



## September 2011 Edition

Labor Day weekend always marks the unofficial end of Summer and we all know what that means....it won't be long until the Final OPSS Rule is posted and the new 2012 CPT® and HCPCS codes are published. Before the mad rush of chargemaster updates require the majority of our time, lets look at the required October revisions and other important subjects impacting a facility's chargemaster.

This month's issue of *Chargemaster Corner* highlights:

- Modifiers and the Chargemaster
- October Updates For The Chargemaster
- New Codes For 2012

### Modifiers and the Chargemaster

Modifiers play a vital role in compliant coding and billing practices for health care providers. Correct modifier use is also an important factor when avoiding fraud, abuse or noncompliance issues for not only federal and state programs, but also various commercial payers, who are incorporating modifiers into their reimbursement protocols. Several cited RAC and CERT billing errors are the result of incorrect use of modifiers.

**What are Modifiers?** A modifier is a two-digit numeric or alphanumeric character reported with a CPT® or HCPCS code, when appropriate. Modifiers are designed to give Medicare and commercial payers additional information needed to process a claim. A modifier provides the means by which a facility can communicate with the payer that a service or procedure has been altered by some special circumstances(s) while not changing the definition of the code. Some examples of when a modifier may be appropriate include:

- 1) A service or procedure has been increased or decreased in complexity or performance.
- 2) Only part of the intended service or procedure could be performed
- 3) An evaluation and management service was performed on the same date as a procedure
- 4) An adjunctive service was performed.
- 5) A bilateral procedure was performed.
- 6) A service or procedure was performed more than once during a calendar day
- 1) Unusual events occurred during a procedure or service.

**Reference:** *CPT Assistant*, May, 2003

Some modifiers provide additional information/data while others impact the facility's reimbursement. Whenever a modifier is reported on the UB-04 claim form to any payer, documentation must also support both the CPT® or HCPCS code and modifier as well. How the modifier is appended to the reported code is usually accomplished one of two ways: 1) hard-coded in the facility's chargemaster, or 2) assigned by HIM coding professionals. How a facility's chargemaster can be structured to accommodate modifiers as well as the most appropriate modifiers to reside in the chargemaster will be the main article for this month's *Chargemaster Corner* edition. The thoughts and comments expressed in this newsletter are the opinion of OptumInsight's healthcare consultants based on best practice. Hospitals may have established more stringent audit and validation processes performed by revenue analysts who focus on claims containing NCCI edits, modifier-related problems, medical necessity issues, respond to department charging questions, and serve as a liaison between HIM and billing staff. Charge validation and claim resolution functionalities structured in this manner may certainly influence the facility's choice of including a greater number of modifiers in their chargemasters than those recommended in this article.

### HIM Coding Professionals and the Chargemaster

HIM coders have become more involved in the structure and maintenance of the facility's chargemaster. In the past, HIM coders typically had the responsibility to assign surgical CPT® codes in the range of 10000-69999. This is no longer true in today's complicated coding and billing arena. HIM coders sometimes assign codes in the 9XXXX code range as well as others. For any and all codes assigned by HIM, modifiers will/should also be appended at the time the correct CPT® and/or HCPCS code(s) is selected.

### Informational Modifiers

Informational modifiers generally have no impact on the facility's reimbursement, however, when reported correctly these modifiers will often avoid the facility's required use of modifier -59, discussed later. The following modifiers provide additional information to the payer:

Modifiers	Modifier Applications
E1-E4	Eyelids (upper/lower, right/left side)
FA-F9/TA-T9	Finger modifiers; Toe modifiers
RT/LT	Anatomical right or left
GG/GH	Screening and Diagnostic Mammography performed on same date of service
LC/LD/RC	Specific coronary artery evaluated/treated
GP/GN/GO	Rehabilitation modifiers

Modifiers	Modifier Applications
EA/EB/EC	Non-ESRD anemia modifiers for Pharmaceuticals

Based on the facility's chargemaster structure and charge capture expertise of the clinical departments utilizing the following modifiers, hard-coding (assigned directly from the chargemaster) these modifiers in the chargemaster works well and eliminates HIM and/or billing staff time when trying to determine the most appropriate modifier to attach to the reported code:

Modifier	Clinical Department*
50 or 52	Radiology, Vascular Lab
RT or LT	Radiology, Vascular Lab
FA-F9, TA-T9	Radiology
GN, GO, GP	Rehabilitation Services

\*Departments typically utilizing these modifiers, other departments may certainly be appropriate

Radiology and vascular studies performed on both extremities/anatomical structures (right and left side) must be reported with modifier 50, Bilateral Procedure. Adding a separate charge line for "bilateral" procedure will not only provide the clinical department the ability to have a charge equitable to performing two procedures, but also allow the appropriate reporting of modifier 50. If/when the radiological exam involves less than the required number of views for certain extremity examinations (post-reduction), modifier 52 (reduced service) must be reported to indicate the examination was not performed to the full extent as described by the code. Vascular procedures, which are not completed or are limited due to physician preference or patient issues, are aptly reported with this modifier. Modifier 52, used as described above, would be assigned to only a few specific examinations and procedures.

Anatomical modifiers RT, LT as well as the finger (FA-F9) and toe (TA-T9) modifiers are easily reported from the departmental chargemasters and will match the order, specifying the exact extremity and/or finger/toe to be examined. Minimal reporting errors occur when these modifiers are hard-coded in radiology as well as other departments' chargemaster.

Rehabilitation service modifiers are informational modifiers compliantly and easily reported by hard-coding them to the associated codes representing physical, occupational and speech therapy services.

### Modifiers with Reimbursement Implications

The following modifiers play an important role in the facility's financial viability:

Modifier	Description
25	Significant, separately identifiable E/M Service Provided by same Physician on Same Date Day of the procedure or other service
50	Bilateral, reimbursed 200% for procedures containing X/S status indicators, 150% for T status procedures
52	Reduced Service
59	Distinct Procedural Service
73	Cancelled procedure prior to anesthesia induction
74	Cancelled procedure after anesthesia induction
91	Repeat laboratory procedure
FB	Item provided without cost to provider
FC	Partial credit received for replaced device

**Modifier 25** has become a recent focus by the Office of Inspector General and other governmental agencies. The inappropriate reporting of an evaluation and management code along with this modifier for routine care associated with diagnostic or therapeutic procedures, (such as education, preparation, and on-going nursing care) has been identified as fraudulent billing practices. It is stated that separate reimbursement received is inappropriate when, in fact, the reimbursement associated with the diagnostic, therapeutic or surgical procedure code includes the routine clinic services generally represented by the reporting of the E/M code. The use of modifier 25 indicates that the E/M service was significantly separate, above and beyond the other service(s) provided. The assignment of modifier 25 is recommended to be the responsibility of the HIM coding professional and not generated from the chargemaster. If, after reading the medical documentation, both the E/M and procedure are appropriate, modifier 25 would be appended to the E/M code. This modifier 25 should be assigned and/or validated by HIM professionals to confirm documentation supports the reporting of both the E/M and other surgical procedures.

**Modifier 52**, reduced service, should be appended to a surgical CPT® code only after HIM validates appropriate documentation supports the use of this modifier. Should the surgical procedure be abbreviated due to patient complications, the operative report will indicate this. All surgical CPT® codes assigned by HIM coding professionals will include the assignment of the appropriate modifiers, and modifier 52 will be no exception.

**Modifier 59** is never recommended to reside in the facility's chargemaster. This modifier potentially circumvents NCCI (National Correct Coding Initiative) edits, often allowing two procedures to be billed and reimbursed when, in fact, only one CPT® code was eligible for payment.

**Modifier 59** indicates that two or more CPT® codes reported on the same day may be certainly appropriate when performed for different sessions, on different procedures, different sites, separate incision, separate injury. Every charge generated by any clinical department has the potential to be impacted by NCCI edits. Having procedure charges with modifier 59 hard-coded in the chargemaster dramatically increases a facility's risk of a focused governmental audit. Reporting this controversial modifier only when documentation clearly supports it is a challenge most hospitals encounter on a daily basis. Expertise at the charge-capture level is generally not found residing within the clinical areas; rather, HIM coding specialists are best at determining the appropriateness of reporting modifier 59. The chargemaster should definitely only be considered as the last resort.

**Modifier 91**, Repeat laboratory testing, should be assigned "only" after validating with laboratory and/or medical record documentation that, indeed, the test was repeated based on specific orders from the physician. Clinical discretion plays an important role in determining if this laboratory modifier is appropriate. This modifier must be used to indicate that a test was performed more than once on the same day for the same patient, only when it is necessary to obtain multiple results in the course of treatment. This modifier may not be used when the tests are re-run to confirm initial results due to testing problems with specimens or equipment or for any other reason when a normal, one-time, reportable result is all that is required. Improper or excessive use of this modifier may pose liability for the facility and billing staff, HIM coders as well as laboratory management should ensure utilization of this modifier is appropriate. For those medically necessary repeat procedures, modifier 91 will often ensure appropriate reimbursement is recognized.

Optum does not recommend the laboratory chargemaster contain modifier 91; however, should the facility even contemplate modifier 91 to be hard-coded in the laboratory's chargemaster, the number of charge lines currently in this clinical department's chargemaster will double. You would virtually see two charge lines for every procedure, one for the initial charge and the second for the repeated procedure, with modifier 91 hard-coded. Having the laboratory department keep track of charges encompassing multiple shifts and staff, and whether the correct charge line was reported, would require an extremely large amount of time. Responsibility for assigning modifier 91 should not be from the chargemaster, but rather, laboratory and/or HIM coding professionals. Review of each outpatient charge will undoubtedly also take time, but result in a more compliant billing process.

**Modifiers FB and FC** are used when the facility replaces a medical device and receives partial/full credit from the

vendor. Reimbursement is correspondingly reduced because payment for the device is included with the surgical procedure's CPT® codes. Should the facility's costs be reduced based on a partial or full credit received from the vendor, reimbursement for the surgical procedure will also be affected. The surgical department's implant log may include a note indicating receipt of a partial/full credit; however, the patient's chart must also reflect this. Sometimes hospitals will add two charge lines in the chargemaster for surgery to utilize, so the charge can be edited or over-ridden to reflect the charge/price reduction. These charge lines can also allow the department to report the HCPCS "C" code for the medical device, however, the required FB or FC modifier is often overlooked. Receipt of incorrect payment (over as well as under) will become a compliance issue. Establishing billing flags within the charge capture process may be used to alert HIM coding and/or billing of the required FB/FC modifier. The facility may also have multiple HCPCS "C" coded medical devices for which the FB/FC modifier could be required. Pacemakers (C2619, C2620, C2621, C1785, C1786) as well as leads (C1899, C1779, C1898, C1778, C1897), neurostimulators (C1820, C1767) among others could potentially require one of these two modifiers. The chargemaster is not the most optimum and compliant area on which to gauge on staff's accuracy in reporting these modifiers.

**Modifiers 73/74** (procedure cancelled before/after induction of anesthesia). Most of the surgical procedures utilizing anesthesia are reported from the surgical code range of 10000-69999. Most surgical CPT® codes are assigned by HIM coding professionals, however, some facilities elect to hard-code all CPT® codes into the chargemasters. When the operative report or procedure note indicates the procedure was not completely performed due to contraindications, modifier 73 or 74 would be appended to the surgical CPT® code. Modifier 73 will signal the MAC/FI or payer the reimbursement should be reduced by 50%. Modifier 74 provides clarification to all payers the procedure was not cancelled after anesthesia was administered, and reimbursement will not be impacted with the facility receiving 100% of the assigned APC. Because of the financial implications these specific modifiers may impose, the chargemaster is not the recommended source for reporting modifiers 73 or 74.

**Other Modifiers:** There are certainly many more modifiers to discuss, but the above-mentioned modifiers are the most common ones. A coordinated discussion between the chargemaster directors, HIM coding staff, Compliance as well as the Revenue Cycle Team should validate the above recommendations. It is a facility's ultimate goal to submit claims with the most accurate data, supported by clinical documentation, in the most effective and efficient manner possible. HIM-assigned modifiers will undoubtedly be

supported by clinical documentation and reduce the facility's exposure to potential financial liability.

## October Updates For The Chargemaster—Time to Start Planning

CMS granted transitional pass-through payments for two new medical devices. Available October 1, 2011:

HCPCS Code	Long Description
C1830	Powered bone marrow biopsy needle
C1840	Lens, intraocular (telescopic)

Transmittal 2296, issued September 2, 2011 does not provide billing instructions for C1830; however, research indicates this device is a small hand-held drill which drives a single lumen needle set into the medullary cavity of the iliac crest with minimal operator exertion. The Jamshidi needle has been used since 1971 and there has been no substantial advancement in marrow sampling methodology or technology, until now. This battery-powered bone marrow biopsy system has been granted FDA approval and used to access the bone marrow space quickly and efficiently. Revenue code 0272, *Sterile Supply*, would be the appropriate revenue code assignment for C1830.

HCPCS C1840 is separately reimbursed when billed with CPT® codes 66982, *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration of 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 66984 *Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification)*. This implantable medical technology enlarges images in front of the eye approximately 2.2 to 2.7 times their normal size, providing magnification to be projected onto healthy perimacular areas of the retina instead of the macula alone. The intraocular telescopic lens is used to treat dry macular degeneration and helps to reduce the “blind spot” and allows the patient to distinguish and discern images that may have been unrecognizable or difficult to see as a result of this incurable eye disease. Revenue code 0278, *Other Implants*, should be assigned to the charge line containing C1840.

Pharmacy's chargemaster may experience two minor changes if the following drugs are contained in the facility's formulary:

HCPCS Code	Long Description	APC
C9286	Injection, belatacept, 1 mg	9286
J0638	Injection, canakinumab, 1 mg	1311

Recently approved by the FDA, Belatacept is transfused in 30-minute intravenous infusion sessions and selectively blocks T-cell costimulation to help prevent organ rejection after transplant. Belatacept, also known as Nulojix, is given as adjunct therapy with other anti-rejection and corticosteroid medications to prevent acute rejection of donated kidneys in transplant recipient adults.

Canakinumab, (brand name *Ilaris*), can be used to treat rare genetic conditions in adults and children. Injected under the skin, the patient may be trained to administer this specific medication at home so be mindful this medication could end up on the “Self-Adminstrable” drug list. This medication may be used for other purposes as well.

Both C9286 and J0638 would be reportable with revenue code 0636, *Drugs Requiring Detailed Coding*, and are separately reimbursed, effective October 1, 2011.

As of the writing of *Chargemaster Corner*, the above HCPCS codes are the only codes impacting the facility's chargemaster. Please be aware that as we get closer to October 1, CMS may publish additional transmittals or update the HCPCS file necessitating additional revisions.

## New CPT® Codes for 2012

The American College of Radiology (ACR) has published an article entitled “Bundling of CPT® Codes to Continue in 2012”, which does not provide detailed information on the specific CPT® codes and descriptors for 2012, but does provide information of codes being considered for payment bundling. The article discusses the revisions of nuclear medicine lung ventilation/perfusion and hepatobiliary code facilities. It does appear the bundling of radiology S&I codes into the surgical CPT® code will continue next year.

As in years past, there is anticipated to be over 400 CPT® coding revisions for 2012, impacting nearly every clinical department. Add to this number the HCPCS code changes and facilities will once again face some major chargemaster revisions.

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.

At this 11<sup>th</sup> 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 from nearly all 50 states. I have a great time participating and attending the conference’s three day sessions.”

For information on this years’ conference, or to mark your calendar to attend next year, visit the website at <http://www.shopingenix.com/Standalones/Essentials/pages/overview.html>. Visit this site and register to win a free conference registration!!

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