

Chargemaster Corner



September 2010 Edition

When it comes to reimbursement, the chargemaster is of the utmost importance for any facility, large or small. Compliance and financial problems can result if your hospital's charge description master (CDM) is not periodically updated.

This month's edition of *Chargemaster Corner* discusses new CCI edits, new HCPCS codes on the horizon and new potential reimbursement reductions, for which the chargemaster will and does play an important role. The story only begins with the chargemaster and Ingenix will help explain these new changes while helping your staff with future required chargemaster revisions.

Please feel free to forward this month's *Chargemaster Corner* to your department directors and key revenue cycle personnel.

October 2010 Update

The 'integrated' Outpatient Code Editor (I/OCE) program processes claims for all outpatient institutional providers including hospitals that are subject to the Outpatient Prospective Payment System (OPPS) as well as hospitals that are NOT (Non-OPPS).

Updated on a quarterly basis, the software maintains the editing logic of previous versions, assignment of APC numbers for services added to meet Medicare's mandated OPPS implementation. The updated October 2010 I/OCE indicates what actions to take when an edit occurs, and the reason(s) why the actions are necessary. For example, an edit can cause a line item to be denied payment while still allowing the claim to be processed for payment.

Additionally, CMS discusses deleted, new as well as revised HCPCS codes and OCE claim edit changes impacting the facility's claim submission processes and reimbursement. Previously issued as a Transmittal, CMS now publishes the new I/OCE Specifications and Summary of Data Changes at the following website:
http://www.cms.gov/OutpatientCodeEdit/02_OCEQtrReleaseSpecs.asp#TopOfPage

October's update appears to be quite impressive compared to previous years' October updates. Often CMS waits until the new calendar year to introduce major coding revisions. This year seems to be an exception. CMS has introduced 6 new HCPCS codes for reporting Medicare-specific Spinal canal and upper extremity magnetic resonance angiography (MRA) procedures. Similar to the MRA chest, pelvis, lower extremity, abdomen and breast procedures where Medicare requires HCPCS "C" codes while the 7XXXX CPT codes are billed to the commercial payers. MRA of the spinal canal will be reportable with the three new HCPCS codes representing with contrast, without contrast as well as with and without contrast. Upper extremity MRA procedures have the same reporting choices.

"These reporting scenarios should be very familiar to most MRI/MRA departments of the hospital", states John Arno, RT, (R), ARRT, CPC-A, MPA, Senior Chargemaster Consultant. "The chargemaster may contain both CPT and HCPCS codes for all six procedures which most facilities elect to add. Another choice is to convert CPT to HCPCS codes for Medicare claims through the use of a claims billing edit."

The new HCPCS codes specific for Medicare reporting are as follows:

Medicare HCPCS	Short Description	Revenue Code	APC
C8931	MRA, w/dye, spinal canal	0610, 0618	00284
C8932	MRA, w/o dye, spinal canal	0610, 0618	00336
C8933	MRA, w/o&w/dye, spinal canal	0610, 0618	00337
C8934	MRA, w/dye, upper extr	0610, 0618	00284
C8935	MRA, w/o dye, upper extr	0610, 0618	00336
C8936	MRA, w/o&w/dye, upper extr	0610, 0618	00337

John continues. "While these new HCPCS codes are being added to the chargemaster, the radiology directors should be aware of the potential net reimbursement impact the department may experience. The above MRA procedures will be paid by Composite APC 8007 or 8008 when multiple imaging procedures from the same family are performed on the same date of service. As of this date, Composite APC 8007 is reimbursed \$710.55 with Composite APC 8008 reimbursed \$993.11 (national unadjusted rate). Additionally, Medicare is changing the status indicators for CPT codes 72159 and 73225 from "E" (non-covered by Medicare) to "B" (Alternative code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12X and 13X) may be available.

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Facilities providing the above MRA services should begin plans for the department's chargemaster update. The six new HCPCS codes are reportable for procedures on and after October 1, 2010. Transmittal R123NCD issued July 9 provided a revision to the NCD manual specific for MRA procedures. CMS has now combined NCDs for MRA and MRI procedures into one coverage policy. CMS provides coverage policy directives for specific MRI/MRA procedures and has stated "Effective June 3, 2010, all other uses of MRI or MRA for which CMS has not specifically indicated coverage or non-coverage continue to be eligible for coverage through individual local contractor discretion." "Medicare undoubtedly wants the claims data and it appears coverage for these new procedures will remain with the discretion of the separate MACs and carriers," Mr. Arno concludes. "For Medicare to obtain the claims data, these services will need to be covered and reimbursed."

Medicare-Specific HCPCS Codes for Smoking Cessation

Smoking is the most preventable cause of disease and death in the U.S. People who continue to smoke after the age of 65 have a higher overall risk of disease and death than those who quit. Smoking contributes to and can exacerbate heart disease, cancer, stroke, lung disease, hypertension, diabetes, osteoporosis, macular degeneration and cataracts.

Medicare covers 2 types of counseling:

- Intermediate cessation counseling is 3 to 10 minutes per session; and
- Intensive cessation counseling is greater than 10 minutes per session.

Medicare will cover 2 quit attempts per year. Each quit attempt may include a maximum of 4 intermediate or intensive counseling sessions, with the total annual benefit covering up to 8 sessions in a 12-month period. The health care provider and patient have the flexibility to choose between intermediate and intensive counseling.

To be eligible to receive this benefit, a beneficiary must have a condition that is adversely affected by smoking or tobacco use, or that the metabolism or dosing of a medication that is being used to treat a condition the beneficiary has is being adversely affected by his or her smoking or tobacco use.

Medicare has also created two new "C" codes that will replace current smoking cessation counseling CPT codes 99406 and 99407. Effective October 1, 2010, Medicare beneficiaries receiving smoking cessation services must be reported using the following:

Medicare HCPCS	Short Description	Revenue Code
C9801	Smoke/tobacco cessation counseling, greater than 3 minutes up to 10 minutes	0942
C9802	Smoke/tobacco cessation counseling, greater than 10 minutes	0942

Assigned to APC 00031, these HCPCS codes are presumed to be reimbursed at the same rate the present 99406 and 99407 CPT codes are.

Penny Allison, BSN, RN, Chargemaster Practice Manager has analyzed other chargemaster-required updates for October 1. "Several new HCPCS codes are being introduced which will undoubtedly impact the facility's pharmacy chargemaster. Currently the facility may be reporting these drugs using C9399, Unclassified drugs and biologicals, or reported without a HCPCS code. But these new HCPCS codes will definitely need to be reviewed by the pharmacy staff to confirm the facility does or does not currently have these drugs in the formulary."

Medicare HCPCS	Short Description	Revenue Code	APC	Stat Ind
C9269	C-1 esterase, berinert	0636	09269	G
C9270	Gammaplex IVIG	0636	09270	G
C9271	Velaglucerase alfa	0636	09271	G
C9272	Denosumab Injection	0636	09272	G
C9273	Sipuleucel-T, per infusion	0636	09273	G

As of the writing of this article, the specific dosages per HCPCS code were not available. Multipliers should be developed for those pharmaceuticals administered in larger dosages than HCPCS code(s) descriptor indicate.

Penny continues, "In addition to the above new HCPCS codes, CPT 90662 *Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use* will change from status indicator E (Not covered by Medicare) to status indicator L (Reimbursed based on Cost). This drug will now be covered and reportable to Medicare."

A new medical device, HCPCS C1749, is eligible for reporting effective October 1, 2010. Medicare's short description (Endo, colon, retro imaging) is too short to provide a clear description for the device or how the item is used. "This is the first medical device in several years that has separate reimbursement available for facilities," Penny observes. "This will be an important HCPCS code for hospitals to assign. Since limited data is available facilities must be vigilant when watching CMS

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directions as additional and information is disseminated.”

Proposed Reimbursement for Therapy Services

In the proposed rule entitled “Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011” (Proposed Professional Fee Schedule), CMS is proposing to apply a 50 percent payment reduction to the PE (practice expense) component of the second and subsequent therapy services for multiple “always therapy” services furnished to a single patient in a single day. CMS feels there are duplicate labor activities which are currently included in the PE for the service period for several high volume pairs of therapy services such as cleaning room/equipment; education/instruction/counseling/coordinating home care; greet patient/provide gowning; obtain measurements, as well as ROM/strength/edema; and post-treatment patient assistance. Using 2009 claims data, CMS identified 3.4 million pairs of CPT codes furnished on any given day. Given the duplicative clinical labor activities and supplies as shown in the code combination examples, CMS believes it would be appropriate to extend the 50 percent MPPR policy that is currently applied to surgical services and the TC of imaging services, to the PE component of certain therapy services.

Because it would be difficult to determine the precise beginning and end of therapy sessions and CMS does not presently believe that beneficiaries would typically have more than one therapy session in a single day, and they are proposing to apply the 50 percent MPPR policy to the PE component of subsequent therapy services provided to the same patient on the same day, rather than in the same session. It was noted that many therapy services are time-based CPT codes, so multiple units of a single code may be billed for a single session that lasts for a longer period of time than one unit of the code. The proposed MPPR policy would apply to multiple units of the same therapy service, as well as to multiple different services, when furnished to the same patient on the same day. Full payment would be made for the service or unit with the highest PE and payment would be made at 50 percent of the PE component for the second and subsequent procedures or units of the service.

This MPPR policy would apply to 46 “always therapy” services furnished to a patient on the same day, regardless of whether the services are provided by one therapy discipline or multiple disciplines (e.g. physical therapy, occupational therapy, or speech-language pathology services). This proposed policy would apply to those services paid under the PFS that are furnished in the office setting as well as those services paid at the

PFS rates that are furnished by outpatient hospitals, home health agencies (Part B), comprehensive outpatient rehabilitation facilities (CORFs), skilled nursing facilities (SNFs) (Part B), rehabilitation agencies, and other entities paid by Medicare for outpatient therapy services. CMS also estimates that this proposal would reduce (not redistribute) payments for therapy services in settings outside of the PFS (e.g., outpatient hospital departments, skilled nursing facilities) by approximately 13% in CY 2011. (Statistics provided by the American Physical Therapy Association) <http://www.apta.org/AM/Template.cfm?Section=FeeSchedule&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=74784>

Because hospital outpatient therapy services are reimbursed by the MPFS (Medicare Professional Fee Schedule), facility’s therapy reimbursement is potentially in jeopardy for CY2011. The comment period for the Proposed Rule closed August 24, 2010 so it is hoped your opinion and concerns were received.

Several therapy as well as hospital organizations have voiced strong opposition to this proposed rule. At this point it is unclear if CMS will adopt this proposal. If implemented, therapy department’s net reimbursement will certainly be impacted.

Physician Supervision in 2011

Physician supervision requirements were again a focus in the Proposed OPFS Rule CY2011. Therapeutic infusions were the most interesting discussions when CMS elaborated on their considerations of developing a sort of two-phase supervision requirements. Direct physician supervision would be required for the initiation of the service, followed by the general supervision of the remainder of the service. The requirement for “direct” supervision begins with the initiation of the infusion or service and would culminate when the patient becomes stable and the supervising physician/non-physician professional feels the patient’s remainder of the infusion/procedure can be delivered safely under general supervision.

Currently, CMS provided a list of services under consideration for these so-called “nonsurgical-extended-duration” therapeutic services which include G0378/G0379 (observation services) as well as hydration, therapeutic infusions as well as injections. At the present blood administration and chemotherapy services are not included in this list but CMS is reviewing data and collecting comments, which may influence the final decision. To be considered for addition to these specific criteria, a service must:

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- Be of extended duration, frequently extending beyond normal business hours
- Largely consist of a significant monitoring component typically conducted by nursing or other auxiliary staff
- Be of sufficiently low risk, such that the service typically would not require direct supervision often during the service
- Not be a surgical service that includes recovery time

CMS is also collecting comments on a requirement questioning whether or not the point of transfer from direct to general supervision should be documented in the patient's medical record. In addition, CMS is interested in learning about requiring hospitals to develop internal guidelines and protocols for every nonsurgical-extended-duration therapeutic service. Ingenix discussions with Infusion/Oncology Directors identify real concerns from a documentation standpoint as well as lack of clear clinical practice protocols. "Each patient is different and the direct to general supervision transfer can vary for each service provided" Ms. Glenda Schuler, RHIT, CPC, CPC-H, Senior Chargemaster Consultant states. "While it sounds like CMS is easing up on the physician supervision requirements, the real challenge will be protocols and documentation."

CMS also considered whether to exclude all outpatient CAH services from all supervision requirements for payment purposes but decided against this alternative. CMS believes that since CAHs are reimbursed at 101 percent for their services; they could afford to hire enough staff to provide direct supervision. "CMS has not visited the same CAH facilities Ingenix has," adds Glenda. "These hospitals have difficulty locating physicians to practice in their communities. Direct physician supervision is a big concern for CAH facilities and while they have been exempt from this requirement up to this point, unless CMS changes their minds, those days are over in CY2011. CMS has stated that Medicare should purchase services from CAHs that are of the same basic level of safety and quality as from other hospitals."

Billing Point-of-Care Laboratory Tests

The charging for point-of-care laboratory tests continually presents billing and modifier concerns for many facilities. Point of care tests are on the rise. Studies have shown that rapid turnaround times can improve patient outcomes by avoiding inefficiencies in administrative follow-ups and minimizing delays in treatments that could otherwise result in adverse complications and costly consequences. The revenues generated from the sales of POCT products in the U.S.

totaled \$2,128.8 million in 2009. Collecting those dollars is the subject of this article.

Point of care tests are performed house-wide. Cardiac cath lab, emergency departments, clinics, operating rooms and nursing units are a few clinical departments where it is common to find a point of care unit located. When additional orders are written which include the same tests performed by point of care (POC) methodology, this results in double billing or NCCI edit violations. The National Correct Coding Initiative Edit Manual, Chapter 10 (Laboratory Services provides a few specific CPT coding examples which may or may not be performed via POC methodology, but one can see the complexity of reporting the correct CPT codes no matter how the test is performed:

EXAMPLES:

The Emergency Department performs and report automated UA no micro (CPT 81003) (POC). Physician reviews results and later that day adds a microscopic exam to the order (CPT 81015) which the laboratory performs. These two codes will generate a CCI edit. As a result, charges for CPT 81003 must be removed and the laboratory cannot report CPT 81015 alone, but rather the most comprehensive CPT code of 81001 - Automated UA with microscopy be reported.

Note: Because most laboratory departments' protocol includes the UA when doing a microscopic exam, two urinalysis codes cannot be reported.

Many hospitals have established billing protocols for those areas using POC testings in that: 1) If the POC results are negative, the department may charge for that POC test; or 2) If the POC results are positive and specimen must be sent to the laboratory for further testing, the POC test is not reportable.

EXAMPLES:

The physician orders a CBC (and does not specify a differential is to be performed). The laboratory processes the specimen and reports results of the automated hemogram. (CPT 85027). The report includes abnormal results for hemoglobin, hematocrit and WBC. The physician follows with a request for differential to be performed on the same sample. The laboratory revises the report to include the automated differential. (CPT 85004 + 85027). However, NCCI edits prohibit the reporting of these two codes together on the same date of service. Each were performed but a comprehensive CPT 85025 should be reported instead of the individual two codes.

These reporting examples are commonly encountered but present unique challenges, particularly when one test is performed early in the day and the second is ordered

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and performed in the afternoon by another laboratory technologist. The reversal of the initial charge, or the cancellation of the first test must be initiated with the most comprehensive code reported, often resulting in one CPT code reported instead of two.

Infusion Therapy and Heparin Flush

When reviewing numerous UB-04 claim forms during chargemaster engagements, Ingenix most often sees charges for heparin flush charges (J1642 *Injection, heparin sodium, (heparin lock flush), per 10 units*) as well as angiocaths, needles and other supplies necessary to initiate an infusion. Medicare published the following:

If performed to facilitate the infusion or injection, the following services are included and are not reported separately:

- Use of local anesthesia
- IV start
- Access to indwelling IV, subcutaneous catheter or port
- Flush at conclusion of infusion
- Standard tubing, syringes and supplies

Reference: Transmittal 902, Issued April 7, 2006.
Claims Processing Manual, Chapter 4, Implementation May 8, 2006

In addition, National Correct Coding Initiative Edits, Chapter 1, Paragraph C.1 state: After vascular access is achieved, the access must be maintained by a slow infusion (e.g., saline) or injection of heparin or saline into a “lock”. Since these services are necessary for maintenance of the vascular access, they are not separately reportable with the vascular access CPT codes or procedures requiring vascular access as a standard of medical/surgical practice.

The next concern is that of cost versus a charge issue for many facilities. Pharmacy’s cost in ordering and supplying heparin throughout the facility are quite sizeable for most facilities and shifting these costs to nursing units may be one option, or considering the Heparin costs as department overhead, similar to mixing bottles, containers, syringes, etc. To compensate for tubing, syringe and supply costs, facilities have most commonly included these costs into the IV solution charge and/or the administration charge. But there still is a department cost to department charge disparity, when one department has the cost and another department charges for the procedure.

Review of the chargemaster is important to ensure the flush solutions as well as supplies are not separately charged. Ensuring the “cost” of these items is included on the claim is an equally important challenge and not an easy one to resolve.

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