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The Impact of Current and Coming Regulations and Trends on Your Chargemaster

Rebecca Kidder, RN, CS-P
Senior Consultant, Compliance Technologies
MedAssets



Lone Star Summer Institute
Dallas, TX
September 15, 2010

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Objectives

- **Assess CDM compliance pitfalls**
- **Prioritize compliance updates**
- **Understand latest regulatory updates and their impact**



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“No CDM is an Island...”

- Integral to effective revenue cycle management
- Bridges the gap between clinical services and finance
- Acts as a translator between two diverse “languages”



Risks of a Poorly Maintained CDM

- Allegations of fraud or abuse
- Fines and penalties
- Take-backs
- Delayed A/R
- Negative publicity
- Increased scrutiny
- Loss of revenue





THOUSANDS of patient claims...
THOUSANDS of CDM line items...
OPPORTUNITIES for error...
INFINITE

Who Is Watching?

- **OIG (Office of Inspector General)**
- **DOJ (Dept of Justice)**
- **FTC (Federal Trade Commission)**
- **CERT (Compliance Error Rate Testing)**
- **RAC (Recovery Audit Contractor)**
- **MAC (Medicare Administrative Contractor)**
- **MIC (Medicaid Integrity Contractor)**
- **PSC (Program Safeguard Contractor)**
- **ZPIC (Zone Program Integrity Contractor)**



Priorities

- Updates/new code releases
- FI instructions
- Problem prone areas



Untimely Updates

- **2010 CPT® New Code Release Effective January 1, 2010**
 - Dialysis graft access which includes the **diagnostic** imaging procedure to replace the existing dialysis access code
 - Add-on code for dialysis graft access for **intervention**
 - Paravertebral facet joint injections that include imaging guidance to replace the existing paravertebral facet joint injection codes (also expanded number of levels)
 - CPT Category I codes for Cardiac CT to replace the Category III codes
 - Myocardial perfusion codes to replace the existing codes
 - Pulmonary Rehabilitation
 - A single HCPCS now describes the billable service

Untimely Updates (cont'd)

- **2010 CPT New Code Release Effective July 1, 2010**

- Acoustic Cardiography
 - Three new codes to describe acoustic cardiography
- Epidurals with Ultrasound
 - Only report these codes when ultrasound guidance is utilized
- Facial Lipodystrophy syndrome
 - Radiesse gel which is injected in the vocal cord is still being reported with C1878. According to the transmittal regarding the C9800 it appears you were only to report it after 3/23/2010 until the other new codes were effective (7/1/2010) when the G0429 together with Q2026/Q2027 could be reported for use of Radiesse or Sculptra specifically for facial lipodystrophy.

Untimely Updates (cont'd)

- **2010 CPT New Code Release Effective July 1, 2010**

- Myocardial Perfusion
 - The new codes use the phrase "when performed" so these codes should be used even if no wall motion or ejection fraction was performed. CPT codes 78472, 78473, 78481, and 78483 should not be reported in conjunction with new CPT codes 78451-78454.
- Infant Pulmonary Function Tests
- High Resolution Anoscopy
- Drugs and pharmaceuticals
 - 7 new codes with pass through status
- H1N1 Vaccines

Untimely Updates (cont'd)

- **Revised Codes**

- Review to ensure they still describe the service accurately
- OB Panel including 86592
 - **2010-01-01 n/a Syphilis test, non-treponemal antibody; qualitative (e.g., VDRL, RPR, ART) 1994-01-01 2009-12-31 Syphilis test; qualitative (e.g., VDRL, RPR, ART)**
 - When syphilis screening is performed using a treponemal antibody approach (86780), do not use 80055. Use the individual codes for the tests performed in the obstetric panel
- Allogeneic stem cell transplant codes revised effective July 1, 2010

- **Deleted Codes**

- Facet injection codes, 64470-64476
- Myocardial perfusion scan codes, 78460-78465
- CT heart, 0144T-0151T

- **Status Indicator Changes**

- Consultation codes
- Loss of pass through status for (17 codes)
- Pneumococcal Vaccine
 - Effective retroactively to April 1, 2010, is an adjustment by CMS to the status indicator (SI) for CPT code 90670 – Pneumococcal conjugate vaccine, 13 valent, for intramuscular use. The SI = K, meaning it is eligible for separate APC payment.

Current Affairs

Current and upcoming issues and their impact on your CDM



Current Affairs – RAC (Region C)

- Drug Units (18)
- Nebulizer Demo
- Pediatric Codes
- Barium Swallow
- Medically Unlikely Edits
- Blood Transfusions
- Untimed Codes
- IV Hydration
- Bronchoscopy Services



Anatomy of a CPT Code

1. J2505 - ²Injection, ¹pegfilgrastim, ³6 mg.
 2. 97804 - ¹Medical nutrition therapy; ²group (2 or more individual(s)), ³each 30 minutes.
 3. 97150 - ¹Therapeutic procedure(s), ²group (2 or more individuals).
 4. 97116 - ¹Therapeutic procedure, 1 or more areas, ³each 15 minutes; ²gait training (includes stair climbing).
 5. 96360 - ¹Intravenous infusion, ²hydration; ²initial, ³31 minutes to 1 hour.
 6. 36570 - ¹Insertion of ²peripherally inserted central venous access device, with subcutaneous port; ²younger than 5 years of age.
- ¹Description
 - ²Limitations/Qualifiers
 - ³Measurement – units of service

Current Affairs – RAC

- **Neulasta®**

- **J2505 - Injection, pegfilgrastim, 6 mg**

Neulasta is supplied in 0.6 mL prefilled syringes for subcutaneous injection. Each syringe contains 6 mg pegfilgrastim. The recommended dosage of Neulasta is a single subcutaneous injection of 6 mg administered once per chemotherapy cycle.



DESCRIPTION	HCPCS	REVENUE	BILLING UNIT
PEGFILGRASTIM 6MG INJ	J2505	0636	1

Current Affairs – RAC

- **Adenosine – 1 unit per each 30mg/day**

- J0152 - Injection, adenosine for diagnostic use, 30 mg.
 - J0150 - Injection, adenosine for therapeutic use, 6 mg.

- **Formoterol – Maximum 2 vials (20micrograms each)/day**

- Q4099 deleted and replaced with J7606 for 2010

- **Arformoterol – Maximum 2 vial (15micrograms each)/day**

- **Budesonide –**

- For code J7626 and J7627 (budesonide, unit dose), **bill one unit** of service for each vial dispensed, regardless of whether a 0.25 mg vial or a 0.5 mg vial is dispensed.

Current Affairs – RAC (cont'd)

- **Untimed Codes**

- 97116 - Therapeutic procedure, 1 or more areas **each 15 minutes**; gait training (includes stair climbing)
- 97150 - Therapeutic procedure(s), group (2 or more individuals)
- 92507 - Treatment of speech, language, voice, communication and/or auditory processing order; individual
- 95831 - Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk
- 97012 - Application of a modality to 1 or more areas; traction, mechanical
- 97535 - Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, **each 15 minutes**.

Current Affairs – RAC (cont'd)

- **Untimed Codes**

PITFALL

DESCRIPTION	CPT	REVENUE	BILLING UNITS
GAIT TRAINING	97116	0420	
PT GROUP EX 1HR	97150	0420	4
SPEECH THERAPY PED 2HR	92507	0440	8

SOLUTION

DESCRIPTION	CPT	REVENUE	BILLING UNITS
GAIT TRAINING EA 15 MIN	97116	0421	1
PT GROUP EX	97150	0423	1
SPEECH THERAPY PED	92507	0441	1

Current Affairs – RAC (cont'd)

- IV Hydration

- Initial Service = Quantity of 1

- 96360 - Intravenous infusion, hydration; **initial**, 31 minutes to 1 hour
- 96365 - Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); **initial**, up to 1 hour
- 96374 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or **initial** substance/drug



Current Affairs – RAC (cont'd)

- Infusion additional hours

- 96361 – Intravenous infusion hydration; **each additional** hour (list separately in addition to code for primary procedure)
- 96336 – Intravenous infusion, for therapy, prophylaxis or diagnosis (specify substance or drug); **each additional** hour (list separately in addition to code for primary procedure)
- 96367 – Intravenous infusion, for therapy, prophylaxis or diagnosis (specify substance or drug); **additional sequential** infusion, up to 1 hour (list separately in addition to code for primary procedure)
- 96368 – Intravenous infusion, for therapy, prophylaxis or diagnosis (specify substance or drug); **concurrent infusion** (list separately in addition to code for primary procedure)



Current Affairs – RAC (cont'd)

DESCRIPTION	CPT CODE	REVENUE CODE	BILLING UNITS
THERAP HYDRATION INITIAL 31-90MIN IV	96360	0260	1
THERAP INF INITIAL 16-90MIN IV	96365	0260	1
THERAP IVP 1 ST DRUG INITIAL	96374	0260	1
THERAP IVP SAME DRUG >30MIN EA	96376	0260	
THERAP IVP NEW DRUG EA ADDNL	96375	0260	
THERAP IM/SC EA INJ	96372	0260	

Current Affairs – RAC (cont'd)

- **Pediatric codes exceeding age parameters**

- 36555 - Insertion of non-tunneled centrally inserted central venous catheter; **younger than 5 years** of age
- 36556 - Insertion of non-tunneled centrally inserted central venous catheter; **age 5 years or older**
- 99143 - Moderate sedation**younger than 5 years of age**, first 30 minutes intra-service time
- 99144 - Moderate sedation services**age 5 years or older**, first 30 minutes intra-service time

Current Affairs – RAC (cont'd)

- Medically Unlikely Edits – Apply to all HCPCS/CPT codes above the maximum units per day
- Barium Swallow – Report **once** per day
- Blood Administration – Report **once** per day
- Bronchoscopy Services – Report 31625, 31628, 36129 **once** per day, excluding claims with modifier 59
- Nebulizer Demonstration/Eval – Report **once** per day

Current Affairs – OIG





A Big Mac

Or...

Two all beef patties, special sauce, lettuce, cheese, pickles, onions, on a sesame seed bun

Current Affairs – OIG

-  **80048**
- **Basic metabolic panel (Calcium, total)**
- **This panel must include the following:**
 - Calcium, total (82310)
 - Carbon dioxide (82374)
 - Chloride (82435)
 - Creatinine (82565)
 - Glucose (82947)
 - Potassium (84132)
 - Sodium (84295)
 - Urea nitrogen (BUN) (84520)
-  **85025**
- **Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count.**
- **It includes:**
 - Hgb (85018)
 - Hct (85014)
 - RBC (85041)
 - WBC (85048)
 - Platelet count (85049)
 - Differential WBC count (85004)

Current Affairs – OIG

We will review the extent to which clinical laboratories have inappropriately unbundled laboratory profile or panel tests to maximize Medicare payments. Pursuant to the “Medicare Claims Processing Manual,” Pub. No. 100-04, ch. 16, § 90, to ensure the accuracy of payments, Medicare contractors must group together individual laboratory tests that clinical laboratories can perform at the same time on the same equipment and then consider the price of related profile tests. **Payment for individual tests must not exceed the lower of the profile price or the total price of all the individual tests.** We will determine whether clinical laboratories have unbundled profile or panel tests by submitting claims for multiple dates of service or by drawing specimens on sequential days. We will also determine the extent to which the Medicare carriers have controls in place to detect and prevent inappropriate payments for laboratory tests.

Current Affairs – OIG 2010 Work Plan

- Laboratory test unbundling
- Developments in technology have made it possible to perform multiple clinical tests on a single blood sample simultaneously, greatly decreasing labs' labor costs as well as costs associated with occupational hazards due to contact with blood and medical waste. To reflect these lower costs, the coding system used for billing these tests—referred to as “automated multichannel tests”—includes generic codes to indicate that the tests were done as part of an automated series, or “profile,” rather than individually.
- Each profile code specifies the number of tests performed. A profile is generally reimbursed at a lower rate than the same combination of tests submitted separately, or “unbundled,” using the specific code for each test. An overpayment may occur when tests are submitted and paid for separately if they were in fact performed as a profile.

Current Affairs – OIG

Charge for Panel

Fee schedule x 2 or 25th percentile

- 80048 - Basic metabolic panel (Calcium, total)
- This panel must include the following:
 - Calcium, total (82310)
 - Carbon dioxide (82374)
 - Chloride (82435)
 - Creatinine (82565)
 - Glucose (82947)
 - Potassium (84132)
 - Sodium (84295)
 - Urea nitrogen (BUN) (84520)
- Price = **\$61.00**
- Fee schedule = \$10.71

Charges for Individual Tests

Fee schedule x 2 or 25th percentile

- Component Tests
 - Calcium, total (82310) = \$25.00
 - Carbon dioxide (82374) = \$20.00
 - Chloride (82435) = \$20.00
 - Creatinine (82565) = \$26.00
 - Glucose (82947) = \$24.00
 - Potassium (84132) = \$25.00
 - Sodium (84295) = \$23.00
 - Urea nitrogen (84520) = \$24.00
- Total prices = **\$187.00**
- Total fee schedule = \$54.06

Current Affairs – Potential OIG/RAC Issues

- **Physician orders for lab tests**

- Reflex testing
- Hospital protocols
 - CBC versus CBC with differential

- **Overlapping panels**

- CPT states, “Do not report two or more panel codes that include any of the same constituent tests performed from the same patient collection. If a group of tests overlaps two or more panels, report the panel that incorporates the greater number of tests to fulfill the code definition and report the remaining tests using individual test codes (e.g., do not report 80047 in conjunction with 80053).”

Overlapping Panels

- **80047 Description**

- Basic metabolic panel (Calcium ionized)
- This panel must include the following:
 - Calcium, ionized (82330)
 - Carbon dioxide (82374)
 - Chloride (82435)
 - Creatinine (82565)
 - Glucose (82947)
 - Potassium (84132)
 - Sodium (84295)
 - Urea Nitrogen (BUN) (84520)

- **80053 Description**

- Comprehensive metabolic panel
- This panel must include the following:
 - Albumin (82040)
 - Bilirubin, total (82247)
 - Calcium, total (82310)
 - Carbon dioxide (bicarbonate) (82374)
 - Chloride (82435)
 - Creatinine (82565)
 - Glucose (82947)
 - Phosphatase, alkaline (84075)
 - Potassium (84132)
 - Protein, total (84155)
 - Sodium (84295)
 - Transferase, alanine amino (ALT) (SGPT) (84460)
 - Transferase, aspartate amino (AST) (SGOT) (84450)
 - Urea nitrogen (BUN) (84520)

Current Affairs – OIG

- **Modifier GY**

Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit (01/01/2008) We will review the appropriateness of providers' use of modifier GY on claims for services that are not covered by Medicare.

CMS' "Medicare Carriers Manual," Pub. No. 14-3, pt. 3, § 4508.1, states that modifier GY is to be used for coding services that are statutorily excluded or do not meet the definition of a covered service. Beneficiaries are liable, either personally or through other insurance, for all charges associated with the provision of these services. Pursuant to CMS's "Medicare Claims Processing Manual," Pub. No. 100-04, ch. 1, § 60.1.1, providers are not required to provide beneficiaries with advance notice of charges for services that are excluded from Medicare by statute. As a result, beneficiaries may unknowingly acquire large medical bills that they are responsible for paying.

In FY 2008, Medicare received over 75.1 million claims with a modifier GY totaling approximately \$820 million. We will examine patterns and trends for physicians' and suppliers' use of modifier GY.

Current Affairs – OIG

- **Bilateral Lithotripsy**

- Billed two times per day versus once
- Use modifier 50 versus LT and RT

Current Affairs – Modifiers

- **Used with CPT and HCPCS codes when a service requires more definition or explanation**
 - Services have been increased or reduced
 - An evaluation and management service was performed on the same date as a procedure
 - Bilateral procedure was performed
 - Repeat testing occurred
 - Identify the professional rendering the service
- **Impacts reimbursement**
 - The modifier that affects pricing should be placed in the primary position
 - Modifiers may result in additional or reduced reimbursement

Current Affairs – Modifiers

- **Modifiers used in OPPS**
 - **Modifiers LT, RT, 50** – unilateral and bilateral procedures
 - **Modifier 25** – significant, separately identifiable
 - Modifiers GP, GO, GN – therapy modifiers
 - **Modifier 59** – distinct procedural service
 - Modifier 26 – professional component
 - Modifier 52 – reduced service
 - Modifier 73 & 74 – aborted procedures
 - Modifier 91 – repeat diagnostic lab test

Current Affairs – Modifiers

- **Left and right procedures**
 - Left and right are only used when a procedure is performed on one side of the body and is a paired organ
 - Bilateral modifier (50) is not valid
 - Code description includes the word “unilateral,” use LT and RT even if performed on both sides
- **When not to use LT and RT**
 - E&M codes
 - Pathology and lab codes
 - Immunization, vaccine/toxoid codes
 - Medicine codes that specify LT or RT in description
 - Allergy and clinical immunology codes
 - Osteopathic and chiropractic manipulation codes

Current Affairs – Modifiers

- **LT and RT code examples**
- **71100 Radiologic examination, ribs, unilateral; 2 views**
- **69100 Biopsy external ear**

DESCRIPTION	CPT CODE	REVENUE	MODIFIER
XR RIB 2VW RT	71100	0324	RT
XR RIB 2VW LT	71100	0324	LT
BX EXT EAR RT	69100	0361	RT
BX EXT EAR LT	69100	0361	LT

Current Affairs – Modifiers

- **Bilateral procedures**

- Diagnostic, radiology and surgical procedures
- Performed on both sides during the same operative session or on the same day
- Code description does not include “bilateral” or “unilateral”
- Procedures that are bilateral by definition

- **Billing notes**

- When using modifier 50, bill for one unit on the claim
- Modifier 50 should follow the procedure code
- Be aware of payor specific guidelines, some may prefer LT and RT to 50

Current Affairs – Modifiers

- **Modifier LT, RT and 50 examples:**

- 76645 Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation
- 73120 Radiologic examination, hand; 2 views

DESCRIPTION	CPT CODE	REVENUE	MODIFIER
US BREAST UNIL RT	76645	402	RT
US BREAST UNIL LT	76645	402	LT
US BREAST BIL	76645	402	
XR HAND 2V RT	73120	320	RT
XR HAND 2V LT	73120	320	LT
XR HAND 2V BILAT	73120	320	50