

Special points of interest:

- January 2012 OPPS

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New Molecular Pathology Procedure Code Section Added For 2012



The new year brought many changes to CPT© codes, but the most changes occurred in laboratory where a new section was created called Molecular Pathology. Seventy-eight procedures for Tier 1 and 23 procedures for Tier 2 for a total of 101 new codes released by the American Medical Association (AMA). This new section is located right after the urinalysis section. Once you have seen these codes one would wonder how to bill for these procedures.

MLN Matters MM7654 <http://www.cms.gov/MLNMattersArticles/downloads/MM7654.pdf> effective January 1, 2012 gives some clarification on how to bill for these procedures. These procedures will be assigned a “B” indicator (“Payment for covered services are always bundled into payment for other services not specified”). There will be no payment amounts or RVU’s assigned to these codes and no separate payment will be paid.

According to CMS each new Molecular Pathology Procedure test codes represents a test(s) that is currently being utilized and can be billed to Medicare. When these procedures are billed to Medicare, CMS understands that there are current CPT© codes that are “stacked” and represents the new 2012 test(s) being performed.

CMS example, Laboratory A has a genetic test that is generally billed as follows in order to represent the performance of the entire test:

83891 x 1 + 83898 x (multiple times) + 83909 x (multiple times) + 83912 x 1.

If the new 2012 CPT ©was active Medicare would reimburse for a single code that corresponds to the “stacked” procedure rather than billing for each procedure.

As of January 1, 2012 Medicare *requests* that Medicare claims for these procedures reflect BOTH the existing CPT ©“stacked” procedure codes that are required for payment and the NEW single CPT© code that would have been utilized for payment if the new CPT© code was active and not a “B” indicator.

Laboratory departments and patient financial services should review the process for these procedures; from ordering the genetic tests, charging and how it will be captured on the UB. This will be a dilemma that facilities have to face when charging these procedures.

To read transmittal R2365CP go to: <http://www.cms.gov/transmittals/downloads/R2365CP.pdf>



CMS is establishing one new device pass-through code

New Device Pass-Through Categories

CMS is establishing one new device pass-through category effective January 1, 2012.

C1886 Catheter, extravascular tissue ablation, any modality (insertable) with a Status Indicator of H in APC 1886.

CMS determined that a portion of the APC payment amount associated with the cost of C1886 is in APC 0415, Level II, Endoscopy, lower airway. The device offset from payment represents this deduction from pass-through payments for category C1886, when it is billed with a service included in APC 0415. The device offset amount for APC 0415, along with the device offsets for other APC's is available under "Annual Policy Files" on the CMS OPPS web site at <http://www.cms.gov/HospitalOutpatientPPS/>

Device pass-through category C1840 must be billed with procedure code C9732 (Insertion of ocular telescope prosthesis including removal of a crystalline lens) effective January 1, 2012.

C9732 is a new procedure code for 2012 and has been assigned a status indicator of T in APC 0234, Level IV Anterior Segment Eye Procedures. The new offset for CY 2012 for APC 0234 can be found under "Annual Policy Files" on the CMS OPPS web site at <http://www.cms.gov/HospitalOutpatientPPS/>

To read Transmittal 2386 dated January 13, 2012 go to: <http://www.cms.gov/transmittals/downloads/R2386CP.pdf>

Cardiac Resynchronization Therapy Payment for CY 2012

Effective for services furnished on or after January 1, 2012, cardiac resynchronization therapy involving an implantable Cardioverter defibrillator (CRT-D) will be recognized as a single, composite service that combines the implantable Cardioverter defibrillator procedures and the pacing electrode insertion procedures when performed on the same date of service.

A new claims processing edit has also been implemented that will return incorrectly coded claims on which a pacing electrode insertion procedure described by CPT® code 33225 ((Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing Cardioverter-defibrillator or pacemaker pulse generator (including upgrade to dual chamber system)) is billed without one of the primary insertion codes as specified in the 2012 CPT® code book. Section 10.2.2 has been added to Pub 100-04 Medicare Claims Processing Manual, Chapter 4, to reflect these changes.

For more in depth OPPS details contained in Transmittal 2386 go to: <http://www.cms.gov/transmittals/downloads/R2386CP.pdf>

For ASC guidance see Transmittal 2378 at <http://www.cms.gov/transmittals/downloads/R2378CP.pdf> page 3.

PROVENGE Administration

On July 1, 2011, HCPCS code Q2043 was assigned to Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion, along with the status indicator of "G". For CY 2012 CMS will continue this HCPCS code on pass-through status.

CMS notes that the HCPCS long descriptor for CY 2012 for code Q2043 includes payment for the drug itself, as well as "all other preparatory procedures" which refers to the transportation process of collecting immune cells from a patient during a non-therapeutic leukapheresis procedure, the sending of the immune cells to the manufacturing facility and the transportation of the immune cells back to the site of service for administration. Payment for Q2043 does not include OPPS payment for the drug.

For NCD coverage of PROVENGE see Transmittal 140 dated January 6, 2012 at <http://www.cms.gov/transmittals/downloads/R140NCD.pdf> and for further guidance see Transmittal 2386 dated January 13, 2012 at: <http://www.cms.gov/transmittals/downloads/R2386CP.pdf> page 12.

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3-Day Payment Window Policy and the Impact on Wholly Owned or Wholly Operated Physician Practices

Per Transmittal 2373 Dated December 21, 2011 — For services on or after January 1, 2012, when a patient is seen in a wholly owned or wholly operated physician practice and is admitted as an inpatient within 3-days (or, in the case of non-IPPS hospitals, 1 day); the 3-day payment window will apply to diagnostic and non-diagnostic services that are clinically related to the reason for the patient’s inpatient admission regardless of whether the inpatient and outpatient diagnoses are the same.

A wholly owned practice is wholly owned by the hospital if the hospital is the sole owner of the entity; and a wholly operated practice is a practice that is operated by a hospital that has exclusive responsibility for conducting and overseeing the practice’s routine operations, regardless of whether the hospital also has policymaking authority over the practice.

CMS established the new payment modifier PD (Diagnostic or related non-diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days), and require that this modifier be appended to the entity’s preadmission diagnostic and admission related non-diagnostic services, reported with HCPCS/CPT codes, which are subject to the 3 day payment window policy. The hospital is responsible for notifying the entity of an inpatient admission for a patient who received services in a wholly owned or wholly operated entity within the 3-day (or, when appropriate, 1-day) payment window prior to the inpatient stay. The modifier is available for claims with dates of service on or after January 1, 2012, and entities should begin to coordinate with their billing practices and claims processing procedures with their hospitals to ensure compliance by the July 1, 2012 deadline.

For further guidance go to Transmittal 2373 at: <http://www.cms.gov/transmittals/downloads/R2373CP.pdf>

See also physician Transmittal 2371 at: <http://www.cms.gov/transmittals/downloads/R2371CP.pdf>

New CY 2012 HCPCS Codes and Dosage Descriptors for Certain Drugs, Biologicals and Radiopharmaceuticals

Eight new HCPCS codes have been created for reporting drugs and biologicals in the hospital outpatient setting for CY 2012.

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CY 2012 HCPCS Code	CY 2012 Long Descriptor	CY 2012 PI	CY 2012 SI	CY 2012
A9585	Injection gadoburool,0.1 ml	N1	N	N/A
C9287	Injection, brentuximab vedotin, 1 mg	K2	G	9287
C9366	EpiFix, per square centimeter	K2	G	9366
J0257	Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg	K2	K	1415
J7180	Injection, factor xiii (antihemophilic factor, human), 1 i.u.	K2	G	1416
J7326	Hyaluronan or derivative, gel-one, for intra-articular injection, per dose	K2	K	1417
J8561	Everolimus, oral, 0.25 mg	K2	K	1418
Q4122	Dermacell, per square centimeter	K2	K	1419

There were several HCPCS and CPT© codes for drugs, biologicals, and radiopharmaceuticals that have had descriptor changes. Also, several temporary HCPCS C-codes have been deleted and replaced with permanent HCPCS Codes for CY 2012. CMS is encouraging all hospitals to pay close attention to accurate billing for units of service consistent with the dosages contained in the long descriptors of the active CY 2012 HCPCS and CPT© codes. To see the entire listing of these codes go to pages 7-8 of Transmittal 2386 dated January 13, 2012 at: <http://www.cms.gov/transmittals/downloads/R2386CP.pdf>

For ASC guidance see Transmittal 2378 dated December 29, 2011 at <http://www.cms.gov/transmittals/downloads/R2378CP.pdf> pages 4-6.



New Items Approved For Telehealth Services



Transmittal 2354 dated November 18, 2011 confirms that CMS has added four new codes to the list of Medicare distant site telehealth services. They are as follows:

99406—Smoking and tobacco cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

99407—Smoking and tobacco cessation counseling visit; intensive, greater than 10 minutes

G0436—Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate greater than 3 minutes up to 10 minutes

G0437—Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate greater than 10 minutes

CMS is also allowing initial inpatient telehealth consultation codes G0425-G0427 to be billed with the place of service (POS) emergency department.

To read Transmittal 2354 go to: <http://www.cms.gov/transmittals/downloads/R2354CP.pdf>

Recovery Audit Program MAC-issued Demand Letters

Transmittal 202 dated January 6, 2012 reflects a change in the RAC issuance of Demand Letters. Previously the Recovery Auditors (formerly known as RACs) had the responsibility for issuing demand letters through the demonstration and thus far in the national program. This responsibility is now being shifted to the MACs in an effort to increase consistency and efficiency through the automation process. This transmittal updates pre-existing 100.5 requires in order to more closely reflect the current mass adjustment process.

“The CMS may grant the Recovery Auditor read only access to the C/CWF (and any other systems at the CMS’s sole discretion to obtain additional information pertaining to potential improper payments. The Recovery Auditor shall submit claim adjustments directly to the Enterprise Data Centers (EDC) via the file-based mass adjustment processes; manual adjustments via the MCA/Contractor shall be limited to those that cannot be accommodated through more automated means. The MAC/Contractor shall identify the origin of any manual adjustments by assigning Recovery Auditor adjustment reason and/or discovery codes as appropriate. The MAC/Contractor shall establish receivables and issue all demand letters for any Recovery Auditor identified overpayment, following the same process as for any other payment recoupment. All demand letters shall include the initiating Recovery Auditor name and contact information. The MAC/Contractor shall be responsible for fielding any administrative concerns, such as the issuance of demand letters and timeframes for recoupment and the appeals process. The Recovery Auditor shall remain responsible for any audit specific communications, such as reviewer rationale inquiries.”

To read Transmittal 202 go to: <http://www.cms.gov/transmittals/downloads/R202FM.pdf>

Ambulance Transportation HCPCS Codes



Transmittal 1003 dated November 25, 2011 notes instructional guidance on the use of HCPCS codes effective January 3, 2012.

“Contractors shall revise their claims processing systems in order to allow HCPCS codes identifying Medicare statutorily excluded ambulance transportation and transportation related services into their systems for adjudication. Claims containing these statutorily excluded ambulance transportation and transportation related service codes shall be rejected or denied as statutorily excluded. Those providers/suppliers wishing to bill for statutorily excluded ambulance transportation and transportation related services in order to obtain the “Medicare denial” shall bill for such services by attaching the “GY” modifier to the HCPCS code identifying the service according to long-standing CMS policy.”

To read Transmittal 1003 go to: <http://www.cms.gov/transmittals/downloads/R10030TN.pdf>

“The CMS may grant the
Recovery Auditor”

Six New Screening and Counseling G Codes for 2012

Beginning with dates of service on and after October 14, 2011, CMS will cover annual alcohol screening and annual screening of adults for depression. Effective on claims with dates of service on and after November 8, 2011, CMS will cover intensive behavioral therapy for cardiovascular disease and screening for Chlamydia, gonorrhea, syphilis and hepatitis B. Effective for claims on and after November 29, 2011 CMS will cover intensive behavioral therapy for obesity.

CY 2012 HCPCS	CY 2012 Long Descriptor	CY 2012 Status	CY 2012 APC
G0442	Annual alcohol misuse screening, 15 minutes	S	0432
G0443	Brief face to face behavioral counseling for alcohol misuse, 15 minutes	S	0432
G0444	Annual depression screening, 15 minutes	S	0432
G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior, performed semi-annually, 30 minutes	S	0432
G0446	Intensive behavioral therapy to reduce cardiovascular disease risk, individual, face-to-face, annual, 15 minutes	S	0432
G0447	Face-to-face behavioral counseling for obesity, 15 minutes	S	0432

New for 2012 Six G Codes for Screening and Counseling Services.

For more detailed guidelines on the proper billing of these new G codes read pages 13-16 of Transmittal 2386 dated January 13, 2012 at <http://www.cms.gov/transmittals/downloads/R2386CP.pdf>

Advanced Diagnostic Imaging (ADI)

Beginning January 1, 2012, suppliers who furnish the Technical Component (TC) of Advanced Diagnostic Imaging (ADI) must be accredited to bill for certain Medicare services such as MRI, CT, Nuclear Medicine procedures and Positron Emission Tomography (PET). Plain x-rays, ultrasound and fluoroscopy and hospital outpatient procedures are EXCLUDED. For dates of service on or after January 1, 2012, the Medicare Administrative Contractors (MAC) will deny claims for the -TC of ADI that are submitted under the Physician Fee Schedule who have not been accredited.

Please refer to *MLN Matters Special Article #SE1122* <http://www.cms.gov/MLN MattersArticles/Downloads/SE1122.pdf> for guidance on the application process and the quality standards that must be met to reach accreditation.

Beginning January 1, 2012 suppliers who furnish the Technical Component of Advanced Diagnostic Imaging must be accredited...

Use of Modifiers For Discontinued Services

CMS has revised their guidance for the use of modifiers for discontinued services in the Medicare Claims Processing Manual, Chapter 4, section 20.6.4 <http://www.cms.gov/manuals/downloads/clm104c04.pdf>. The verbiage for the use of Modifier -73 now includes "This modifier may also be used to indicate that a planned surgical or diagnostic procedure was discontinued, partially reduced or cancelled at the physician's discretion after the administration of anesthesia." Modifier -52 had the word "cancellation" added to its descriptor. The effects on payment when these modifiers are used has also changed to read as follows: "Procedures that are discontinued, *partially reduced or cancelled* after the procedure has been initiated and/or the patient has received anesthesia will be paid at the full OPPS payment amount. Modifier -74 is used for these procedures." "Procedures for which anesthesia is not planned that are discontinued, *partially reduced or cancelled* after the patient is prepared and taken to the room where the procedure is to be performed will be paid at 50 percent of the full OPPS payment amount. Modifier -52 is used for these procedures.

Transmittal 2386 can be located at: <http://www.cms.gov/transmittals/downloads/R2386CP.pdf>



Rural Health Resource Websites and Contacts for Regional Offices of Rural Health Coordinators

American Hospital Association Rural Health Care

<http://www.aha.org/advocacy-issues/rural>

Critical Access Hospitals Center

<http://www.cms.gov/center/cah.asp>

Disproportionate Share Hospital

http://www.cms.gov/AcuteInpatientPPS/05_dsh.asp

Federally Qualified Health Centers Center

<http://www.cms.gov/center/fqhc.asp>

Health Resources and Services Administration

<http://www.hrsa.gov>

Hospital Center

<http://www.cms.gov/center/hospital.asp>

HPSA/PSA (Physician Bonuses)

<http://www.cms.gov/hpsapsaphysicianbonuses>

Medicare Learning Network

<http://www.cms.gov/MLNGenInfo>

National Association of Community Health Centers

<http://www.nachc.org>

National Association of Rural Health Clinics

<http://www.narhc.org>

National Rural Health Association

<http://www.ruralhealthweb.org>

Rural Health Clinics Center

<http://www.cms.gov/center/rural.asp>

Rural Assistance Center

<http://www.raconline.org>

Swing Bed Providers

http://www.cms.gov/SNFPPS/03_SwingBed.asp

Telehealth

<http://www.cms.gov/Telehealth>

Regional Office Rural Health Coordinators

Below is a list of contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues.

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Since 1989 HMI Corporation, a Healthcare Management Company, a subsidiary of Healthcare Provider Services, has been assisting acute care, teaching, critical access, long term care, nursing home, home health, and skilled nursing facilities, as well as physician groups, with clinical reimbursement through accurate coding and billing for all financial classes as well as maintaining compliance with Federal payers.

HMI's consultant specialists perform compliance reviews, billing, and coding medical reviews, as well as other revenue improvement services, utilizing the provider's chargemaster. HMI also provides physician education to strengthen the medical staff's E/M coding for compliance and to improve reimbursement.

HMI offers a full-service program to assist providers in positioning themselves to meet federal compliance guidelines, with an emphasis on PPS reimbursement. This process also includes inpatient and outpatient record review, on-going chargemaster maintenance, and on-site education/training of clinical staff and physicians. Our twenty-two year success has been primarily founded on facilitating quality consulting service, on-going accountability through management plan objectives and guaranteed service based on our ability to deliver results.

Q & A Corner

Q: Our hospital is getting an edit from our Medicare contractor for modifier AY for several laboratory tests. These tests are considered related to the ESRD consolidated billing. Are we required to append the AY modifier to these laboratory tests?

A: Yes. Medicare issued guidance early in 2011 with the ESRD Prospective Payment transition to state that modifier AY was to be used by ESRD facilities when any laboratory test(s) were not being performed as part of the ESRD consolidated billing. This was adopted by the Medicare contractors when editing hospitals outpatient claims. It is there way of ensuring that ESRD services included in the payment rate are not being done in other settings. Hospitals are to append the AY modifier to the codes of specific diagnostic services that are deemed to be unrelated to the patient's ESRD (or CKD) diagnosis. This lets the contractor know to pay these services separately from the payment made to a patient's ESRD facility. CMS issued a clarification that stated the AY modifier would not be necessary effective January 1, 2012 as the consolidated billing edit for laboratory services will be bypassed when billed in conjunction with an emergency room service. Furthermore, CMS published additional guidance effective April 1, 2012 that states modifier ET will need to be reported with laboratory services that are performed for an emergency room patient and have a date of service that differs from the date of the line item with revenue code 045X for the emergency room visit. Source: CMS Pub 100-04, Chapter 8, Section 50.1.6

<http://www.cms.gov/manuals/downloads/clm104c08.pdf>



HMI would like to take this time to thank all of our service men and women who protect our country and it's freedoms.