



October 2011 Edition

Recently the chargemaster team attended AHIMA's 83rd Convention in Salt Lake City. As expected, the most popular sessions were discussions pertinent to ICD-10-CM implementation, revenue cycle and electronic health record. Clinical documentation improvement (CDI) sessions, however, drew an equal number of attendees. It is evident that CDI efforts undertaken now will assist in the preparation of ICD-10-CM, by enhancing the facility's documentation detail through focused efforts with HIM coding and medical staff.

OptumInsight's *Chargemaster Corner* will include articles focusing on typical documentation practices where insufficiencies are often identified. After all, the chargemaster contains the charge for these procedures but if documentation doesn't support the procedure, gross revenue and net reimbursement is ultimately lost. We hope you enjoy this added feature, which will begin with next month's issue, November 2011.

Is This Supply Separately Reportable?

Medicare provides little guidance for a facility to follow when determining if a supply item is routine versus non-routine, separately billable or not separately chargeable. When lacking specific guidance, hospitals struggle in trying to develop their own facility-specific reporting guidelines. Medicare has, however, periodically updated the Claims Processing Manual which contains some references a facility can follow.

OptumInsight often reviews chargemasters containing HCPCS codes from the HCPCS LEVEL II chapters "Medical and Surgical Supplies" (A HCPCS codes) as well as "Enteral and Parenteral Therapy" (B HCPCS codes). For a hospital paid by OPSS, many of these A and B HCPCS codes contain status indicator A, reimbursed by fee schedule. Medicare states the following concerning HCPCS codes that contain a status indicator other than H or N:

When medical and surgical supplies (other than prosthetic and orthotic devices as described in the Medicare Claims Processing Manual, Chapter 20, §10.1) described by HCPCS codes with status indicators other than —H or —N are provided incident to a physician's service by a hospital outpatient department, the HCPCS codes for these items should not be reported because these items represent supplies. Claims containing charges for medical and surgical supplies used in providing hospital outpatient services are submitted to the Medicare contractor

providing OPSS payment for the services in which they are used. The hospital should include charges associated with these medical and surgical supplies on claims so their costs are incorporated in rate setting, and payment for the supplies is packaged into payment for the associated procedures under the OPSS in accordance with 42 CFR 419.2(b)(4). Claims Processing Manual Chapter 4

Based on this cited reference, Medicare reference seemingly encourages facilities to report supplies separately so that the charges/costs are reflected on the claim form, ultimately impacting CMS' future rate setting and payment considerations. CMS has, throughout Chapter 4, indicated a facility's charge should reflect the cost of the procedure as well as supply items. Therefore, separately reporting the supply items provides a detail of each supply item utilized. The HCPCS code should not be reported on the charge line if it contains a status indicator of A.

Medicare also states the following:

In another example, if hospital outpatient staff perform a surgical procedure on a patient in which temporary bladder catheterization is necessary and use a catheter described by HCPCS code A4338 (Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each), the hospital should not report A4338 because the catheter was used as a supply and would be paid through OPSS payment for the surgical procedure. The hospital should include the charge associated with the urinary catheter on the claim.

In this cited reference, Medicare notes A4338 might be separately paid if reported on a UB-04, TOB 0131, since it has a status indicator of A. However, Medicare discourages the assignment of this HCPCS code to the catheter charge line, since the facility is reimbursed for the supply with the procedure which utilizes this specific supply item.

Rather, Medicare states the hospital should include the charge for the urinary catheter on the claim. This, of course, can be accomplished one of two ways: 1) separately report the charge for the urinary catheter, revenue code 0272; or 2) include the charge for the catheter into the charge for the procedure, e.g. CPT 51701-51703. Either way, the charge for the supply would be reflected on the claim.

Our chargemaster consultants received many questions from clients specific for reporting kits, packs and trays individually on the claim. Medicare has stated the following:

"Kits - Manufacturers frequently package a number of individual items used in a particular procedure in a kit. Generally, to avoid complicating the category list unnecessarily and to avoid the possibility of double coding, CMS has not established codes for such kits. However,

hospitals are free to purchase and use such kits. If the kits contain individual items that separately qualify for transitional pass-through payments, these items may be separately billed using applicable codes. Multiple units - Hospitals must bill for multiple units of items that qualify for transitional pass-through payments when such items are used with a single procedure by entering the number of units used on the bill

It has been OptumInsight's recommendation for a facility to "always" report supply items eligible for HCPCS "C" codes. When kits contain multiple items eligible for "C" code assignment, each supply item must be individually reported. Usually the supply items eligible for "C" codes are not disputed by commercial payers. Medicare also continues to state that if a kit or tray or system contains items eligible for reporting with more than one category or HCPCS "C" code, the hospital should report each category separately for each component. The use of explode panels or mother/parent charge lines may be the best way to ensure the separate capture of multiple supply items. Reference: Claims Processing Manual, Chapter 4, Section 60.4.

Charge lines for angiocaths, needles, syringes and tubing may be difficult to defend if challenged by a commercial payer. While these items are low-cost supply items, they do represent high-volume utilization for most facilities. If presently charging, they do represent a sizeable amount of gross revenue. However, Medicare has stated the following:

"IV Start Kits, Needles, Syringes. *If performed to facilitate the infusion or injection or hydration, the following services and items are included and are not separately billable: 1. Use of local anesthesia; 2. IV start; 3. Access to indwelling IV, subcutaneous catheter or port; 4. Flush at conclusion of infusion; and 5. Standard tubing, syringes and supplies. Reference: Medicare Claims Processing Manual, Chapter 12, Section 30.5.c"*

Medicare not only states the above specific supply items should not be separately reported, but the AMA's CPT book does as well. Charges for these "routine" supplies should be included in the initial hour of infusion (therapeutic, hydration or chemotherapy) and/or injection procedures (IM, IV push) to ensure revenue neutrality for the facility.

There is, however, no reference published by Medicare which states that heparin or saline flushes are not separately billable. Considered a "standard of medical practice", a healthcare professional routinely flushes a hep lock, angiocath, subcutaneous port or central line before and after the administration of medications. These costs, however, reside with pharmacy, the department which purchases these medication products. The flush procedure, as noted above (no 4) is included in the injection and procedure charges. Therefore, until Medicare publishes a more finite policy, a

charge for the heparin/saline flush can be separately charged if documentation supports these charges.

Several facilities have asked if IV Solutions are separately billable for a surgical patient. Usually the patient always has an IV fluid running when entering the operating room and their comments reflected that IV solutions would be routine to the surgical procedure and therefore not separately reportable. Medicare states the following:

"Hospitals are strongly encouraged to report 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. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS codes are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient. Reference: Medicare Claims Processing Manual, Chapter 17, Section 90.2"

It is felt that if these IV solutions are found to be ordered by the physician, and documentation clearly states the IV solutions were administered, the charges for IV fluids and solutions are separately billable per above Medicare's reference.

Medicare does not state how the charge/cost for a supply item is reported, but rather "the charge must be reported on the UB-04 claim form." The charge/cost can be listed individually or included in the procedure charge utilizing the supply item.

The above cited references are, of course, taken from the various Medicare manuals. Commercial payers may certainly apply their own reporting rules, often discovered after a defense audit has been conducted and communication back to the facility identifies supplies not separately reportable. As Medicare has stated, the "charge" for the supply item can be reported individually or included in the charge for the procedure which utilizes the specific supply item. If any payer is taking exception with line-item detail for supplies, simply increasing the price of the procedure by the cost of the supply item to avoid future confrontations with payers. Additionally, patients seeking validation that all supplies charged on their bill were utilized during the procedure will avoid staff time performing an audit to confirm all billed charges were appropriate.

2012 Code Books Will Not Contain "All" New Codes

You are probably anxiously waiting for the mail person or UPS driver to deliver the new 2012 coding books and can't wait to rip off the plastic wrap like a little child on Christmas morning! OK, that is a little exaggerated....but please be reminded. The Current Procedural Terminology

2011 book contains printed codes from 0019T to 0259T. Category III codes 0260T, 0261T were accepted at the June 2010 CPT Editorial Panel meeting for the 2012 CPT production cycle. These codes did not appear in the 2011 CPT book and while they are available for reporting now, will not be printed until CPT 2012. The Category III codes from 0262T-0275T were effective July 1, 2011 and will debut in print in next year's coding books as well. Category III codes 0276T-0290T are new and effective January 1, 2012 and will be found in printed format in Appendix B, Summary of Additions, Deletions, and Revisions, as well as included in the Category III chapter.

Not printed in the 2012 CPT books, and eligible for reporting as of January 1, 2012 are the following Category III codes:

CPT	Description
0291T+	Intravascular optical coherence tomography (coronary native vessel or graft) during diagnostic evaluation and/or therapeutic intervention, including imaging supervision, interpretation, and report; initial vessel (List separately in addition to primary procedure)
0292T+	Intravascular optical coherence tomography (coronary native vessel or graft) during diagnostic evaluation and/or therapeutic intervention, including imaging supervision, interpretation, and report; each additional vessel (List separately in addition to primary procedure)
0293T+	Insertion of left atrial hemodynamic monitor; complete system, includes implanted communication module and pressure sensor lead in left atrium including transeptal access, radiological supervision and interpretation, and associated injection procedures, when performed
0294T+	Insertion of left atrial hemodynamic monitor; pressure sensor lead at time of insertion of pacing cardioverter-defibrillator pulse generator including radiological supervision and interpretation and associated injection procedures, when performed (List separately in addition to code for primary procedure)
0295T	External electrocardiographic recording for more than 48 hours up to 21 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation

CPT	Description
0296T	External electrocardiographic recording for more than 48 hours up to 21 days by continuous rhythm recording and storage; recording (includes connection and final recording)
0297T	External electrocardiographic recording for more than 48 hours up to 21 days by continuous rhythm recording and storage; scanning analysis with report
0298T	External electrocardiographic recording for more than 48 hours up to 21 days by continuous rhythm recording and storage; review and interpretation
0299T	Extracorporeal shock wave for integumentary wound healing, high energy, including typical application and dressing care; initial wound
0300T+	Extracorporeal shock wave for integumentary wound healing, high energy, including typical application and dressing care; each additional wound (List separately in addition to code for primary procedure)
0301T	Destruction/reduction of malignant breast tumor with externally applied focused microwave including interstitial placement of disposable catheter with combined temperature monitoring probe and microwave focusing sensocatheter under ultrasound thermotherapy guidance

The AMA's website contains additional parenthetical instructions and reporting guidelines for use of these 11 new CPT codes, which will not be printed in the CPT book until 2013.

Status indicators for each of these new CPT codes as well as reimbursement amounts are currently not available. They will be available for review when 2012 Addendum B is published, with the Final OPPS Rule, around the first of November, 2011.

If you are looking for a conference that presents coding and reimbursement changes for **CY 2012** impacting your chargemaster, mark your calendar to attend this year's Essential Coding and Billing Conference in Las Vegas. Take a look at the following website for additional information:

<http://www.shopingenix.com/standalones/essentials/pages/overview.html>

Quarterly Provider Update

Medicare offers a Quarterly Provider Update (QPU), intended to make it easier for all types of healthcare providers and suppliers to understand the changes made or proposing to be made in the various Medicare programs. To make it easier, the provider can sign up for e-mails, giving notification of the posting of QPU data.

Found at: <https://www.cms.gov/quarterlyproviderupdates/> this website provides an overview, by provider type, of the revisions effective at the present time, those revisions implemented on a quarterly basis back to CY2002, and even gives an insight on issues under consideration for the next quarter. The Quarterly Provider Update-Instructions .pdf file provides a link to the Transmittal Number. By the click of the mouse, the provider can click on the hyperlink and read the transmittal in its entirety.

Two versions of the QPU are found on CMS' website, one in Adobe Acrobat file, sorted by Provider Type for each category, regulation or issuances. The second file is a zipped Word file. The Word file may be manipulated for ease in finding Regulations or Transmittals, Change Requests (CR) and Publication Numbers.

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. 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.

Please keep in mind that if your facility installs a "spam" software tool, this newsletter may not reach you. We attempt to update all e-mail addresses when notification is received, but unfortunately this month there were approximately 6 former subscribers that had to be removed because e-mail addresses were no longer correct or active. When your e-mail address changes or you change employment, please remember to forward the new information to Chargemaster.Comer@gmail.com to continue receiving every monthly edition.

OptumInsight 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 OptumInsight offers, please forward your inquiry to Joe.Martinez@Optum.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.comer@gmail.com.

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 a "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 a 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 find an archive for previous *Chargemaster Corner* articles as well.

