

Chargemaster Corner



November 2010 Edition

By now your 2011 CPT books have been ordered and hopefully delivered. While the HCPCS Level II books are not expected until mid-December, CMS has published the lengthy OPPS Final Rule along with the long-HCPCS description file(s). This edition of *Chargemaster Corner* is dedicated to a few potential areas we feel may need additional focus and attention when implementing the 2011 CPT coding changes.

The next best resource in understanding the new year's coding changes is the AMA's 2011 *Insider's View*. A few have been shipped and received; most of us are still waiting. This year's required coding changes are numerous; in fact, it has been several years since we have had this volume of changes. Highlights of these code revisions and updates are provided in this month's edition of *Chargemaster Corner*.

Next month's edition will contain excerpts from the OPPS Final Rule as well as continuation of the CPT and HCPCS codes impacting the facility's chargemaster.

We also would like to extend a warm welcome to recent Ingenix seminar attendees who expressed interest in receiving the newsletter. Their names have been added to the distribution list for *Chargemaster Corner*. While this issue does discuss many procedures reviewed during the recent all-day 2011 Chargemaster Update seminars, preparing for implementation for the new codes is never easy. We hope the added discussions below are helpful for all.

Interventional Radiology

For 2011, coders and interventional radiology staff will quickly recognize the complete restructure of CPT codes representing lower extremity atherectomy, angioplasty and stent placement procedures, now fondly classified as "revascularization" procedures. The new revascularization therapies are described in three arterial vascular territories: Iliac, Femoral Popliteal and Tibial/peroneal. Coding guidelines have been developed specific for each anatomical region for coders and technologists to refer to and 2011 CPT codebook contains added paragraphs that will require close scrutiny.

Radiology S&I (supervision and interpretation codes) as well as surgical CPT codes for lower extremity procedures have either been deleted or their descriptions revised. New descriptions contain "other than/except for coronary, carotid, vertebral, iliac and lower extremity artery"; virtually eliminating those codes from reporting with iliac, femoral/popliteal and tibial/peroneal vasculature procedures.

Currently there may be 3 or more CPT codes the facility uses to report these interventional procedures. In 2011 a single CPT code contains the procedure as well as radiology supervision and interpretation. Coders and staff are cautioned about the importance of reading the entire full-length description before assigning the CPT code. One code will now be used for two procedures by the noted phrase "when performed". For example, CPT 37221 reads "Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed". CPT 37220 will be reportable for angioplasty in the iliac artery, with CPT 37221 reported for a stent placement with angioplasty when performed. So regardless if angioplasty was performed, when a stent is placed in the iliac artery, CPT 37221 will be the code assigned.

John Arno, ARRT, CPC-A, MPA, Senior Chargemaster consultant, cautions radiology departments next year. "The department's productivity measurements used in 2010 will require a total overhaul in 2011. With one procedure replacing two or more CPT codes, a department's productivity will be significantly reduced if the number of reported procedures has been historically used to measure departmental activity. Additionally, charge tickets, cheat sheets, order entry screens currently used will also need to be scrapped. It is "back to the drawing board" where we are more than likely going to have to start back at the beginning," John states. "I don't think it is too early to begin plans on how the department will change current charging practices. Pricing will definitely need to be reviewed and perhaps a sample of patient bills used as a guide in determining prices for next year's "all inclusive" procedures. This next year will be a challenge for many radiology departments."

Cardiac Cath Labs

Similar to the discussion above for Interventional Radiology procedures, Cardiac Cath Lab CPT codes have also undergone a major change. "Ingenix feels the hospital will need to essentially blow up the current department's chargemaster and rebuild it," Penny Allison, RN, BSN, Chargemaster Practice Manager advises. "It is almost impossible to develop a crosswalk of deleted 2010 CPT codes to the new 2011. It is easier,

Chargemaster Corner

however, to begin with the new 2011 codes and map the current 2010 CPT codes into the new procedure codes.”

The cardiac cath CPT codes are built on progressive hierarchies with the most intensive services inclusive of the lesser procedures. We currently report as many as 5 or more CPT codes for a left heart catheterization, bypass graft injections, ventricular angiography, coronary angiography and supervision and interpretation codes. For 2011 one CPT code will include all of these specific procedures. Review of Medicare’s reimbursement does note a small increase of net reimbursement for next year. Currently CPT 93510 (main left heart cath CPT code) is reimbursed \$2,676 (national unadjusted reimbursement amount). Next year, the all inclusive CPT code is reimbursed at \$2,727 (national unadjusted reimbursement amount).

If the facility wishes to remain revenue neutral next year, an analysis of current charges for each procedure should be performed. “With next year’s codes including all separately reported services we currently report, the charge assigned to each new CPT code should be made after careful review,” cautions Penny. “Maintaining consistent revenues may be very important for the hospital and how they assign the charges for these new procedures will be important.”

Emergency Department

CMS has again stated they are pleased with the facility’s reporting of E/M codes 99281-99285 and are not currently planning on introducing national guidelines for hospitals to use, either for clinic encounters or emergency room services. But a very small single statement added in the 2011 CPT codebook may be overlooked by many hospitals and has a huge gross revenue impact next year. Currently, CMS has stated: *Specifically with respect to CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes), hospitals must follow the CPT instructions related to reporting that CPT code. Any services that CPT indicates are included in the reporting of CPT code 99291 should not be billed separately by the hospital.* Final OPPS Rule 2009

Page 22 (2011 CPT Professional Edition), Critical Care Services, contains a complete paragraph in green font. When we read this paragraph it reminds providers that each of the procedures listed are included in critical care services (CPT 99291-99292) and should not be separately reported. However, the last statement states “Facilities may report the above services separately.”

“This is huge for hospitals,” states Joe Martinez, CPC, Senior Healthcare Consultant. “Hospitals struggle to

ensure charges for chest x-rays, pulse oximetry, cardiac output measurements, arterial blood gases and even venipunctures are not reported by the various ancillary departments when the emergency room encounter warrants CPT 99291, critical care. Most facilities combine these identified procedures manually and add the charges together with critical care charge. Other hospitals have created billing edits to drop off these charges so they do not appear on the claim. Whatever method the facility chooses, it is most often a manual effort to ensure the facility complies with the current reporting requirements.”

The 2011 OPPS Final Rule, page 750 states: *CMS will recognize the existing CPT codes and will implement claims processing edits which will conditionally package payment for the ancillary services reported on the same date of service as critical care in order to avoid overpayment.* “Hospitals should remove any billing edits currently in place which prohibits these codes from reported on the UB-04. Next year we will go back to reporting all services ordered, documented and performed. Individual payments will not be recognized for each individual CPT code, but the facility’s “costs” will once again be noted on the claim form. Most hospitals find this to be a major benefit,” Joe advises. “All manual efforts hospitals use can be eliminated as of January 1, 2011.”

Pharmacy Changes

Pharmacy has numerous HCPCS changes, many containing dosage changes. While the facility replaces deleted HCPCS codes with the newly created codes, careful focus to the assigned multiplier is imperative. Medicare has reversed their previous decision which allowed hospitals to report numerous HCPCS code for the same drug, each code with a specific dosage. For example, gamma globulin is reportable with HCPCS codes J1460-J1550 for dosages of 1cc through 10cc. HCPCS codes containing these various dosage amounts are deleted in 2011, forcing hospitals to use the code with the lowest dosage and establish a multiplier for various dosages administered. Gamma globulin is reportable in 2011 using J1460 (1cc) and the hospital must “multiply” the units based on the various dosages administered. “This will eliminate the overall size of a facility’s chargemaster”, states Penny. “It does present additional challenges for pharmacy staff to ensure the multiplier is accurate.”

One great new HCPCS code in 2011 is the creation of HCPCS C9274, Crotalidae Polyvalent Immune Fab (Ovine) 1 vial. Many hospitals currently administer “Crofab” to patients presenting with venomous snake bites. This antivenom is terribly expensive and, up to this point did not have a reportable HCPCS code.

Chargemaster Corner

Reimbursement has been assigned to this code as \$1,947.49 (national unadjusted reimbursement amount). "This is very exciting for hospitals, particularly when the drug has been packaged, admits Penny. On the other end of the spectrum, Ibuprofen injection 100mg was granted pass-through status with the assignment of C9279. This product will be reimbursed at \$1.40.

CT Pelvis and Abdomen

Who didn't see this coming? With the frequency physicians have ordered combination CT scans of both abdomen and pelvis, the AMA has created three new codes:

CPT 74176 Computed tomography, abdomen **and** pelvis, without contrast material(s)

CPT 74177 Computerized tomography, abdomen **and** pelvis; with contrast material(s)

CPT 74178 Computerized tomography, abdomen **and** pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions

If/should the physician order only a CT pelvis or only a CT abdomen, CPT codes 72192-72194 and 74150-74170 remain in the 2011 CPT book. When both abdomen **and** pelvis are ordered, however, the facility must report the combination CPT code. It is surprising why the AMA did not also include another commonly ordered procedure, e.g. CT chest. Perhaps that might be awaiting us in 2012. As departments prepare to implement the above CT abdomen and pelvis procedures, once again productivity measurements must be adjusted. Since one CPT code will be reported next year instead of two, the overall department's reported procedures will be reduced, ultimately affecting the department's statistics.

Other Changes

There are over 800 CPT and HCPCS code changes for 2011. Most clinical departments will have one or more required chargemaster revisions. While this month's edition was devoted to the potentially problematic clinical departments, which is not to say other departments are equally important. Clinics, sleep lab, laboratory, GI lab, cardiology, medical supplies, diagnostic radiology, neurology and wound products are noted to contain CPT code revisions.

Modifier 33

This modifier is no where to be found in the 2011 CPT book. Discussed only at the November 2010 CPT Symposium, the AMA announced the new CPT

modifier, related to mandated preventive services performed in order to comply with the Affordable Care Act. An AMA staff member released the following draft:

Modifier 33 Preventive Service: When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding modifier 33 to the procedure.

The AMA stated that additional information would be posted to its website in the near future. Hopefully, prior to January 1, 2011 additional information will be published to guide facilities and physicians on the use of this brand new, hot off the press modifier.

Therapy Payment Reductions Slated for 2011

Discussed in the Medicare CY 2011 physician fee schedule proposed rule published on July 13, 2010, CMS issued Transmittal 800 on November 3, 2010, Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services. With an implementation date of January 3, hospital rehabilitation departments will experience a new multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services paid under the physician fee schedule. The reduction will be similar to that currently applied to multiple surgical procedures and to diagnostic imaging procedures.

The transmittal explains: Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. We are applying a MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 75 percent payment for the PE.

The transmittal goes into additional detail on payment methodology and reduction formulas. To see how this multiple therapy reduction will affect your hospital's reimbursement next year, please discuss the financial implications of this payment reduction with your rehabilitation director and hospital financial team.

Chargemaster Corner

Personal Reflections

I was on another extremely long flight home last Friday night after a full and fun week of conducting educational seminars in the south. The five hour transcontinental flight was completely full and as I put my seatbelt on, I suddenly realized my knees were painfully wedged beneath my chin. How do they stuff so many people in seats that are so small?? There is no room to even move!!! I watched the flight attendants deliver their well-rehearsed safety speeches with a lack of enthusiasm yet again, probably for the fifth time that day. The safety speech was a requirement for their job, something they had to do on every flight. They functionally demonstrated the airplane's life vests, oxygen masks and exit doors without a smile and with a zombie-like expression. Passengers just ignored them, either because they had heard the same thing a million times before, or did not feel the mundane and unenthusiastic safety speech was important enough to pay attention too.

My travel schedule is no different than that of my co-workers. Life on the road is sometimes difficult, often challenging, but very rewarding. As I watched the flight attendants on my recent flight, I vowed to never treat my next client as "just another client." While many of the findings discovered during a coding audit or chargemaster review are the same issues identified during the many previously conducted hospital reviews, it is so exciting to see a brand new department director suddenly "get it" or help a hospital identify a new source of revenue after correcting erroneous CPT codes in the chargemaster. No hospital is the same; each has unique challenges that must be addressed with educational opportunities provided. Flight attendants travel to fun and exciting towns, so do I. But nothing is routine in the consulting business.

Unlike another flight, another safety speech, another cramped seat in the back of the plane, after over ten years of consulting I still love each new chargemaster review and have fun performing each hospital audit with enthusiasm, focus and respect. Unlike the tired and well-seasoned flight attendant, we still find consulting fun and our enthusiasm is conveyed to every hospital we work with. As the new year approaches, the Chargemaster Consulting Team is thankful for the many hospitals and clients we have partnered with over the years and sincerely hope our enthusiasm and love for our job continues to be contagious. Healthcare consulting is still fun, we hope you find your job in your present position as equally rewarding. Happy Thanksgiving!!!
Glenda Schuler, RHIT, CPC, CPC-H
Senior Healthcare Consultant
Ingenix Consulting

Ingenix' Essential Coding and Billing Conference in Las Vegas!!!

If you are looking for a conference that presents coding and reimbursement changes for **CY 2011 for your chargemaster**, mark your calendar to attend this year's Essential Coding and Billing Conference in Las Vegas.

At this 10th annual conference attendees will learn more about key issues including regulatory changes, compliance concerns, and the latest code updates for 2011. "This is one conference that I not only present the new years' coding changes for the chargemaster, but I attend other experts' sessions and learn new issues and topics that affect most hospitals that I provide consulting services for," states Glenda Schuler, Senior Healthcare Consultant. "It's a time to catch up with clients, hear about reporting challenges and issues from providers in almost all 50 states. I have a great time participating and attending during the conference's three days."

For information on this years' conference, or to mark your calendar to attend next year, visit <http://www.shopingenix.com/Standalones/Essentials/pages/overview.html>



November 29-December 1, 2010
JW Marriott Las Vegas Resort & Spa

Hope you enjoy receiving the *Chargemaster Corner* from Ingenix Consulting. Each month this newsletter will be circulated 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 Ingenix via 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

Chargemaster Corner

interest in this monthly CDM newsletter and hope you find it helpful.

Ingenix Consulting offers a variety of services to assist hospitals in the inpatient and outpatient coding and chargemaster functions including: 1) Focused and comprehensive chargemaster review; 2) continual chargemaster maintenance; 3) CPT Coding Audits; 4) Chart-to-claim audit; 5) MS-DRG audits; 6) Educational opportunities via audioconference/onsite; 7) Physician audits, 8) Denials Management, and 9) physician educational opportunities. If you wish to receive information about any of the consulting services Ingenix offers, please forward your inquiry to Joe.Martinez@ingenixconsulting.com or phone 866-867-4248. Ingenix – bringing you insight and expertise to your chargemaster reporting challenges. In addition, e-mail your questions and subjects you would like to be included in future articles to: Chargemaster.corner@gmail.com.
