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CODING & COMPLIANCE FOCUS NEWS

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Inside ICD-10: Continues this Month

It is important for facilities to understand the implications of the October 2013 deadline for implementation of the Internal Classification of Diseases, 10th Revision (ICD-10).

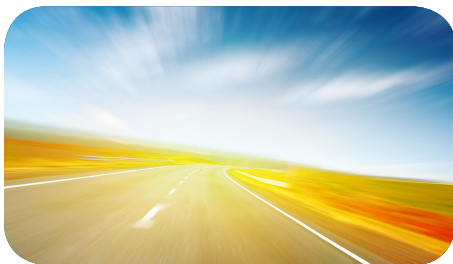
ICD-10 will impact every aspect of the revenue cycle and more. From patient registration to case management and beyond, the ICD-10 code set will affect a variety of departments. The complexity and the scope of ICD-10 is so much more than codes and that is why it is important that staff and providers become knowledgeable about ICD-10.

In addition to latest coding and compliance articles that are published monthly in CCFN, we will provide additional ICD-10 articles each month. Our editorial coverage will include answers to your frequently asked questions, the latest news in ICD-10 and tidbits of information of which you may not be aware.

Our goal is to provide noteworthy information that will assist in a successful transition into the new world of ICD-10. If you have suggestions for feature ICD-10 articles, please send your suggestion to compliance2@medassets.com.

We hope you enjoy this addition of CCFN.

FEATURE ARTICLE



3 What's Driving ICD-10-PCS? Focus on Fundamentals and Guidelines

The ICD-10-PCS code set follows code conventions much like the ICD-9-CM system, writes Darnacea Harris, MHA, RHIT, CCS, in this edition of CCFN. For 2011, there are 11 coding conventions (A1-A11). Among the conventions applied to ICD-10-PCS are the composition of each character in ICD-10-PCS; requirements for consulting the index; instructions for using code tables; defining the use of the word "and;" and the appropriate circumstance to query the physician for supporting documentation.

DOC2DOC

5 CMS Bundling Methodology: Latest in a Topsy-Turvy Year for Medicare

With all the proposed methodologies of reimbursement coming from The Centers for Medicare & Medicaid Services (CMS) aimed at improving quality and coordination of care in the eligible Medicare population, this has certainly been a topsy-turvy year, according to Denise Nash, MD, CCS, CIM, who reports on bundling methodology from CMS.

TALKING POINTS

6 Out With The Old and In With the New! A Summary of the 2012 CPT Code Updates

It's time for providers to prepare their chargemasters for the annual AMA CPT® code changes, writes Shelley Nave, who also notes that there are 522 changes for 2012. However, reports Nave, MedAssets has identified 499 changes.

8 Review of Critical Q4 CMS Changes for MPFS, MUE and NCCI

Karen Hegerle, RHIT, summarizes CMS updates to the Medicare Physician Fee Schedule, Medically Unlikely Edits and the National Correct Coding Initiative Edits.

14 Calculations, Clarifications and Corrections Highlight Q4 Hospital OPSS Updates

Renee Guilbeau, RHIA, CIRCC, reports on a wide range of CPT/HCPCS updates in the fourth quarter from CMS. There's something for everyone.

MODIFIERS CORNER

15 How and When to Use Modifier GA

Modifier GA is appended to a CPT or HCPCS code when an Advance Beneficiary Notice of Noncoverage has been issued to a Medicare beneficiary and the provider expects Medicare will deny reimbursement, reports Sandy Palmer, RHIT.

INSIDE ICD-10

16 What Should We Do with Claims that Span the ICD-10 Implementation Date?

Dr. Smith begins treating a wound care patient at the end of September 2013, explains Emmanuel Akosa, RHIA, MBA. The patient continues to be seen after the Oct. 1, 2013 deadline. Akosa then asks, when submitting the claim, would you use ICD-9 and/or ICD-10?

18 Do you know the ICD-10 Elevator Conversation?

The International Classification of Diseases, 9th edition, Clinical Modification (ICD-9-CM) was developed by the World Health Organization (WHO) and implemented in the United States in 1979, reports Q. Warner, CCP, CPC.

WHAT'S DRIVING ICD-10-PCS?

Focus on Fundamentals and Guidelines

Prior editions of the *Coding & Compliance Focus Newsletter (CCFN)* have spotlighted the characters of ICD-10-PCS, as well as General Equivalency Mappings (GEMs). This article will focus on the fundamental principles and guidelines that drive ICD-10-PCS.

Much like ICD-9-CM, code assignment is based on a set of general principles that guide the coder in selecting the most appropriate code. ICD-10-PCS includes four general principles:

Diagnostic Information is Not Included in Procedure Description – When procedures are performed for specific diseases or disorders, the disease or disorder is not contained in the procedure code. There are no codes for procedures exclusive to aneurysms, cleft lip, strictures, neoplasms, hernias, etc. The diagnosis codes, not the procedure codes, specify the disease or disorder.

Not Otherwise Specified (NOS) Options are Restricted – ICD-9-CM often provides a “not otherwise specified” code option. Certain NOS options made available in ICD-10-PCS are restricted to the uses explained in the ICD-10-PCS draft guidelines. A minimal level of specificity is required for each component of the procedure.

Limited Use of “Not Elsewhere Classified” (NEC) Option – ICD-9-CM often provides a “not elsewhere classified” code option. Because all significant components of a procedure are specified in ICD-10-PCS, there is generally no need for an NEC code option. However, limited NEC options are incorporated into the classification system where necessary. For example, new devices are frequently developed; therefore it is necessary to provide an “Other Device” option for use until the new device can be explicitly added to the coding system.

Level of Specificity – All procedures currently performed can be specified in ICD-10-PCS. The frequency with which a procedure is performed was not a consideration in the development of the system. What is available, however, is a unique code for variations of a procedure that can be performed.

The ICD-10-PCS code set follows code conventions much like the ICD-9-CM system. For 2011, there are 11 coding conventions (A1-A11). Among the conventions applied to ICD-10-PCS are the composition of each character in ICD-10-PCS; requirements for consulting the index; instructions for using code tables; defining the use of the word “and;” and the appropriate circumstance to query the physician for supporting documentation.

ICD-10-PCS provides general guidelines, as well as guidelines that apply to a section or sections. The purpose of these groupings is to provide clarity and ease of application. For example, guidelines for the Medical and Surgical section (section 0) include general guidelines grouped by character.

Example: B2. Body System
General Guidelines
B2.1a

The procedure codes in the general anatomical regions body systems should only be used when the procedure is performed on an anatomical region rather than a specific body part (e.g., root operations Control and Detachment, drainage of a body cavity) or on the rare occasion when no information is available to support assignment of a code to a specific body part.

Example: Control of postoperative hemorrhage is coded to the root operation Control found in the general anatomical region's body systems.

General guidelines related to the Root Operations resemble guidelines contained within ICD-9-CM. There are 16 general guidelines related to Root Operations in ICD-10-PCS. The following is a list of the more common guidelines.

CONVENTION	ICD-10-PCS GUIDELINE	EXAMPLE
Multiple Procedures	B3.2	Laparoscopic cholecystectomy converted to an open cholecystectomy is coded as percutaneous endoscopic Inspection and open Resection.
Discontinued procedures	B3.3	A planned aortic valve replacement procedure is discontinued after the initial thoracotomy and before any incision is made in the heart muscle, when the patient becomes hemodynamically unstable. This procedure is coded as an open Inspection of the mediastinum.
Biopsy followed by more definitive treatment	B3.4	Biopsy of breast followed by partial mastectomy at the same procedure site, both the biopsy and the partial mastectomy procedure are coded.
Excision vs. Resection	B3.8	Left upper lung lobectomy is coded to Resection of Upper Lung Lobe, Left rather than Excision of Lung, Left.
Excision for Graft	B3.9	Coronary bypass with excision of saphenous vein graft, excision of saphenous vein is coded separately.

Other characters within the Medical Surgical category of ICD-10-PCS that include general guidelines are body part, approach, and device. The obstetrics section (section 1) also includes general guidelines. A complete description of ICD-10-PCS coding guidelines can be found at www.cms.gov/ICD10.

Along with a more extensive knowledge of anatomy and physiology, clinical performance of procedures, and the purpose of devices, coders will need to familiarize themselves with these guidelines in order to apply appropriate code assignment. Although there is still ample time before the mandated transition to ICD-10-CM/PCS, it is not too early for coders to begin to review and understand clinical processes, and associated ICD-10-PCS coding guidelines.

About the Author

Darnacea Harris, MHA, RHIT, CCS, is an AHIMA approved ICD-10-CM/PCS Trainer with more than 20 years experience in the coding, compliance and reimbursement industry. Darnacea has previously held such positions CCA Rules Manager, Assistant Director HIM, HIM Manager, Coding Manager, and Consultant. She has also held teaching positions at several colleges and universities where she taught coding, billing, HIM, and supporting courses.

References

- Centers for Medicare and Medicaid Services. *2011 ICD-10-PCS Code Tables and Index*. Retrieved June 8, 2010
- Centers for Medicare and Medicaid Services. *2011 ICD-10-PCS Reference Manual*. Retrieved June 8, 2010.
- Zeisset, Ann (2010). ICD-10-PCS Root Operation Groups, Part 4: Root operations that always involve a device, involve examination only, or define other objectives. *Journal of AHIMA* 81(10); 72-74.



CMS Bundling Methodology: Latest in Topsy-Turvy Year for Medicare

With all the proposed methodologies of reimbursement coming from The Centers for Medicare & Medicaid Services (CMS) aimed at improving quality and coordination of care in the eligible Medicare population, this has certainly been a topsy-turvy year.

First we had Accountable Care Organizations (ACOs) and then on Aug. 23, 2011 the CMS Innovation Center released four variations of a pilot program commencing January of 2012 (Model 1). Initially, this pilot will run for three years and may last up to five years. For everyone who has a hand in coordinating services for the eligible population, the idea is to stop working in silos and to start a dialogue ensuring that patients receive the best acute care in order to avoid the costly aftercare often represented by emergency room visits and readmissions for complications.

An episode-of-care is the health services that a patient receives:

1. For a particular health condition or illness
2. During a period of relatively continuous care from a provider
3. One reimbursement amount is set for all the care associated with the condition or illness
4. Maybe defined spanning a specific number of days

Episode-of-care reimbursement is a healthcare payment method in which providers receive one lump sum for all the

services they provide related to a condition or disease. In the episode-of-care payment method, the unit of payment is the episode, not each individual health service. The continuum of care covers facility costs (i.e. hospital, nursing home, and clinic and outpatient rehab). Also covered are the technical and professional components of procedures in radiology, pathology and lab. Physician professional fees for anesthesia, surgery and consults are also included in the bundled payment. Therefore, the episode-of-care payment method eliminates individual fees or charges. Forms of episode-of-care reimbursement are capitation, global payment, retrospective gain sharing, and prospective payment. An example of a program defining an episode of care is the federal government's payment method for home care. The per-episode home health payment covers all home care services and non-routine medical supplies delivered to the patient during a 60-day period.

The four episodes released by CMS are:

1. **Inpatient Stay Only:** Hospitals receive a discounted payment, but physicians receive full fee-for-service rates. CMS requires the minimum discount to Medicare to increase from 0 percent during the first six months to 2 percent in year three of the bid.
2. **Inpatient Stay Plus Post-discharge Services:** Hospitals and physicians receive fee-for-service rates that are

retrospectively reconciled with a target price. CMS requires a 3 percent minimum discount to Medicare for 30 to 89 days after discharge and a 2 percent discount for an episode that is 90 days or longer.

3. **Post-discharge Services Only:** Hospitals and physicians receive fee-for-service rates that are retrospectively reconciled with a target price. In this case, applicants to the program propose the discount to Medicare.
4. **Inpatient Stay Only:** A payment amount is established prospectively for the admitting hospital; the hospital then distributes pay to physicians. Applicants to the program propose the discount amount to Medicare, at a minimum of 3 percent.

Models one, two and three would be based on a target price by applying a discount to total costs to similar historical episodes (retrospective payment bundling). In the fourth model, Medicare would make a single prospective payment to the hospital. Under Model 4 physicians and other practitioners would submit "no pay" claims to Medicare and would be paid from the bundled episode.

To view the full PDF, go to innovations.cms.gov/documents/pdf/fact-sheet-bundled-payment-final82311.pdf

MODEL	MODEL 1 – Inpatient Stay Only	MODEL 2 – Inpatient Stay plus Post-discharge Services	MODEL 3 - Post-discharge Services Only	MODEL 4 – Inpatient Stay Only
Eligible Awardees	<ul style="list-style-type: none"> Physician group practices Acute care hospitals paid under the IPPS Health systems Physician-hospital organizations Conveners of participating health care providers 	<ul style="list-style-type: none"> Physician group practices Acute care hospitals paid under the IPPS Health systems Physician-hospital organizations Post-acute providers Conveners of participating health care providers 	<ul style="list-style-type: none"> Physician group practices Acute care hospitals paid under the IPPS Health systems Long-term care hospitals Inpatient rehabilitation facilities Skilled nursing facilities Home health agency Physician-hospital organizations Conveners of participating health care providers 	<ul style="list-style-type: none"> Physician group practices Acute care hospitals paid under the IPPS Health systems Physician-hospital organizations Conveners of participating health care providers
Payment of Bundle and Target Price	Discounted IPPS payment; no separate target price	Retrospective comparison of target price and actual FFS payments	Retrospective comparison of target price and actual FFS payments	Prospectively set payment
Clinical Conditions Targeted	All MS-DRGs	Applicants to propose based on MS-DRG for inpatient hospital stay	Applicants to propose based on MS-DRG for inpatient hospital stay	Applicants to propose based on MS-DRG for inpatient hospital stay
Types of Services Included in Bundle	Inpatient hospital services	<ul style="list-style-type: none"> Inpatient hospital and physician services Related post-acute care services Related readmissions Other services defined in the bundle 	<ul style="list-style-type: none"> Post-acute care services Related readmissions Other services defined in the bundle 	<ul style="list-style-type: none"> Inpatient hospital and physician services Related readmissions
Expected Discount Provided to Medicare	To be proposed by applicant; CMS requires minimum discounts increasing from 0% in first 6 mos. to 2% in Year 3	To be proposed by applicant; CMS requires minimum discount of 3% for 30-89 days post-discharge episode; 2% for 90 days or longer episode	To be proposed by applicant	To be proposed by applicant; subject to minimum discount of 3%; larger discount for MS-DRGs in ACE Demonstration
Payment from CMS to Providers	<ul style="list-style-type: none"> Acute care hospital: IPPS payment less pre-determined discount Physician: Traditional fee schedule payment (not included in episode or subject to discount) 	Traditional fee-for-service payment to all providers and suppliers, subject to reconciliation with predetermined target price	Traditional fee-for-service payment to all providers and suppliers, subject to reconciliation with predetermined target price	Prospectively established bundled payment to admitting hospital; hospitals distribute payments from bundled payment
Quality Measures	All Hospital IQR measures and additional measures to be proposed by applicants	To be proposed by applicants, but CMS will ultimately establish a standardized set of measures that will be aligned to the greatest extent possible with measures in other CMS programs		

To date a handful of diverse models have been implemented:

Medicare’s Participating Heart Bypass Center Demonstration:

Under this demonstration, which ran from 1991 to 1996, seven hospitals received a single payment covering hospital and physician services for coronary artery bypass graft (CABG) surgery. The participating hospitals received a single payment and determined how they would share the amount with physicians. The payment rate was also updated based on the Medicare hospital prospective payment and physician fee schedule rates.

Medicare’s Cataract Surgery Alternate Payment Demonstration:

From 1993 to 1996, this demonstration project used a negotiated bundled payment option for all services routinely provided within an episode of outpatient cataract surgery, including physician and facility fees, intraocular lens costs, and

the costs of selected pre- and postoperative tests and visits. Payment rates were determined by competitive bidding and were 2 to 5 percent lower than the non-demonstration payment rates.

Geisinger Health System’s ProvenCare:

Under this program, which began in 2006, payment is bundled for all non-emergency coronary artery bypass graft (CABG) procedures including the preoperative evaluation, all hospital and professional fees, and management of any complications (including readmissions) occurring within 90 days of the procedure.

Dr. Johnson and Ingham Medical Center:

In 1987, an orthopedic surgeon partnered with a local hospital to offer a fixed price for knee and shoulder arthroscopic surgery, which included all related physician and hospital charges for surgery and any subsequent service for two years after surgery.

Medicare’s Acute Care Episode Demonstration:

Beginning in 2009, Medicare began paying the five participants a flat fee to cover hospital and physician services for cardiac care (CABG, valves, defibrillators, pacemakers, etc.) and orthopedic care (hip and knee replacement). The participating sites have the discretion to reward clinicians and other hospital staff who meet certain quality and efficiency goals.

PROMETHEUS Payment, Inc.:

With grants from the Commonwealth Fund and the Robert Wood Johnson Foundation, PROMETHEUS developed a bundled payment system to cover a full episode of care for 21 episodes including acute myocardial infarction, hip and knee replacements and CABG. PROMETHEUS was implemented in three sites in 2009.

Fairview Health Services:

Fairview Health Services in Minnesota is currently working with Target, 3M, and other large, self-insured employers to develop flat fee "care packages" around specific chronic conditions, such as diabetes and asthma. Employers and patients can use online tools to purchase a package that best fits their needs.

Blue Cross Blue Shield of Massachusetts (BCBSMA):

The Alternative QUALITY Contract (AQC): In 2009, BCBSMA introduced the AQC to provider and hospital groups in Massachusetts. As of November, 2009, 20 percent of the BCBSMA provider network had signed on to the AQC. The AQC is a global payment system tied to nationally accepted measures of quality. The payment rate is set for all services and costs associated with a patient’s care, is risk-adjusted for patients’ health status, sex, and age, and is updated annually for inflation. The AQC covers all conditions that a BCBSMA member may present with, includes all services that the member may require across the continuum of care, and rates performance based on a detailed list of process, outcome, and patient experience measures. The contract also includes a pay for performance component where providers are eligible for an additional 10 percent of total payment if they meet certain quality benchmarks.

(To view the full PDF, go to: www.hret.org/bundled/resources/BundledPayment.pdf.)

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Out With The Old and In With the New!

A Summary of the 2012 CPT Code Updates

It's that time of year again when healthcare providers are preparing their chargemaster for the annual AMA CPT® code changes. According to the AMA 2012 Appendix B and the AMA Correction Document CPT® 2012, there is a total of 522 changes for 2012. However, MedAssets has identified 499 changes for 2012. The 2012 CPT code changes include new, revised and deleted codes.

To assist in what might be considered a maze of confusion we are providing an overview to explain the differences between the CPT code changes published in the AMA 2012 Appendix B and the changes based on MedAssets review and analysis of the 2012 CPT code changes.

MedAssets not only analyzed the changes published in the AMA Appendix B, but also the changes that were published in the AMA Annual CPT data files as well as the Oct. 7, 2011 AMA publication of the Correction Document CPT 2012. Upon our review and analysis, we found some CPT codes that were identified in Appendix B as "new" or "deleted" that were not actually new or deleted codes for 2012. In this article we will explain the reasoning for the discrepancy between AMA and the MedAssets new and deleted code volume.

First, for 2012, the Appendix B listed CPT codes as new codes when these codes were actually implemented in 2011. This includes Category I vaccine code (90654), Category II and Category III codes. Since the 2011 new codes did not appear in the 2011 CPT manual, these codes will be published for the first time in the 2012 CPT manual. On the other hand, the AMA did not list several new codes in the Appendix B. These Category II and Category III codes were released in 2011, effective Jan. 1, 2012, but will not appear in the CPT manual until 2013.

Please note, there is one code listed in Appendix B and in KnowledgeSource as a "new" code; however, this code may already be established in your CDM. CPT code 77425 was deleted in 1999; however, the AMA has recycled this code for 2012. Based on our review and analysis, MedAssets has identified 273 new codes for 2012.

Next, MedAssets identified deleted codes in Appendix B that were actually deleted in CY 2010. Based on our review of deleted codes, there appears to be 96 codes that are deleted for 2012. This would also include codes that were deleted in 2011 with an effective date of Jan. 1, 2012 that were not listed in Appendix B as deleted codes.

On Oct. 7, 2011, AMA published *Corrections Document CPT 2012* in which were included five additional deleted codes, effective Dec. 31, 2011. These codes were not listed in Appendix B or in the Annual CPT Data files. However, we have included these five codes in MedAssets total number of deleted codes for 2012.

Just as in previous years, the AMA revised the long descriptions of a few CPT codes for 2012. The changes to the descriptions should be carefully reviewed as the revision may change how the code was previously reported. Although, the AMA's Appendix B listed 141 revised CPT codes for 2012, after further review there are only 130 codes that appear to be "true" revisions. True revisions are when the revised CPT code description alters the intent of the CPT code. Therefore, how the code was reported in 2011 may be reported differently in 2012. MedAssets does not include other revisions, such as grammatical changes in its count of revised CPT codes for 2012.

In Appendix B, the AMA listed two Category II codes as being revised, but later changed the status of these codes (1127F and 1128F) as reinstated codes effective July 1, 2011.

We have included a comparison table below that provides a high level summary of the AMA Appendix B 2012 changes.

In 2010, the AMA began a new CPT code numbering methodology by resequencing codes. Resequencing is a method of displaying a CPT code outside of its numerical CPT code range. The CPT codes are resequenced based on their description and their relations with another code rather than by their number. The AMA has continued this numbering methodology by adding new resequenced CPT code for 2012.

In the CPT manual, resequenced CPT codes may be identified in red font within the subcategories to provide guidance where to locate the resequenced CPT code within that subcategory.

Conclusion

This article is only a high-level overview of the 2012 CPT changes. Reviewing the 2012 changes does not end here! MedAssets would like to invite you to participate in one of our 2012 CPT Codes Updates or one of our OPPS Final Rule webinars that will provide additional information to assist you as you work through your chargemaster to make changes to include the 2012 updates. Please review the [compliance webinar schedule](#) in this publication for dates and to registration information for these upcoming webinars.

About the Author

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SUMMARY OF CHANGES APPENDIX B

Category	New Codes	Revised Codes	Deleted Codes	Re-sequenced Codes	Recycled/Reinstated Codes
Evaluation & Management (99201–99499)	0	9	0	0	0
Surgery (10040–68899)	61	86	47	13	0
Radiology (70010–79999)	10	08	18	02	0
Pathology/Laboratory (80048–89399)	103	05	02	0	0
Medicine (90281–99199) & (99500–99607)	18	25	16	07	0
Category II (0001F–7025F)	59	05	05	0	0
Category III (0019T–0259T)	31	3	11	0	0
Total	282	141	99	22+	1*

*Denotes number is included in the total number of new codes

+ Denotes number is not included in the total changes published in Appendix B



Review of Critical Q4 CMS Changes for MPFS, MUE and NCCI

Editor's Note: This article summarizes changes in the Oct. 1, 2011 fourth quarter CMS updates. Written by key MedAssets analysts, it is intended to provide a valuable overview of the quarterly CMS updates for MedAssets clients.

Medicare Physician Fee Schedule (MPFS) Q4 Changes

Although CMS has published the October 2011 update of the Medicare Physician Fee Schedule, there are no new or deleted Healthcare Common Procedure Coding System (HCPCS) codes. There are, however, a number of HCPCS codes with MPFS payment indicator changes. These changes are retroactive to Jan. 1, 2011. If providing these services you will want to ensure that your billing and coding staff are aware of the changes in payment indicators.

- Co-Surgery changes- 21
- Bilateral Surgery (Modifier 50) changes- 6
- Physician Supervision changes- 19
- Assistant at Surgery Changes- 3
- Team Surgery changes- 23

These should be reviewed with staff to determine the impact of the modifications.

All revisions are retroactive and effective Jan. 1, 2011

Co-Surgery Indicator Changes from 0 to 1

HCPCS	SIGNIFICANCE
21089, 26859,	This indicator change points out that Co-surgeons could be paid for these procedures, though supporting documentation is required to establish the medical necessity of two surgeons for the procedure.
38129, 38589,	
43289, 43659,	
44238, 44979,	
45499, 47379,	
47579, 49329,	
49659, 50549,	
51999, 54699,	
55559, 58578,	
58579, 58679,	
59898	

Bilateral Surgery (Modifier 50) Changes

HCPCS	SIGNIFICANCE
95928, 95928-TC,	Have been granted a "bilateral surgery" indicator of "2" (150 percent payment adjustment does not apply).
95928-26, 95929,	
95929-TC, 95929-	
26	

Be aware of the physician supervision changes as some of these are significant and will impact physician supervision requirements for physician office practices and hospital facilities.

Pay particular attention to the procedure codes that are changing from indicator 1 to 3 as they are changing from general supervision to personal supervision.

Additionally, review those services changing from indicator 9 to 1, 2 or 3. These procedures were originally set up as "Concept does not apply," however, effective Jan. 1, 2011, these now require some level of supervision.

Physician Supervision of Diagnostic Procedures	Significance
	01-Procedure must be performed under the general supervision of a physician.
	02-Procedure must be performed under the direct supervision of a physician.
	03-Procedure must be performed under the personal supervision of physician.
	09-Concept does not apply
	21-Procedure may be performed by a technician with certification under general supervision of a physician; otherwise must be performed under direct supervision of a physician.

31579		From 03 to 09
75901		From 03 to 09
75902		From 03 to 09
75954		From 03 to 09
76813		From 01 to 03
76813	TC	From 01 to 03
76814		From 01 to 03
76814	TC	From 01 to 03
91132		From 09 to 03
91132	TC	From 01 to 09
92270		From 09 to 01
92275		From 09 to 01
92285		From 09 to 01
92286		From 09 to 01
92511		From 09 to 03
93025		From 09 to 02
93025	TC	From 01 to 02
93025	26	From 09 to 02
95925	TC	From 21 to 09

Assistant At Surgery Changes

HCPCS	SIGNIFICANCE
+15201 +19291	Indicator changes from- 0 (Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity) to- 1 (Statutory payment restriction for assistants at surgery applies to this procedure, Assistant at surgery may not be paid)
+14302	Indicator changes from- 0 (Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity) to 2 (Assistant at surgery may be paid).

Team Surgery Changes

HCPCS	SIGNIFICANCE
21089, 29999, 37501, 38129, 38589, 43289, 43659, 44238, 44979, 45499, 47379, 47579, 49239, 49659, 50549, 50949, 51999, 54699, 55559, 58578, 58579, 58679, 59898	From- 0 (Team surgeons not permitted for this procedure.) To-1 (Team surgeons could be paid, though supporting documentation required to establish medical necessity of a team; pay by report.)

[Links to CMS Transmittal and MLN Matters: CMS Transmittal 2276, Change Request \(CR\) 7528](#)

[MLN Matters® article MM7528](#)

Fourth Quarter, 2011: Medically Unlikely Edits

The goal of Medically Unlikely Edits (MUEs) is to reduce the error rate for Part B claims. CMS has assigned an MUE to specific Category III, CPT and HCPCS codes. This number is the maximum number of units of the service that may be reported for one beneficiary on one specific date of service.

CMS has not assigned MUEs to all Category III/CPT/HCPCS codes nor does CMS publish all of the assigned MUEs. The list of unpublished MUEs remains confidential.

CMS publishes a quarterly update to the MUE tables in the form of three separate files:

- Facility Outpatient files for the services provided in a hospital, or clinic
- Practitioner Services files for services provided by physicians
- DME files (includes HCPCS A, B, D-H, K-V) for supplies/devices provided for the care of the beneficiary

Fourth Quarter, 2011 CMS Update to MUEs

MUE 4TH QTR 2011	FACILITY OUTPATIENT SERVICES	PRAC- TITIONER SERVICES	DME SUPPLIER SERVICES
Additions	1	1	0
Revisions	0	0	0
Deletions	0	0	0

Additions

CMS added MUEs for HCPCS code G0429 – Provision of test materials and equipment for home INR monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets Medicare coverage criteria. This criteria includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include four tests reported for both Facility Outpatient Services

and Practitioner Services. This service is assigned an MUE of 1.

CMS did not publish any newly assigned MUEs for DME HCPCS codes.

Revisions

There were no revisions to existing MUEs for Facility Outpatient Services and Practitioner Services or DME in the fourth quarter of 2011.

Deletions

CMS also did not publish any deletions for Facility Outpatient Services and Practitioner Services or DME.

Additional information may be reviewed within KnowledgeSource or www.cms.gov.

Fourth Quarter, 2011: National Correct Coding Initiative (NCCI) Edits

National Correct Coding Initiative Edits (CCI) may account for a large percentage of issues related to rejected claims. As part of a preventative claim denial process, providers should be aware of quarterly CCI edit changes which may impact their services. Effective Oct. 1, 2011, will be CCI Edit version 17.3 for professional services, and version 17.2, incorporated into I/OCE version for facility services. Providers can directly access the NCCI edit files at www.cms.gov/NationalCorrectCodInitEd. The NCCI edits are available in the MedAssets KnowledgeSource product.

For version 17.3 Professional 1380 new Column1/2 or Comprehensive/Component edit pairs have been added, 811 pairs have been deleted; and 32 pairs have a modifier indicator change. For version 17.2 Facility, 2243 new Column1/2 or Comprehensive/Component edit pairs have been added, 336 pairs have been deleted and 101 pairs have a modifier indicator change.

ADDITIONS, DELETIONS & CHANGES BY NCCI SERVICE TYPE & CODE RANGE

NCCI SERVICE TYPE/CODE RANGE	17.3 PRO ADDITIONS	17.3 PRO DELETIONS	17.3 PRO CHANGE TO MODIFIER INDICATOR	17.2 FACILITY ADDITIONS	17.2 FACILITY DELETIONS	17.2 FACILITY CHANGE TO MODIFIER INDICATOR
CATEGORY III CODES 0001T-9999T	19	0	0	243	0	0
ANESTHESIA 00100-01999	0	0	0	14	0	0
INTEGUMENT 10000-19999	0	0	0	3		0
MUSCULOSKELETAL 20000-29999	42	1	0	251	10	0
RESPIRATORY, CARDIOVASCULAR, HEMIC & LYMPH 30000-39999	31	608	0	114	1	0
DIGESTIVE CPT 40000-49999	348	6	2	51	18	10
URINARY, MALE GENITAL, FEMALE GENITAL, MATERNITY CARE/DELIVERY 50000-59999	689	0	27	36	0	43
ENDOCRINE, NERVOUS, EYE, AUDITORY 60000-69999	26	0	0	46	8	7
RADIOLOGY 70010-79999	6	0	3	74	1	19
PATH/LAB 80000-89999	8	0	0	167	0	0
E/M, MED/OTHER 90000-99999	2	2	0	110	298	15
SUPPLEMENTAL SERVICES A0000-V9999	209	194	0	1134	0	7
TOTAL	1380	811	32	2243	336	101

ADDITIONS, DELETIONS AND CHANGES BY NCCI EDIT CATEGORY

NCCI SERVICE TYPE/CODE RANGE	17.3 PRO ADDITIONS	17.3 PRO DELETIONS	17.3 PRO CHANGE TO MODIFIER INDICATOR	17.2 FACILITY ADDITIONS	17.2 FACILITY DELETIONS (UNDETAILED)	17.2 FACILITY CHANGE TO MODIFIER INDICATOR
ANESTHESIA SERVICE INCLUDED IN SURGICAL PROCEDURE	0	0			190	
CPT "SEPARATE PROCEDURE" DEFINITION	465	11		50	10	
CPT MANUAL AND CMS CODING MANUAL INSTRUCTIONS	2	0		204		
HCPCS/CPT PROCEDURE CODE DEFINITION	0	0		102		
MISUSE OF COLUMN2/WITH COLUMN1 CODE	751	314		421	115	
MORE EXTENSIVE PROCEDURE	0	4		43	10	
MUTUALLY EXCLUSIVE PROCEDURE	16	19		322	6	
STANDARDS OF MED/SURGICAL PRACTICE	146	463		921	5	
SEQUENTIAL PROCEDURE	0	0		180		
STANDARD PREPARATION/MONITORING SERVICES FOR ANESTHESIA	0	0		0		
FROM MODIFIER INDICATOR 0 TO 1	-	-	3	0		18
FROM MODIFIER INDICATOR 1 TO 0	-	-	29	0		83
TOTAL	1380	811	32	2243	336	101

Highlights: 17.3 Professional

- Code 38220 – Bone marrow; aspiration only – has become a misuse of column 2/column 1 component code within a large range of vertebral procedures such as arthrodesis, laminectomy, discectomy, vertebral fusions and/or arthroplasties. Modifier usage will be allowed if appropriate.
- Code(s) for appendectomies to include 44950 44955 44960 and 44970 as misuse of column2/column1 components have been incorporated into digestive system, urinary system, female and male genital system procedures. Modifier usage will not be allowed.
- Code(s) for thawing, freezing and CMV antibody testing (86644 86927-86932 and 86945) will be considered a component of the actual blood product. HCPCs with modifier usage will be allowed under the misuse of column 2/column 1 criteria.
- 1 view or 2 view chest x-rays (71010, 71020) are now considered a component of pleural or thoracic catheter insertions (32422 32550 32551 93503) with modifier usage allowed under the misuse of column 2/column 1 criteria.
- Conscious sedation (99148 99149) will no longer be considered a component of 36147 – Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava).
- EKGs (93000 93005 93010, 93040-93042) will no longer be considered a component of the annual wellness visits (G0438 G0439).
- Code(s) 88387, 88388 – Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies - have become component codes for a large range of pathology and laboratory comprehensive codes. Modifier usage is allowed.
- Code G0428 – Collagen Meniscus Implant procedure for filling meniscal defects (e.g., CMI, collagen scaffold, Menaflex) is comprehensive to and not allowed with component codes for arthroscopic knee procedures or conscious sedation. Modifier usage is allowed under appropriate circumstances for arthroscopic knee procedures but not for the conscious sedation.
- Modifier status changes for component code(s) 74150-74170 – stand alone CT abdomen or 72192-72194 stand alone CT pelvis procedures when used in conjunction with comprehensive code(s) for combined CT abdomen & pelvic procedures 74176-74178. Modifier usage will now be allowed under appropriate circumstances.
- The annual wellness visits G0438, G0439 are comprehensive to component codes for other E/M services.
- Vaccine codes 90656-90662 cannot be combined with components codes for specific name vaccine HCPC codes Q2036-Q2039 as mutually exclusive procedures.
- MRAs C8931-C8936 are comprehensive to component MRI procedures 72141 72142 72146-72149 72157-75159 73218-73223 73225 and also fall under the composite APC Q3.

About the Author:

Karen Hegerle, RHIT, has over 30 years of experience in both medical teaching facilities as well as community hospitals in Health Information Management and Cancer Registry. She has been employed by MedAssets for the past four years and has been involved in Knowledge, PQRI, Medical Necessity, Coach, Coding & Compliance and the Help Desk.

Highlights: 17.2 FACILITY

- Code(s) 10021 and 10022 – Fine needle aspirations with or with/out guidance are now considered “sequential procedures” in combination with excision of tumors of the soft tissue, subcutaneous/subfascial or bone. Addition of a modifier will be allowed.

CMS Bundling Methodology
(continued from page 6)

Episode manager, a MedAssets product, is a web application which can manage multiple bundled payment methodologies, including the Prometheus Evidence-informed Case Rate (ECR®) algorithms and methodology for 21 episode bundles consisting of chronic, acute and procedural episodes. This tool may be of assistance to healthcare providers considering preparation for the CMS healthcare reform.

DRGs, define the time period for the episode as well as the services which will be included in the episode. After receipt of the letter, Medicare will provide historical Medicare claims data to potential applicants applying for Models 2-4.

Because CMS Innovation Center received much interest about the Bundled Payments for Care Improvement initiative (BPCI) released on Aug. 23, 2011 and based on the feedback from the community of potential applicants, the Innovation Center is modifying two deadlines relating to Model 1 of BPCI. Applications for BPCI Model 1 are now due on Nov. 18, 2011. The deadlines for bundled payment Models 2, 3 and 4 remains March 15 for applications.

About the Author

Denise M. Nash, MD, CCS, CIM, is the medical director and product owner for the Bundled Payments solution for MedAssets. Denise has more than 20 years experience in the healthcare industry. She has worked for CMS in hospital auditing and has expertise in negotiation and implementation of risk contracting for managed care plans. Denise also has worked with individuals as well as physician groups on utilization improvements to improve financial performance for the risk-based contracts. She has worked with both hospitals and physician practices on the legal aspects of adding new services to the respective facilities. Denise is a consultant on compliance/HIPAA at physician practices, hospitals and insurance plans and has worked for the Office of the Inspector General (OIG) of New Hampshire in its Fraud and Abuse Division.



Calculations, Clarifications and Corrections Highlight Q4 Hospital OPSS Updates

Can you believe it? We are now in the final quarter of the year and it is yet again time to discuss CPT/HCPCS updates.

Changes to Device Edits Retroactive to January 2011

Effective retroactive to Jan. 1, 2011, CMS states that CPT code 64569 -- Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator, has been added as an appropriate procedure for device code C1778 -- Lead, neurostimulator (implantable). Therefore, if a claim(s) was submitted with the date of service after Jan. 1, 2011 and returned to provider (RTP), the claim may now be resubmitted.

CMS further clarifies that HCPCS code C1778 will not be added as a required device for procedure code 64569 because CMS considers the device to be non-essential to CPT code 64569.

The most recent lists for procedure-to-device and device-to-procedure edits can be found under [Device, Radiolabeled Product, and Procedure Edits](#).

Remember, if claims fail to pass these edits it will result in the claim being RTP.

New Device Pass-Through Categories

Effective Oct. 1, 2011, CMS has established two new categories for transitional pass-through payment. They are the following:

C1830 -- Powered bone marrow biopsy needle (SI H, APC 1830)

C1840 -- Lens, intraocular (telescopic) (SI H, APC 1840)

Device Offset from Payment

Medicare regulations state that CMS will deduct from the pass through payments for devices an amount that reflects the portion of the APC payment amount that the agency determines is associated with the cost of the device.

With this said, CMS was unable to identify a portion of the APC payment amount associated with the cost of the powered biopsy needle code C1830 in APC 0003 Bone Marrow Biopsy/Aspiration. Therefore, CMS will not make any deduction from pass through payment for category C1830 and has established an offset amount for C1830 of \$0.

CMS will not make any deduction from pass through payment for category C1830 and has established an offset amount for C1830 of \$0.

Claim Instructions for C1840

Telescopic intraocular lens code C1840 will be reimbursed when either of these CPT procedure codes is billed with the code. These two procedure codes are the following:

66982 -- Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or 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 (APC 0246)

66984 -- Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification) (APC 0246)

CMS was able to identify a portion of the APC payment amount associated with the cost of C1840 in APC 0246 Cataract Procedures with IOL Insert. Therefore, the device offset payment amount for APC 0246 is \$221.71.

Drugs, Biologicals, and Radiopharmaceuticals

CMS continues to encourage providers to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the item is paid separately or packaged.

Average Sales Price (ASP)

The following reimbursement for drugs and biologicals provides payment for both the acquisition and pharmacy overhead cost associated with the drug or biological:

Non Pass - Through ASP +5 percent

Pass - Through ASP +6 percent

Updated payment rates are listed in the October 2011 OPPS Addendum A and B. To view this information go to: <https://www.cms.gov/HospitalOutpatientPPS/AU/list.asp#TopOfPage>

Drugs and Biologicals with New OPPS Pass-Through Status

The following two drug codes are assigned status indicator (SI) G for pass-through payment effective Oct. 1, 2011 under their associated APCs:

C9286 – Injection, belatacept, 1 mg
(APC 9286)

J0638 – Injection, canakinumab, 1 mg
(APC 1311)

Note: C9286 is a new HCPCS code effective Oct. 1, 2011

Updated Payment Rates

An incorrect payment rate for a HCPCS code in the third quarter is corrected in the October OPPS 2011 Pricer. The corrected payment rate and minimum unadjusted copayment are listed below:

Effective July 1 through Sept. 30, 2011

J9185 – Injection, fludarabine phosphate,
50 mg - \$104.52 / \$20.90
(SI K, APC 0842)

Additional Recurring Topics

CMS continues to mention “recurring” topics each quarter. For an overview regarding these subjects, please see below.

Correct Reporting of Biologicals When Used As Implantable Devices

If a HCPCS code describes a biological product that may either be surgically implanted or inserted or otherwise applied in the care of a patient, hospitals should not report separately the biological HCPCS code, except if the biological has pass-through status.

Medicare states that this is due to the fact that under the OPPS, hospitals are reimbursed by a packaged APC payment for surgical procedures which includes implantable devices without pass-through status. CMS goes on to mention how hospitals may include charges for these items in their charge for the procedure.

Correct Reporting of Units for Drugs

CMS states, yet again, that units should be reported in multiples of the units included in the HCPCS descriptor and provides us with an example of this. Medicare cautions providers that before submitting a claim it is extremely important to review the complete long descriptors for the applicable HCPCS code(s).

Reporting of Outpatient Diagnostic Nuclear Medicine Procedures

When one facility administers a diagnostic radiopharmaceutical product for a nuclear medicine scan performed at a different facility, hospitals must comply with OPPS policy requiring the radiolabeled products to be reported and billed with the nuclear medicine scan. In this case, the first facility may enter into a CMS-defined arrangement where the second facility that performs the scan bills Medicare for both the scan and the radiolabeled product. The second facility then pays the first location some amount for administration of the radiopharmaceutical

Once again CMS reminds us that it is not appropriate to report HCPCS code C9399 – Unclassified drugs or biologicals for drugs and biologicals that are defined as usually self-administered drugs by the patient.

HCPCS Code C9399

Once again CMS reminds us that it is not appropriate to report HCPCS code C9399 – Unclassified drugs or biologicals for drugs and biologicals that are defined as usually self-administered drugs by the patient.

HCPCS code C9399 is to be used solely for the following:

New outpatient drugs or biologicals that are approved by the FDA on or after Jan. 1, 2004 and, Furnished as part of covered outpatient department services for which a product-specific code has not been assigned.

Calculation of Overall Cost to Charge Ratios (CCRs)

Effective on or after May 1, 2010, CMS has updated instructions that contain Worksheet/Column/line edits, reflecting the new “Hospital and Hospital Health Care Complex Cost Report,” form CMS-252-10.

Clarifications to Condition Code 44 Policy

CMS states that in order for a patient’s status to change from inpatient to outpatient, the practitioner responsible for the care of the patient must agree with any decision made by the hospitals Utilization Review committee.

In addition, CMS states that Condition Code 44 policies apply to critical access hospitals (CAHs) as well as other types of hospitals.

Summary of Modifications from I/OCE

Effective April 1, 2011, CPT code 90654 – Influenza virus vaccine, split virus, preservative-free, for intradermal use - is assigned SI L (previously assigned SI E).

Effective Oct. 1, 2011, HCPCS code J0638 – Injection, canakinumab, 1 mg – is assigned SI G (previously assigned SI K).

New ICD-9-CM diagnosis codes effective Oct. 1, 2011, are listed below for Mental Health diagnoses used for Partial Hospitalization. These include the following:

294.20 Dementia, unspecified, without behavioral disturbance

294.21 Dementia, unspecified, with behavioral disturbance

310.81 Pseudobulbar affect

310.89 Other specified nonpsychotic mental disorders following organic brain damage

New Modifier

With a retroactive effective date of Jan. 1, 2008, CMS has added Modifier 92 to the valid modifier list. It is defined as the following:

Alternative Laboratory Platform Testing

When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding Modifier 92 to the usual laboratory procedure code (HIV testing 86701-86703). The test does not require permanent dedicated space. By its design, since it may be hand carried or transported to the vicinity of the patient for immediate testing at that site, the location of the testing is not in itself determinative of the use of this modifier.

When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding Modifier 92 to the usual laboratory procedure code (HIV testing 86701-86703).

Note: (SI) status indicator definition(s):

- E – Items, Codes, and Services: That are not covered by any Medicare outpatient benefit based on statutory exclusion; That are not covered by any Medicare outpatient benefit for reasons other than statutory exclusion; That are not recognized by Medicare for outpatient claims but for which an alternate code for the same item or service may be available; For which separate payment is not provided on outpatient claims. Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).
- G – Pass-Through Drugs and Biologicals. Paid under OPPS; Separate APC payment.
- H – Separate cost-based pass-through payment. Not subject to coinsurance.
- K – Nonpass-Through Drugs and Nonimplantable Biologicals, including Therapeutic Radiopharmaceuticals. Paid under OPPS; separate APC payment.
- L – Not paid under OPPS. Paid at reasonable cost. Not subject to deductible or coinsurance.

About the Author

Renee Guilbeau, RHIA, CIRCC, has been employed with MedAssets for over five years. She is a Registered Health Information Administrator and has an additional credential in Interventional Radiology Cardiovascular Coding (CIRCC). She is a graduate of University of Louisiana at Lafayette.

References

To view this information in its entirety, click on the following links:

www.cms.hhs.gov/transmittals/downloads/R2296CP.pdf

www.cms.hhs.gov/transmittals/downloads/R2277CP.pdf

www.cms.gov/MLN MattersArticles/downloads/MM7545.pdf

www.cms.gov/MLN MattersArticles/downloads/MM7541.pdf

How and When to Use Modifier GA

HCPCS Modifier GA is currently defined by Medicare as: Waiver of liability statement issued as required by payor policy, individual case.

Modifier GA should be appended to a CPT or HCPCS code when an Advance Beneficiary Notice of Noncoverage (ABN, form CMS-R-131) has been issued to a Medicare beneficiary and the provider expects Medicare will deny reimbursement for a covered item or service that was provided.

Providers should expect denial of the covered item or service due to circumstances of not meeting medical necessity for the individual case. Modifier GA is currently used to report an item or service that requires an ABN to be issued to transfer liability to the beneficiary. The beneficiary should sign the ABN prior to the service. Medicare also allows the use of Modifier GA if it was witnessed that the beneficiary refused to sign the ABN. Additionally, occurrence code 32 and the accompanying date the ABN was signed should be reported on the UB-04 form that is submitted to Medicare. If multiple ABNs were provided for separate services billed on the same claim form occurrence code 32 and the date of each ABN should be listed on the UB-04.

Medicare defines medical necessity as the following: Services and items found to be reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member.

In February 2010 Medicare stated that lines submitted with modifier GA would be automatically denied. However, effective April 1, 2010, the auto denial of lines with modifier GA has been suspended until further notice. Medicare payors will make a determination for payment for lines submitted with modifier GA based on a review of the claims with attention to policies that are relevant to the items on the claim. Payors will also review the date the ABN was provided as it relates to the services that did not meet medical necessity.

Examples

In the following examples, when the beneficiary is notified that they will be financially responsible prior to the procedure and an ABN was provided to the beneficiary, the CPT or HCPCS code for the service(s) can be appended with Modifier GA under Medicare OPPS reporting to transfer liability to the beneficiary. The medical necessity requirements for these services are covered in either the Medicare Benefit Policy Manual (BPM) or the Medicare National Coverage Determinations Manual:

- Diabetes education services being provided to a beneficiary who has exhausted their lifetime benefits (BPM 300.3)
- Chiropractic services that are considered "maintenance" rather than active or corrective treatment. CPT codes in range 98940–98943 (BPM 30.5, B)
- Bariatric Surgery for Treatment of Morbid Obesity is performed in an unapproved facility (NCD 100.1)
- Vagus Nerve Stimulation (VNS) performed for resistant depression (NCD 160.18)

Summary

These are the requirements and outcomes for Modifier GA:

- ABN is required due to lack of medical necessity
- ABN was provided to beneficiary prior to the service
- Charges for the service are covered by Medicare in other circumstances
- Provider expects denial for medical necessity reasons
- Medicare makes determination for payment

About the Author

Sandy Palmer, RHIT, is a Coding and CDM Analyst for MedAssets, Integrity Services. Her expertise includes inpatient and outpatient facility coding with a specific emphasis on the Outpatient Prospective Payment System (OPPS). She has more than 12 years experience in Health Information Management and is currently responsible for researching and responding to complex facility coding inquiries as well as database maintenance and management.

References

Medicare Claims Processing Manual
[Chapter 1 – General Billing Requirements](#)
[Chapter 30 – Financial Liability Protections](#)
[Chapter 32 – Billing Requirements for Special Services](#)

Medicare National Coverage Determinations Manual

Medicare Benefit Policy Manual Covered Medical and Other Health Services
[Chapter 15](#)

Medicare Transmittal R7700TN

Suspension of Automatic Denial of Institutional Claims Reporting Modifier -GA

Medicare Transmittal R1921CP

Billing for Services Related to Voluntary Uses of Advanced Beneficiary Notices of Noncoverage (ABNs)



What Should We Do with Claims that Span the ICD-10 Implementation Date?

Take for example, Dr. Smith. He begins treating a wound care patient at the end of September 2013 and the patient continues to be seen after the Oct. 1, 2013 deadline. How would you submit the claim? Would you use ICD-9 and/or ICD-10?

I am sure we have all asked this question and guess what? We are not alone. Many healthcare providers are also asking the same questions regarding the potential issues surrounding claims that span the implementation date; that is, where ICD-9 codes are effective for the portion of the services rendered on Sept. 30, 2013, and earlier and where ICD-10 codes are effective for the portion of the services rendered Oct. 1, 2013, and later. CMS has identified these issues for institutional, professional and supplier claims and

therefore has developed policies to assist with resolving some of these issues.

According to CMS Transmittal 950/Change request 7492, a claim cannot contain both an ICD-9 code and an ICD-10 code. Claims will be RTP/returned as non-processable for all claims that are billed with both ICD9CM/PX codes on the claim.

In some cases, depending upon the policies associated with those services, CMS has indicated that there cannot be a break in service or time. See anesthesia claims table below as an example.

The following tables will assist providers in processing claims that span the periods where ICD-9 and ICD-10 codes may both be applicable.

About the Author

Emmanuel Akosa, RHIA, MBA, is the Director of Charge and Revenue Integrity Services. His expertise includes directing a remote coding operation on a regional level for multi-hospital system. He has more than 10 years experience in Health Information Management and is currently responsible for ICD-10 Implementation Strategy for MedAssets.

Reference

[CMS Transmittal 950](#)

SPECIAL OUTPATIENT CLAIMS PROCESSING CIRCUMSTANCES

Scenario	Claims Processing Requirement	Use FROM or THROUGH Date
3-day /1-day Payment Window	Since all outpatient services (with a few exceptions) are required to be bundled on the inpatient bill if rendered within three days of an inpatient stay; if the inpatient hospital discharge is on or after 10/1/2013, the claim must be billed with ICD-10 for those bundled outpatient services.	THROUGH

PROFESSIONAL CLAIMS

Type of Claim	Claims Processing Requirement	Use FROM or THROUGH Date
All anesthesia claims	Anesthesia procedures that begin on 9/30/13 but end on 10/1/13 are to be billed with ICD-9 diagnosis codes and use 9/30/13 as both the FROM and THROUGH date.	FROM

SUPPLIER CLAIMS

Type of Claim	Claims Processing Requirement	Use FROM or THROUGH Date
DMEPOS	Billing for certain items or supplies (such as caped rentals or monthly supplies) may span the ICD-10 compliance date of 10/1/13 (i.e., the FROM date of service occurs prior to 10/1/13 and the TO date of service occurs after 10/1/13).	FROM

SUMMARY OF CHANGES
APPENDIX B

Providers Bill Type(s)	Facility Type/Services	Claims Processing Requirement	Use FROM or THROUGH Date
11X	Inpatient Hospitals (incl. TERFHA hospitals, PPS hospitals, LTCHs, CAHs)	If the hospital claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
12X	Inpatient Part B Hospital Services	Split Claims – Requires providers split the claim so all ICD-9 codes remain on one claim and all ICD-10 codes remain on the other claim.	FROM
13X	Outpatient Hospital	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim and all ICD-10 codes remain on the other claim.	FROM
14X	Non-patient Lab Services	Split Claims – Require providers split the claim so all ICD-9 codes remain	FROM
18X	Swing Beds	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
21X	Skilled Nursing (Inpatient Part A)	If the [Swing bed or SNF] claim has a discharge and/or through date on or after 10/1/13, then the entire claim is billed using ICD-10.	THROUGH
22X	Skilled Nursing Facilities (Inpatient Part B)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim and all ICD-10 codes remain on the other claim.	FROM
23X	Skilled Nursing Facilities (Outpatient)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim and all ICD-10 codes remain on the other claim.	FROM
32X	Home Health (Inpatient Part B)	Allow HHAs to use the payment group code derived from ICD-9 codes on claims which span 10/1/2013, but require those claims to be submitted using ICD-10 codes.	THROUGH
3X2	Home Health – Request for Anticipated Payment (RAPs)*	* NOTE: RAPs can report either an ICD-9 code or an ICD-10 code based on the one (1) date reported. Since these dates will be equal to each other, there is no requirement needed. The corresponding final claim, however, will need to use an ICD-10 code if the HH episode spans beyond 10/1/2013.	*See Note
34X	Home Health – (Outpatient)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim and all ICD-10 codes remain on the other claim.	FROM
71X	Rural Health Clinics	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim and all ICD-10 codes remain on the other claim.	FROM
72X	End Stage Renal Disease (ESRD)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim and all ICD-10 codes remain on the other claim.	FROM
73X	Federally Qualified Health Clinics (prior to 4/1/10)	N/A – Always ICD-9 code set.	N/A
74X	Outpatient Therapy	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim and all ICD-10 codes remain on the other claim.	FROM
75X	Comprehensive Outpatient Rehab facilities	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim and all ICD-10 codes remain on the other claim.	FROM
76X	Community Mental Health Clinics	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim and all ICD-10 codes remain on the other claim.	FROM
77X	Federally Qualified Health Clinics (eff 4/4/10)	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim and all ICD-10 codes remain on the other claim.	FROM
81X	Hospice – Hospital	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim and all ICD-10 codes remain on the other claim.	FROM
82X	Hospice – Non hospital	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim and all ICD-10 codes remain on the other claim.	FROM
83X	Hospice – Hospital Based	N/A	N/A
85X	Critical Access Hospital	Split Claims – Require providers split the claim so all ICD-9 codes remain on one claim and all ICD-10 codes remain on the other claim.	FROM



Do you know the ICD-10 elevator conversation?

The International Classification of Diseases, 9th edition, Clinical Modification (ICD-9-CM) was developed by the World Health Organization (WHO) and implemented in the United States in 1979.

It is a system of codes used to classify diseases, signs/symptoms, social circumstances, external causes of injury, disease and procedures. It is used to identify fraudulent practices, define health policies and measure quality of care amongst others.

Although this system is updated on an annual basis, the coding structure it is not scalable, flexible and does not enable global comparison of quality care and best practices. Since it has not been restructured in over 30 years and because of the

forementioned reasons noted above, the 10th version of this new coding structure, ICD-10, will be implemented Oct. 1, 2013. So ICD-10 is the new and improved 10th version coding structure. It will be used by our clients and partners to report and record systemic interpretations of disease and procedure classifications and drive payment systems.

About the Author

Q. Warner, CCP, CPC is currently the Vice President of Business Domain & ICD-10 Strategy. She has provided coding, compliance and technical consulting/education to clients across the United States. Her clinical experience compounded with her transformation from health information management to revenue cycle management to development of charge

and revenue integrity technology solutions creates the ideal insight into the pitfalls of the revenue cycle spectrum. Her knowledge of compliance, healthcare informatics and clinical relationships helped drive a successful leadership of the clinical, coding and business intelligence segment and most recently the leadership of the ICD-10 business and product strategy initiatives.

Trade Shows and Events

NOVEMBER 15

Live Event – Contrast Media

[View Website](#)

Pre-Commitment Program

Live Event – Contrast Media

MedAssets will host its next Pre-Commitment Program in Plano, Texas on Nov. 15, 2011 for providers looking to save on commodity supplies. To register, please e-mail precommit@medassets.com.

NOVEMBER 16-19

ASCP Senior Care Pharmacy '11

Phoenix, AZ • Booth 827

[View Website](#)

DECEMBER 4-8

46th ASHP Midyear Clinical Meeting

New Orleans, LA • Booth TBD

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FREQUENTLY ASKED QUESTIONS

In this section, MedAssets has reviewed and analyzed the questions that are received via our compliance help desk. We offer some of the most frequently asked questions and the MedAssets response for your convenience.

Q What CPT® code would you use for an upper gastrointestinal endoscopy, with directed placement of a jejunostomy tube? Is this the same as CPT 43246??

A Code in Question: CPT 43246-Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube.

Providers should report the appropriate CPT code based upon the CPT code description that accurately describes the service/or procedure performed supported by documentation in the medical record. We do not have the specific procedure documentation; however, based upon limited information provided in your scenario, it appears appropriate to report CPT 43246 for upper gastrointestinal endoscopy with placement of a jejunostomy tube if supported by documentation. We have also listed other endoscopy codes associated with jejunostomy tube placement below if documentation does not support upper gastrointestinal endoscopy.

Other Jejunostomy tube placement with endoscopy:

CPT 44372 – Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with placement of percutaneous jejunostomy tube

CPT 44373 – Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with conversion of percutaneous gastrostomy tube to percutaneous jejunostomy tube

Q How should a facility charge for items such as total implants, partial implants, drill bits, supplies, etc. that are brought in by vendors for trial? These trial items are not free and have different prices. These items are mainly used in the surgery department. For example, a patient comes in for a total knee replacement and the physician uses a total implant from a vendor (this implant may or may not be used again). There are too many miscellaneous items to set up a charge for each and every one of them.

A Hospitals have several ways of billing for supplies that are brought in by vendors. Some facilities put every item into their chargemaster and use a mark-up table to determine the billable amount. Other facilities use tiered levels for like items. An example is Implant Joint Knee (or Implant – Vendor provided) level 1 (\$0-\$500), Level 2 (\$501-1000), etc. where the actual cost of the item determines the level and the facility assigns a billable value to each level. A third option used by facilities is a combination of levels and individual line items in which they assign the majority of the items into a level, but higher cost items are given a separate charge amount based on the mark-up table in order to keep the levels in a “reasonable” range.

If the vendor provides the item at no cost, the Medicare Claims Processing Manual, Chapter 32, Section 67, www.cms.hhs.gov/manuals/downloads/clm104c32.pdf, states, “On occasion, providers may receive an item (such as a device or drug) that is offered by a manufacturer/supplier free of charge. Such items, for purposes of these instructions, are considered 'no cost items.' Providers are not to seek reimbursement for no cost items as noted in 1862(a)(2) of the Social Security Act.”

MedAssets Compliance Webinars

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2012 Inpatient PPS
November 15, 30

2012 Outpatient Prospective Payment System (OPPS) Final Rule
December 6, 13, 20, 22
January 5

2012 CPT Code Updates
December 15, 21
January 3

CCFN CROSSWORD NOVEMBER 2011

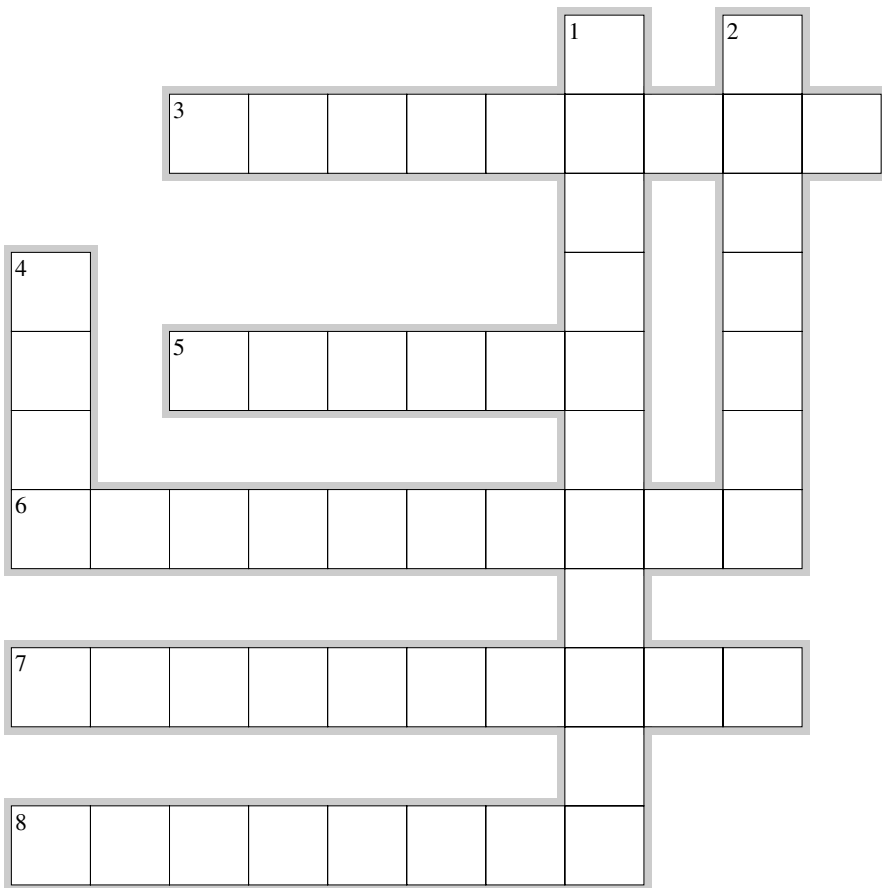
By Toueria Morris, CPC-H

Across

- 3. In ICD-10 PCS, the ___ codes specify the disease or disorder.
- 5. A ___ code is available for variations of a procedure that can be performed.
- 6. Not Otherwise Specified (NOS) options are ___ in ICD-10 PCS.
- 7. In ICD-10 PCS, coders will need a more extensive knowledge of anatomy and ___.
- 8. ICD-10 PCS provides general guidelines and guidelines that apply to a section or ___.

Down

- 1. There are 11 coding ___ for 2011.
- 2. ___ NEC (Not Elsewhere Classified) options are incorporated in the classification system.
- 4. How many general principles are included in ICD-10 PCS?



ANSWERS
 DOWN 1. CONVENTIONS 2. LIMITED 4. FOUR
 ACROSS 3. DIAGNOSIS 5. UNIQUE 6. RESTRICTED 7. PHYSIOLOGY 8. SECTIONS

Tell Us What You Think

CCFN has been in continuous publication since 2004. We'd like to know what you think. What would you like to see? What subjects would you like us to cover? Send us an e-mail (compliance2@medassets.com) and tell us what you think.

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