HMI Corporation

Fourth Quarter 2008

January 7, 2009

Coding & Billing For Prospective Payment Systems

Inside This Issue:

SUMMARY OF THE 2009 OPPS FINAL RULE

CMS released the 2009 Outpatient Prospective Payment System (OPPS) Final Rule November 18, 2008. The following summarizes what became final for CY 2009:

Skin Substitutes

CMS is deleting HCPCS codes in the J734X series and C9357 and replacing them with temporary national codes to be able to track reporting. These codes have a status indicator of "K", with the exception of Q4109 (status indicator N) and Q4114 (status indicator G), and will be separately paid in 2009. CMS will use the data for reporting these codes to make future determinations about packaging. Also, HCPCS code Q4111 is being added to report gammagraft. See table below for the coding crosswalk.

To date, for other nonpass-through biologicals paid under the OPPS that may sometimes be used as implantable devices, CMS has instructed hospitals, via Transmittal 1336, Change Request 5718, dated September 14, 2007, to not separately bill for the HCPCS codes for the products when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. In such cases, we consider payment for the biological used as an implantable device in a specific clinical case to be included in payment for the surgical procedure.

2008 HCPCS Code	CY 2009 HCPCS Code	CY 2009 Long Descriptor
J7340	Q4101	Skin substitute, Apligraf, per square centimeter
J7341	Q4102	Skin substitute, Oasis Wound Matrix, per square centimeter
	Q4103	Skin substitute, Oasis Burn Matrix, per square centimeter
J7343	Q4104	Skin substitute, Integra Bilayer Matrix Wound Dressing (BMWD), per square centimeter
	Q4105	Skin substitute, Integra Dermal Regeneration Template (DRT), per square centimeter
J7342	Q4106	Skin substitute, Dermagraft, per square centimeter
J7344	Q4107	Skin substitute, Graft Jacket, per square centimeter
J7347	Q4108	Skin substitute, Integra Matrix, per square centimeter
J7348	Q4109	Skin substitute, Tissuemend, per square centimeter
J7349	Q4110	Skin substitute, Primatrix, per square centimeter
J7346	Q4112	Allograft, Cymetra, Injectable, 1cc
	Q4113	Allograft, Graft Jacket Express, injectable, 1cc
C9357	Q4114	Integra flowable wound matrix, injectable, 1 cc
N/A	Q4111	Skin substitute, gammagraft, per square centimeter

Coding & Billing for Prospective Payment Systems Newsletter contributors and editorial board:

Thomas P. Holliday, RN, PA, MHA

G. Maria Caston, CCS, CPC-H, CCS-P, CPC, CPS, CFS

William G. Cox, RHIA

Mary Quimby, CPC-H, CPS, CFS

Vickie Faler, RHIT, CPC

Initial Preventive Physical Exam (IPPE)

CMS has added replacement codes for reporting IPPE services. Providers paid under the OPPS will report IPPE visits occurring on or after January 1, 2009, using new HCPCS code G0402 (Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment). This new code is replacing HCPCS code G0344. Policy for reporting a medically necessary hospital visit during the same visit as the IPPE still applies. CPT codes 99201 through 99215 for hospital clinic visits of new and established patients at all five levels of resource intensity may also be appropriately reported, depending on the circumstances, but they must be appended with the CPT -25 modifier, identifying the hospital visit as a separately identifiable service from the IPPE described by HCPCS code G0402.

Section 101(b) of the MIPPA also removes the screening electrocardiogram (EKG) as a mandatory requirement, as identified in section 1861(ww)(1) of the Act, to be performed as part of the IPPE. The MIPPA requires that there be education, counseling, and referral for an EKG, as appropriate, for a once-in-a lifetime screening EKG performed as a result of a referral from an IPPE. The facility service for the screening EKG (tracing only) is payable under the OPPS when it is the result of a referral from an IPPE. Providers paid under the OPPS should report new HCPCS code G0404 (Electrocardiogram, routine ECG with 12 leads, tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination) for services furnished on or after January 1, 2009. HCPCS code G0404 replaces G0367 (Tracing only, without interpretation and report, performed as a component of the initial preventive physical exam).

Providers should note that the two other new related screening EKG codes, HCPCS code G0403 (Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report) and HCPCS code G0405 (Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination), include an interpretation and report and, therefore, are assigned status indicators “M” and “B,” respectively, on an interim basis for the CY 2009. HCPCS code G0403 and HCPCS code G0405 replace predecessor HCPCS code G0366 (Electrocardiogram, routine ECG with 12 leads; performed as a component of the initial preventive examination with interpretation and report) and HCPCS code G0368 (Interpretation and report only, performed as a component of the initial preventive examination), respectively.

IVIG Preadministration

CMS is deleting HCPCS code G0332 IVIG with no replacement code. HCPCS code G0332 will be deleted effective January 1, 2009. Hospitals should report charges for IVIG preadministration-related services in the same manner as hospitals report preadministration-related services charges for other drugs. Hospitals may include the charge for IVIG preadministration-related services on a claim in the charge for the associated drug administration service, in the charge for the IVIG product infused, on an uncoded revenue code line, or in another appropriate manner.

2009 Status Indicator Updates

CMS is expanding status indicator Q to Q1, Q2, Q3 and adding status indicator U – for brachytherapy services, and status indicator R – for blood products. Status indicator "Q1" will be assigned to all "STVX-packaged codes," status indicator "Q2" will be assigned to all "T-packaged codes;" and status indicator "Q3" will be assigned to all codes that may be paid through a composite APC based on composite-specific criteria or separately through single code APCs when the criteria are not met.

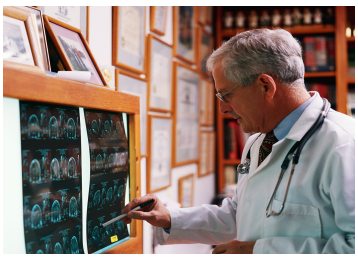
Also, CMS has clarified the definition of status indicator "E" to indicate more precisely that status indicator "E" designates items and services that are not payable when submitted on outpatient claims of any bill type. CMS has also clarified that these items and services are not covered by the Medicare outpatient benefit, in recognition that they may be covered under some circumstances under other benefits of the Medicare program.

Multiple Imaging Services

The multiple imaging composite APCs for CY 2009 are: APC 8004 (Ultrasound Composite); APC 8005 (CT and CTA without Contrast Composite); APC 8006 (CT and CTA with Contrast Composite); APC 8007 (MRI and MRA without Contrast Composite); and APC 8008 (MRI and MRA with Contrast Composite). The composite APCs have status indicators of "S," signifying that payment for the APC is not reduced when it appears on the same claim with other significant procedures.

CMS will provide one composite APC payment each time a hospital bills more than one procedure described by the HCPCS codes in an OPPS imaging family on a single date of service. If the hospital performs a procedure without contrast during the same session as at least one other procedure with contrast using the same imaging modality, then the hospital will receive payment for the "with contrast" composite APC. A single imaging procedure, or imaging procedures reported with HCPCS codes assigned to different OPPS imaging families, will be paid according to the standard OPPS methodology through the standard (sole service) imaging APCs to which they are assigned in CY 2009. Hospitals will continue to use the same HCPCS codes to report imaging procedures, and the I/OCE will determine when combinations of imaging procedures qualify for composite APC payment or map to standard (sole service) APCs for payment.

A single imaging session for purposes of the multiple imaging composite APC payment policy involves more than one procedure within the same family provided on a single date of service. **For example**, a patient who has two MRI procedures three hours apart during a single hospital outpatient encounter would not have to be registered again, and hospital staff might not have to explain the procedure in detail prior to the second scan. In the case of multiple procedures involving contrast that are provided at different times during a single hospital outpatient encounter, establishment of new intravenous access for the second study would not be necessary. Even if the same level of efficiencies could not be gained for multiple imaging procedures performed on the same date of service but at different times, CMS expects that any higher costs associated with these cases would be reflected in the claims data and cost reports CMS uses to calculate the median costs for the multiple imaging composite APCs, and therefore, in the payment rates for the multiple imaging composite APCs. CMS does not believe it is necessary or appropriate for hospitals to report imaging procedures provided on the same date of service but during different encounters any differently than they would report imaging procedures performed consecutively with no time in between.



Packaging

CMS is finalizing, without modification, to package payment for five categories of ancillary and supportive services for CY 2009, specifically guidance services, image processing services, intraoperative services, imaging supervision and interpretation services, and observation services, that are provided in association with independent, separately paid services, without a specific threshold for the cost or utilization of those supportive services. CMS is also finalizing to unconditionally package payment for IVUS, ICE, and FFR services.

CMS responded to commenters in the final rule regarding claims without any separately payable services being returned to the provider, as stated in the CY 2007 OPPS final rule with comment period (71 FR 67995), claims with only packaged codes and no separately payable codes are processed by the I/OCE and rejected for payment, but are included in the national claims history file that CMS analyzes and uses to set payment rates. Therefore, CMS has hospital claims data for packaged codes that are provided without any separately payable service.

In addition, CMS reminds providers that packaged items and services are covered and paid under the OPPS. Hospitals may only provide an ABN when the hospital expects that the service provided to the beneficiary will not be covered under any Medicare benefit category. Although hospitals do not receive separate payment from Medicare for packaged items and supplies, hospitals may not bill beneficiaries separately for any packaged items and supplies because those costs are recognized and paid within the OPPS payment rate for the associated procedure or service. Transmittal A-01-133, issued on November 20, 2001, explains in greater detail the rules regarding payment for packaged services. CMS believes that the vast majority of hospitals understand the correct use of ABNs. For more information on mandatory and voluntary uses of ABNs, read the Medicare Claims Processing Manual, Pub. 100-4, Chapter 30, Sections 50.3.1 and 50.3.2.

Drugs and Biologicals

CMS is deleting several temporary HCPCS codes assigned to drugs and reassigning them to permanent HCPCS J codes. Providers should note that there were 3 codes for reporting Iron Dextran, and will now be reported using only one code, HCPCS code J1750.

2008 HCPCS Code	CY 2009 HCPCS Code	CY 2009 Long Descriptor
C9003	90378	Respiratory syncytial virus immune globulin (rsv-igim), for intramuscular use, 50 mg, each
J0348	J0348	Injection, anidulafungin, 1 mg
C9241	J1267	Injection, doripenem, 10 mg
C9242	J1453	Injection, fosaprepitant, 1 mg
Q4097	J1459	Injection, immune globulin (Privigen), intravenous, non-lyophilized (e.g. liquid), 500 mg
J1751	J1750	Injection, iron dextran, 50 mg
J1752		
Q4098		
C9237	J1930	Injection, lanreotide, 1 mg
C9238	J1953	Injection, levetiracetam, 10 mg
C9244	J2785	Injection, regadenoson, 0.1 mg
J3100	J3101	Injection, tenecteplase, 1 mg
Q4096	J7186	Injection, antihemophilic factor viii/von willebrand factor complex (human), per factor viii i.u.
C9243	J9033	Injection, bendamustine hcl, 1 mg
J9182	J9181	Etoposide 100 MG inj
C9240	J9207	Injection, ixabepilone, 1 mg
C9239	J9330	Injection, temsirolimus, 1 mg

HCPCS Coding

Hospitals include charges for packaged services on their claims, and the costs associated with those packaged services are then added to the costs of separately payable procedures on the same claims in establishing payment rates for the separately payable services. CMS encourages hospitals to report all HCPCS codes that describe packaged services that were provided, unless CPT or CMS provide other guidance. If a HCPCS code is not reported when a packaged service is provided, it can be challenging to track utilization patterns and resource costs.

Hospitals are reminded that CMS, since CY 2005, has required reporting of device HCPCS codes for all devices used in procedures if there are appropriate HCPCS codes available. In this way, CMS can be confident that hospitals have included charges on their claims for costly devices used in procedures when they submit claims for those procedures.

In the July 2008 OPPS quarterly update Transmittal 1536, Change Request 6094,CMS issued on June 19, 2008, CMS clarifies the reporting of CPT codes for hospital outpatient services paid under the OPPS. CPT codes generally are created to describe and report physician services, they are also used by other providers/ suppliers to describe and report services that they provide. Therefore, the CPT code descriptors do not necessarily reflect the facility component of a service furnished by the hospital. Some CPT code descriptors include reference to a physician performing a service. For OPPS purposes, unless indicated otherwise, the usage of the term "physician" does not restrict the reporting of the code or application of related policies to physicians only, but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant CPT codes pursuant to applicable portions of the Act, the CFR, and the Medicare rules. In cases where there are separate codes for the technical component, professional component, and/or complete procedure, hospitals should report the code that represents the technical component for their facility services. If there is no separate technical component code for the service, hospitals should report the code that represents the complete procedure.

Medical and Surgical Supplies

When medical and surgical supplies (other than prosthetic and orthotic devices as described in the Medicare Claims Processing Manual, Chapter 20, §10.1) described by HCPCS codes with status indicators other than "H" or "N," are provided incident to a physician's service by a hospital outpatient department, the HCPCS codes for these items should not be reported because these items represent supplies. Claims containing charges for medical and surgical supplies used in providing hospital outpatient services are submitted to the Medicare contractor providing OPPS payment for the services in which they are used. The hospital should include charges associated with these medical and surgical supplies on claims so their costs are incorporated in rate setting, and payment for the supplies is packaged into payment for the associated procedures under the OPPS in accordance with 42 CFR 419.2(b)(4).

For example, if the hospital staff in the emergency department initiate the intravenous administration of a drug through an infusion pump described by HCPCS code E0781 (Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient), complete the drug infusion, and discontinue use of the infusion pump before the patient leaves the hospital outpatient department, HCPCS code E0781 should not be reported because the infusion pump was used as a supply and would be paid through OPPS payment for the drug administration service. The hospital should include the charge associated with the infusion pump on the claim. In another example, if hospital outpatient staff perform a surgical procedure on a patient in which temporary bladder catheterization is necessary and use a catheter described by HCPCS code A4338 (Indwelling catheter; Foley type, two-way latex with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each), the hospital should not report A4338 because the catheter was used as a supply and would be paid through OPPS payment for the surgical procedure. The hospital should include the charge associated with the urinary catheter on the claim.

When hospital outpatient staff provide a prosthetic or orthotic device, and the HCPCS code that describes that device includes the fitting, adjustment, or other services necessary for the patient's use of the item, the hospital should not bill a visit or procedure HCPCS code to report the charges associated with the fitting, adjustment, or other related services. Instead, the HCPCS code for the device already includes the fitting, adjustment or other similar services. For example, if the hospital outpatient staff provides the orthotic device described by HCPCS code L1830 (KO, immobilizer, canvas longitudinal, prefabricated, includes fitting and adjustment), the hospital should only bill HCPCS code L1830 and should not bill a visit or procedure HCPCS code to describe the fitting and adjustment. *Source:* CMS Transmittal 1657, December 31, 2008.

◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆ ◆

Drug Administration

CMS is finalizing to implement a five-level APC structure for drug administration services, with final assignment of all HCPCS codes as proposed. Table 34 in the Final Rule displays the five finalized APC groups for drug administration services for CY 2009. Additionally, CPT codes for drug administration services have been renumbered from 907XX to 963XX.

Clinic Visits

CMS is revising its definitions of new and established patients as they relate to reporting hospital outpatient visits under the OPPS. Specifically, beginning in CY 2009, the meanings of "new" and "established" patients pertain to whether or not the patient has been registered as an inpatient or outpatient of the hospital within the past 3 years. A patient who has been registered as an inpatient or outpatient of the hospital within the 3 years prior to the visit would be considered to be an established patient for that visit, while a patient who has not been registered as an inpatient or outpatient of the hospital within the 3 years prior to the visit would be considered to be a new patient for that visit.

Critical Care

CMS responds to public comments requesting clarification of services that should be included or bundled into visit codes, hospitals should separately report all HCPCS codes in accordance with correct coding principles, CPT code descriptions, and any additional CMS guidance, when available. Specifically with respect to CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes), hospitals must follow the CPT instructions related to reporting that CPT code. Any services that CPT indicates are included in the reporting of CPT code 99291 should not be billed separately by the hospital. In establishing payment rates for visits, CMS packages the costs of certain items and services separately reported by HCPCS codes into payment for visits according to the standard OPPS methodology for packaging costs

The CPT instructions for reporting critical care services with CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) and the CPT code descriptor specify that the code can only be billed if 30 minutes or more of critical care services are provided. Because hospitals will be reporting CPT codes for critical care services for CY 2009, they must continue to provide a minimum of 30 minutes of critical care services in order to bill CPT code 99291, according to the CPT code descriptor and CPT instructions. Hospitals can report the appropriate clinic or emergency department visit code consistent with their internal guidelines if fewer than 30 minutes of critical care is provided.

Partial Hospitalization

CMS is finalizing patient eligibility criteria at 42 CFR 410.43 as follows:

Partial hospitalization programs are intended for patients who—

(1) Require a minimum of 20 hours per week of therapeutic services as evidenced in their plan of care;

(2) Are likely to benefit from a coordinated program of services and require more than isolated sessions of outpatient treatment;

(3) Do not require 24-hour care;

(4) Have an adequate support system while not actively engaged in the program;

(5) Have a mental health diagnosis;

(6) Are not judged to be dangerous to self or others; and

(7) Have the cognitive and emotional ability to participate in the active treatment process and can tolerate the intensity of the partial hospitalization program.

The table of billable PHP revenue and HCPCS codes originally published in the April 7, 2000 OPPS final rule with comment period (65 FR 18454) was updated and published in Transmittal 1487, Change Request 5999, dated April 8, 2008, and is currently located in the Medicare Claims Processing Manual, Pub. 100-04, Chapter 4, Section 260.1. Table 38 in the Final Rule displays the revised list of billable PHP revenue codes and HCPCS codes shown in Transmittal 1487. This table also includes the four CPT codes that CMS is removing from the PHP code set for CY 2009 and the two new HCPCS G-codes being added to the PHP code set for CY 2009. The four CPT codes being removed are shown in the HCPCS code column with a line struck through each code. The two new HCPCS G-codes being added are shown in the HCPCS code column, in the row with revenue code 0915 (Group Therapy). HCPCS code 90846 is shown as retained in the row with revenue code 0916 (Family Psychotherapy).

Inpatient Only Procedures

CMS is removing 12 CPT codes from the inpatient list. The final list of 12 procedures is displayed in Table 39 in the Final Rule.

Physician Supervision of HOPD Services

As stated, section 1861(s)(2)(C) of the Act authorizes payment for diagnostic services that are furnished to a hospital outpatient for the purpose of diagnostic study. CMS has further defined the requirements for diagnostic services furnished to hospital outpatients, including requirements for physician supervision of diagnostic services, in §§410.28 and 410.32. Section 410.28(e) states that Medicare Part B will make payment for diagnostic services furnished at provider-based departments of hospitals "only when the diagnostic services are furnished under the appropriate level of physician supervision specified by CMS in accordance with the definitions in §§410.32(b)(3)(i), (b)(3)(ii), and (b)(3)(iii)." In addition, in the April 7, 2000 OPPS final rule with comment period (65 FR 18526), CMS stated that their model for the requirement was the requirement for physician supervision of diagnostic tests payable under the MPFS that was set forth in the CY 1998 MPFS final rule (62 FR 59048) that was published in the **Federal Register** on October 31, 1998. CMS also explained with respect to the supervision requirements for individual diagnostic tests that they intended to instruct hospitals and fiscal intermediaries to use the MPFS as a guide pending issuance of updated requirements.

It has been CMS' expectation that hospital outpatient therapeutic services are provided under the direct supervision of physicians in the hospital and in all provider-based departments of the hospital, specifically both on-campus and off-campus departments of the hospital. The expectation that a physician would always be nearby predates the OPPS and is related to the statutory authority for payment of hospital outpatient services--that Medicare makes payment for hospital outpatient services "incident to" the services of physicians in the treatment of patients as described in section 1861(s)(2)(B) of the Act. Longstanding hospital outpatient policy language states that "the services and supplies must be furnished as an integral though incidental part of the physicians' professional services in the course of treatment of an illness or injury." CMS refers providers to 42 CFR §410.27(a) and to the Medicare Benefit Policy Manual, Pub. 100-2, Chapter 6, Section 20.5.1, for further description of hospital outpatient services incident to a physician's service. The Medicare Benefit Policy Manual also states in Chapter 6, Section 20.5.1, that services and supplies must be furnished on a physician's order and delivered under physician supervision.

In summary, direct physician supervision is the standard set forth in the April 7, 2000 OPPS final rule with comment period for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals. While CMS has emphasized and will continue to emphasize the direct supervision requirement for off-campus provider-based departments, they do expect direct physician supervision of all hospital outpatient therapeutic services, regardless of their on-campus or off-campus location. Appropriate supervision is a key aspect of the delivery of safe and high quality hospital outpatient services that are paid based on the statutory authority of the OPPS.

Pathology Services for Prostate Saturation Biopsy

CMS will recognize four new HCPCS G-codes for pathology services associated with prostate saturation biopsy, specifically HCPCS codes G0416 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 1-20 specimens); G0417 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling 21-40 specimens); G0418 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, 41-60 specimens); and G0419 (Surgical pathology, gross and microscopic examination for prostate needle saturation biopsy sampling, greater than 60 specimens). CPT code 88305 will continue to be recognized under the OPPS for those surgical pathology services unrelated to prostate saturation biopsy.

Newsletter Prepared By:

HMI CORPORATION

155 Franklin Road, Suite 100
Brentwood, TN 37027

Phone: (800) 659-5145
Fax: (615) 661-5147
http://www.hmi-corp.com/

HMI would like to express our gratitude to those serving our country here and abroad.

Thank you!

The information contained herein is solely for the purpose of informing you the health care professional of current changes. Every effort has been made to ensure the accuracy of the contents. However, this newsletter does not replace policies or guidelines set by your Medicare FI or replace the ICD-9-CM or CPT/ HCPCS coding manuals. It serves only as a resource.

Since 1989 HMI Corporation, a Healthcare Management Company, 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 fifteen-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.

IN LOVING MEMORY
OF OUR FRIEND AND COLLEAGUE

WILLIAM "BILL" COX

HMI lost a colleague and dear friend on December 28, 2008, at the passing of William "Bill" Cox, following an extended illness.

Bill was a fixture at HMI for over 13 years sharing his wealth of HIM, CDM, and revenue cycle management knowledge with our staff and clients across the country. Bill touched our lives both professionally and personally and will be greatly missed by a multitude of people.