

Chargemaster Corner



October 2010 Edition

While waiting for the Final OPPS Rule to be published and the CPT and HCPCS codes for 2011 to be released, many hospitals are taking this time to prepare for the knowingly hectic end-of-year chargemaster revisions and financial forecasting.

October's edition of *Chargemaster Corner* discusses:

- *Review of 4th quarter MUEs
- *Highlights of 2011 OIG Work Plan
- *Follow-up from September's Article
Is Heparin Separately billable
- *New 2011 Category III CPT Codes

Hope you enjoy this month's edition. Please feel free to forward this month's *Chargemaster Corner* to your department directors and key revenue cycle personnel. By the way, if you change jobs or your facility's e-mail address changes, don't forget to drop *Chargemaster Corner* notification of this change. When e-mail rejections are received, there is no choice but to remove the subscriber's name from the list. To avoid missing an issue, please remember to forward current information to Chargemaster.Corner@gmail.com.

Medically Unlikely Edits, 4th Quarter Changes

The Center for Medicare and Medicaid Services (CMS) published a new MUE file, effective October 1, 2010. Billing staff, HIM coders as well as chargemaster coordinators are reminded to review this file quarterly to identify pertinent changes that impact the facility's billing of certain procedures.

Of those MUEs that CMS has elected to publish, several procedures/supplies have experienced a reduction in the MUE value assigned to the respective HCPCS codes.

CPT	Short Desc	Oct MUE	July MUE
A6501	Comp burn garment bodysuit	1	2
A6502	Comp burn garment chin strap	1	2
A6503	Comp burn garment facial hood	1	2
A6509	Comp burn garment upr trunk/waist	1	2
A6510	Comp burn garment trunk w/arms	1	2
A6511	Comp burn garment lwr trunk	1	2
V2790	Amniotic membrane per proc	1	2

While it certainly makes sense that a compression burn garment would be applied once to a patient's chin or trunk, the reduction from 2 to 1 MUEs for V2790 may become problematic during 4th quarter claim submissions. HCPCS codes A6501-A6511 are reportable with revenue code 0623, Surgical Dressings, **when dressings are provided to the patient for home use.** When these same dressings are used during the patient encounter (e.g. dressings post-procedure), supplies are reportable without HCPCS A6501-A6511, revenue code 027X or 0272. Medicare Claims Processing Manual, Chapter 4, Section 61.1 clarifies this by stating: *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.*

HCPCS A6501-A6511 have status indicator of A, payable under the Surgical Dressing fee schedule. When used during the patient's hospital encounter, revenue code 027X should be assigned, reported without the HCPCS code.

Review of those procedures experiencing an increase from 1 to 2 or 4 MUEs, 10 CPT/HCPCS procedures and devices now demonstrate a higher MUE value than the previous quarter:

CPT	Short Desc	Oct MUE	July MUE
36160	Establish access to aorta	2	1
75964	Repair artery blockage, each	4	1
93542	Injection rt vent/atrial angiography	2	1
93543	Injection left vent/atrial angiography	2	1
99143	Mod Sed <5yrs Init 30 min	2	1
99144	Mod Sed 5 yrs Init 30 min	2	1
99148	Mod Sed <5yrs Init 30 min	2	1
99149	Mod Sed 5 yrs Init 30 min	2	1
L8614	Cochlear device w/int & ext component	2	1
V2630	Anterior chamber intraocular lens	2	1

Interesting, the CPT codes for moderate sedation have increased from 1 to 2. This is presumed to accommodate those multiple and separate surgical procedures performed on the same date of service in which moderate sedation was provided. Certainly an appropriate modifier appended to the second set of CPT codes would further provide clarification of separate surgical procedure/encounter when documentation supports the added CPT codes.

Chargemaster Corner

As a friendly reminder, certain medical supplies/devices also have MUEs assigned. For example, cardioverter-defibrillator, single chamber (implantable) HCPCS C1722 currently has an MUE of 2. “This makes perfect sense,” states Joe Martinez, CPC, Senior Healthcare Consultant. “If one cardioverter-defibrillator unit fails and a second must be inserted during the same encounter, it will allow a facility to report charges for both defibrillators. While this will not happen with great frequency, it certain could,” Joe cautions. “HCPCS C1758, Catheter, ureteral has an MUE value of 3. Other medical device/supplies reportable with HCPCS C1721-C2627 have MUEs assigned and while there were no changes for the 4th quarter 2010, facilities are always cautioned to keep abreast of the MUE values for procedures and services performed in the various ancillary departments of their facility. Accurate charging and correct reporting often do not coincide in the Medicare billing arena.”

OIG Releases 2011 Work Plan

Several new clinical activities and services have been added to the numerous focus reviews by the Office of Inspector General (OIG) for next year. “Future audits and evaluations conducted by hospitals should include these identified areas”, states Penny Allison, RN, BSN, Chargemaster Practice Manager. “The 2011 OIG Work Plan covers not only Part A and Part B providers and services, but also Home Health, Nursing Facilities, ESRD as well as independent diagnostic facilities. Medicaid and Public Health services are also included in this comprehensive work plan. We discuss the OIG Work Plan with hospitals, primarily those focused areas for Medicare Part A and B as well as those impacting Critical Access Hospitals (CAHs),” continues Penny.

Review of the OIG 2011 Initiatives and Audits impacting the facility’s chargemaster and billing functionality include the following:

a) The OIG is renewing their focus on observation services, provided as part of an outpatient visit. This review will include Medicare reimbursement for observation services including the extent the use of observation affected the beneficiaries’ ability to pay out-of-pocket expenses for all services provided during the observation stay.

b) The OIG included in 2011 the hospital’s compliance with safety and quality of intensity modulated radiation therapy (IMRT) and image-guided radiation therapy (IGRT) services. To bill the Medicare program for these services, the facility must meet approved standards for safety and personnel qualifications. While the facility meets requirements

with Medicare CoP (Conditions of Participation), the OIG will also assess CMS’ oversight in the facility’s IMRT and IGRT services.

c) Medicare Outlier Payments will be reviewed to confirm CMS appropriately reconciled the facility’s outlier payments. Previous audits by CMS have identified facilities whose charges were structured in a manner to become eligible for a higher percentage of outlier payments than those of their peers. This initiative is the revisit for accuracy for outlier payments.

d) The OIG will continue review of procedures performed using replacement medical devices. Medicare is not responsible for the full cost of the replaced medical device if the facility receives either full or partial credit from the manufacturer. Reported with the use of modifiers FB (Item provided without cost) or FC (partial credit received on replaced device) the facility can indicate whether partial or full credit was received for the medical device. Without the FB/FC modifier, the facility will receive full reimbursement for the procedure.

“These discussed items are certainly not the full scope of the 2011 OIG Work Plan. We encourage hospitals to download the entire document, highlight those initiatives and audits with potential impact and conduct an internal focused review,” advises Penny. “Use the OIG 2011 Work Plan as a template for future facility audits. There can be no better way than to focus internally on the same potential issues that the OIG externally will be performing.”

To download the 2011 OIG Work Plan, see: <http://oig.hhs.gov/publications/workplan/2011/>

Follow-up from September’s Chargemaster Corner

Last month’s *Chargemaster Corner* contained an article on reporting J1642 *Injection, heparin sodium, (heparin lock flush), per 10 units*, when performing a flush, whether hep lock, central line, or external port. We received several questions specific to this article and would like to provide some additional information.

Noridian, MAC for eleven northern and northwestern states, held an *Ask the Contractor* audioconference on July 15, 2010 in which this very question posed. Please note that this was a “Part B” program in which the following question was asked:

Q3. If we are using heparin, not for the patient for therapeutic purposes, but we are using it to actually flush a catheter between different drug administrations, is that still a billable drug when we are not using it to actually administer it to a patient?

Chargemaster Corner

A3. When heparin is used only for the irrigation of the catheter, the heparin itself is not separately billable.

“By now you must be scratching your head as we are,” admits John Arno, ARRT, CPC-A, MPA, Senior Chargemaster consultant. “We read this from Part B, and Medicare tells hospitals repeatedly *“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.”* I think this is prime example of the right hand doesn’t know what the left hand is doing”, states John. “Certainly the heparin flush represents a cost to the facility. Over a period of time and the high volume we see facilities charge for this specific pharmaceutical, it can amount to a sizeable amount of costs/gross revenue.”

Knowing the MACs were created to consolidate the claim process functionality for both Part A and Part B (among others), one would think there would be consistency among the various healthcare providers to report services consistently. John adds “This just doesn’t seem to be the case here.”

Facilities are encouraged to review directives posted by their respective MACs and even pose questions during audio conferences or seminars sponsored by their contractors to provide clarification.

New 2011 Category III CPT Codes

It’s that time of year when we anxiously check our mailbox for the new CPT and HCPCS code books. CMS’ website is scanned not once but twice to see if the OPPI Final Rule has been posted.

The end of the year is certainly a busy time not only with the holiday rush, but the implementation of the new codes. If you would like to review some of the new 2011 CPT codes, visit the AMA’s website. The new 2011 Category III CPT codes are available.

Twenty-eight new Category III codes will be available for reporting on January 1, 2011. All but two will be found in the new CPT book for 2011 with 0260T-0261T not printed in the CPT book until 2012. The new codes include services typically performed in Cath Lab, Interventional Radiology and Surgery as well as GI Lab and Day Surgical Services. Respiratory Therapy may benefit from using 0243T/0244T and NICU or Pediatric ICU reporting hypothermia services with 0260T/0261T. The long description as well as instructional notes can be found at:

<http://www.ama-assn.org/ama1/pub/upload/mm/362/cptcat3codes.pdf>.

Early preparation by reviewing these published 2011 CPT codes will help avoid the year-end time crunch.

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