe	T	036X, 075X,	$1,971.77
C9731	Bronchoscopic bronchial thermoplasty with imaging guidance (if performed), radiofrequency ablation of airway smooth muscle, 2 or more lobes	T	036X, 075X,	$1,971.77

If there are any commercial payers that do not accept or recognize this Medicare-created HCPCS code, providers will have to default to reporting this procedure using an unlisted CPT code, e.g. 32999. Per code description, image guidance is included in these new codes and not separately reportable.

And finally, CMS reiterated the same verbiage again about the importance of reporting charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the HCPCS code descriptor.

Transmittal 2212: Payment Update for Influenza Virus Vaccine and Pneumococcal Vaccine Codes

Medicare issued an updated notice to remind providers of the reportable vaccine products with their associated administration codes.

Influenza vaccines and administration codes are as follows:

CPT 90655, 90656, 90657, 90658, 90660, 90662
Administration CPT Code G0008 *Administration of influenza virus vaccine*

Pneumococcal Vaccine and administration codes consist of:

CPT 90669, 90670, 90732
Administration CPT Code G0009 *Administration of pneumococcal vaccine*

Hepatitis B Vaccine and administration codes are:

CPT Codes 90740, 90743, 90744, 90746, 90747
Administration G0010 *Administration of hepatitis B vaccine*

Along with reporting both the correct product and administration CPT codes, one of the following diagnosis codes must be also reported. If the sole purpose for the visit is to receive a vaccine or if a vaccine is the only service billed on a claim the applicable following diagnosis code may be used.

V03.82 Pneumococcus
V04.81 Influenza
V06.6 Pneumococcus and Influenza
V05.3 Hepatitis B

"Medicare has provided some additional reporting guidelines," states Penny Allison, RN, BNS, Director of Chargemaster Consulting. "If a diagnosis code for pneumococcus, hepatitis B or influenza virus vaccination is not reported on a claim, the FI/MAC may not add the diagnosis code on the claim. This is not a dramatic surprise. We would not expect any addition or revision to the diagnoses codes reported by the facility. What is surprising," Penny continues, "is that Medicare noted that if the diagnosis code and the narrative description are correct,

but the HCPCS code is incorrect, the carrier or intermediary may correct the HCPCS code and pay the claim. This is the first time that I can recall that Medicare is willing to automatically change the claim and submit payment based on the HCPCS code the FI/MAC and/or carrier changed. Usually there are no questions asked, if incorrect data is submitted the claim is returned with no payment." The implementation date for this directive is July 1, 2011.

It's That Time of Year Again

Do not be surprised if you receive an e-mail from a list serve or a co-worker forwards you the e-mail notification that CMS has published the Proposed OPPS Rule for 2012. "In years past we have seen the Proposed OPPS Rule published the first week of July, or shortly thereafter. It's that time of year when facilities begin reviewing and planning for future reporting and billing revisions due to increased or decreased Medicare reimbursement," reminds Glenda Schuler, RHIT, CPC, CPC-H. "In years past we have seen the proposed rule provide a prelude to significant reimbursement and packaging concepts only to find them implemented almost verbatim in the Final OPPS Rule. Other instances CMS completely changes their minds by issuing entirely different reporting requirements. The publication of the proposed rule in mid-year allows providers to read and review the sometimes huge document as well as submit comments to Medicare. These comments are then reviewed by CMS and often directly influence their decision for the following year's reporting and reimbursements schemes."

Glenda continues, "On April 19, 2011, the Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) issued the proposed rule for the Hospital Inpatient Prospective Payment Systems (IPPS) for Fiscal Year 2012. While Inpatient and Outpatient billing rules are completely different, occasionally the IPPS proposed/final rules contain reporting guidelines impacting how facilities charge and bill for outpatient services. The Inpatient Proposed Rule is published in the May 5, 2011 Federal Register. CMS accepted comments on the Proposed Rule until June 20, 2011-the deadline has now passed. The final rule is expected to be issued by August 1, 2011.

ICD-10-CM/PCS Implementation

By now, most of you know that the mandatory compliance date for implementation of ICD-10-CM and ICD-10-PCS is October 1, 2013. Rumors are floating that CMS may delay this date; however, Medicare has stated that HHS has no plans to extend the compliance date for implementation; therefore, covered entities should plan to complete the steps required in order to implement ICD-10-CM/PCS on October 1, 2013. Additionally, ICD-10-PCS will only be used for facility reporting of hospital inpatient procedures and will NOT affect the use of CPT codes.

However, you may not realize exactly how much work will be required between now and then to make documentation and reporting diagnoses flow smoothly without any serious impact on your existing workflow processes and accounts receivable. ICD-10-CM experts are advising providers that time is valuable and before you know it, October 2013 will be here before you know it.

Medicare has a website dedicated entirely to ICD-10-CM. The website: http://www.cms.gov/icd10/ contains educational resources especially for health care providers to prepare for the transitions. OptumInsight can certainly assist with the transition by providing education, HIT assistance, gap analysis, benchmarking and identifying the vulnerable documentation and coding areas that could cost the facility money under ICD-10-CM.

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