HMI Corporation

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CODING & BILLING FOR PROSPECTIVE PAYMENT SYSTEMS

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PROPOSED CHANGES TO OBSERVATION SERVICES

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CMS is proposing two changes in outpatient payment policy for observation services for 2006:

- First, discontinue use of HCPCS codes G0244 (Observation care by facility to patient), G0263 (Direct admission with CHF, CP, asthma), and G0264 (Assessment other than CHF, CP, asthma) and create two new HCPCS codes to be used by hospitals to report all observation services:

  GXXXX – Hospital observation services, per hour

  GYYYY – Direct admission of patient for hospital observation care

- Second, shift determination of whether or not observation services are separately payable under APC 0339 from the hospital billing department to the OPPS claims processing logic.

Hospitals would bill GXXXX when observation services are provided to any patient admitted to "observation status," regardless of the patient's status as an inpatient or outpatient. Hospitals would additionally bill GYYYY when observation services are the result of a direct admission to "observation status" without an associated emergency room visit, hospital outpatient clinic visit or critical care service on the day of or day before the observation

services. Both of these new HCPCS codes would be assigned a new status indicator that would trigger OCE logic during the processing of the claim to determine if the observation service is packaged with the other

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separately payable hospital services provided or if a separate APC payment for observation services is appropriate.

For CY 2006, CMS is proposing to continue applying the existing 2005 criteria that determine when a hospital stay receives separate payment for medically necessary observation care provided to a patient with congestive heart failure, chest pain, or asthma. In addition, CMS proposes to continue its policy of packaging payment for all other observation services into the payments for the separately payable services with which the observation service is reported.

Vascular Access Procedures

CMS is proposing to reassign many of the CPT codes that are currently in the following APCs:

- 0032—Insertion of Central Venous/Arterial Catheter
- 0109—Removal of Implanted Devices
- 0115—Cannula/Access Device Procedures
- 0119—Implantation of Infusion Pump
- 0124—Revision of Implanted Infusion Pump
- 0187—Miscellaneous Placement/ Repositioning

CMS proposes to create three new APCs:

APC	DESCRIPTION
0621	Level I Vascular Access Codes
0622	Level II Vascular Access Codes
0623	Level III Vascular Access Codes

Procedures will be assigned to each of these based on median cost and clinical homogeneity. No codes will be assigned to APC 0187 as the procedures which were in the classification have been reassigned to more clinically appropriate APCs. This could mean significant changes to reimbursement amounts for vascular access procedures. For example, in CY 2005, APC 0119 was reimbursed at a rate of $7,178.41. The proposed CY 2006 APC reimbursement is $1,608.82. In contrast, the reimbursement for APC 0115 would increase from $1,462.30 in 2005 to $1,867.68 under the proposed 2006 changes.

Multiple Imaging Services

The proposed rule asserts that when multiple images of contiguous areas of the body are acquired in a single session, most of the clinical labor activities are not performed twice and many of the supplies are not furnished twice. Therefore, CMS is

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Multiple Imaging Services

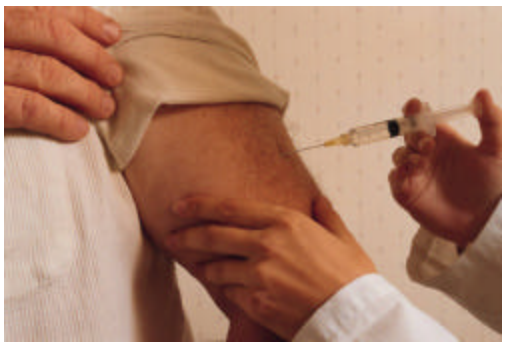
in the OPPS payments for some second and subsequent imaging procedures performed in the same session, similar to their policy of reducing payments for some second and subsequent surgical procedures. CMS has identified 11 "Families" of imaging procedures by imaging modality and contiguous body area. The multiple imaging procedure reduction would apply only to individual services described by codes within one Family, not across Families. For example, no reduction would apply to an MRI of the brain (CPT 70552) in code Family 5, when performed in the same session as an MRI of the spinal canal and contents (CPT 72142) in code Family 6. Full payment would be made for the procedure with the highest APC payment rate, and payment at 50% of the applicable APC payment rate for every additional procedure, when performed in the same session.

Interrupted Procedure Payment Policy Revisions

Currently, facilities receive 100% of the APC payment for "interrupted procedures", or those services to which a -52, or -74 modifier has been appended, and a 50% APC reduction applies to those services with a -73 modifier. Under the proposed changes for 2006, CMS would decrease the reimbursement for services with a -52 modifier to 50% of the full reimbursement rate. CMS is seeking comment from the provider community regarding the clinical circumstances surrounding the use of modifier -74 in order to determine whether or not to reduce this payment rate by 50% as well.

Proposed Changes To Vaccines

CMS is proposing to continue to pay influenza and pneumococcal vaccines at reasonable cost in 2006. Although hepatitis B vaccines previously have been paid under clinical APCs that also include other vaccines, for 2006 CMS is proposing to pay for all hepatitis B vaccines at reasonable cost, consistent with the payment methodology for influenza and pneumococcal vaccines. Influenza and pneumococcal vaccines are exempt from coinsurance and deductible payments under sections 1822(a)(3) and 1833(b) and have been assigned to status indicator "L". Hepatitis B vaccines have no similar coinsurance or deductible exemption and will be assigned status indicator "F".



To view the 2006 proposed rule in its entirety, go to:
http://www.cms.hhs.gov/providers/hopps/2006p/cms-1501p.pdf

Hospital Evaluation And Management

CMS continues to develop and test new hospital E/M codes with no definite plans for implementation. CMS has assured the provider community that they will provide 6-12 months notice prior to implementation of codes and guidelines.

Tracer Codes Required for PET Scans

Effective October 31, 2005, CMS will require the use of the appropriate radiopharmaceutical diagnostic imaging agent (tracer) when billing for PET scans. To view the CMS Transmittal #628, July 29, 2005, click on the following link:
http://www.cms.hhs.gov/manuals/pm_trans/R628CP.pdf

Tracer codes applicable to CPT 78491 and 78492:

Institutional providers billing the fiscal intermediary

HCPCS	Description
Q3000	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Rubidium RB-82
A9526	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Ammonia N-13

Physicians / practitioners billing the carrier:

HCPCS	Description
A4641	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Not Otherwise Classified
A9526	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Ammonia N-13

Tracer codes applicable to CPT 78459, 78608, 78609, 78811-78816:

Institutional providers billing the fiscal intermediary:

HCPCS	Description
C1775 (OPPS Only)	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Fluorodeoxyglucose F18
A4641	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Not Otherwise Classified

Physicians / practitioners billing the carrier:

HCPCS	Description
A4641	Supply of Radiopharmaceutical Diagnostic Imaging Agent, Not Otherwise Classified

OCTOBER 2005 OPPS UPDATES

CMS released Change Request 4035 on August 26, 2005 to notify providers of changes to OPPS effective for dates of service on or after 10/01/05.

To view the change request in its entirety, click on link provided below:
http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM4035.pdf

CMS Proposes To Expand Device Edits

Effective October 1, CMS will expand the list of device edits to apply to more procedure codes that require physicians to use a device, according to *Transmittal 662* dated August 26.

CMS posted an initial list of edits on its website since it issued the 2005 OPPS final rule November 1, 2004. CMS implemented the first phase of device edits in the outpatient code editor (OCE) as of April 1. The new set that will take effect in October incorporates many of the comments the public provided.

You can find a complete list of the new edits on the CMS website: http://www.cms.hhs.gov/providers/hopps/ (Click on the Excel file link under "October 2005 Proposed Device Code Edits.")

Providers should note that some HCPCS procedure codes that require a device do not have an associated edit. The reason for this is that the existing device codes do not describe all of the possible devices a provider could use to perform the particular procedure. CMS wants to avoid unnecessary claim denials for procedures that providers perform with devices that do not have an associated code.

Changes For Brachytherapy

Effective October 1, 2005, CMS is implementing two new HCPCS codes regarding brachytherapy. HCPCS C9725 is being added for "Placement of endorectal intracavity applicator for high intensity brachytherapy". HCPCS C2637 "Brachytherapy source, Ytterbium-169, per source" may be reported for payment as a brachytherapy source under the OPPS. These codes will be grouped into APC 1507 and APC 2637, respectively.

No Cost Device Billing Clarification

In CR 3915 (Transmittal 585, dated June 17, 2005) provided guidance on how to report devices for which the hospital has incurred no charge. When hospitals surgically implant a device for which they have incurred no cost, a token charge (e.g., $1.00) must be entered on the line with the device code. Previously, hospitals were given the option of either reporting a charge of zero for the device, or reporting the token charge. Since the Fiscal Intermediary Standard System will only accept a zero charge for line reflecting a surgical procedure, hospitals should now report a token charge on the line with the device code.

Newly Approved Drugs and Biologicals for Pass-Through Status

Effective October 1, 2005, HCPCS codes C9225 (Fluocinolone acetonide intravitreal implant) and C9226 (Ziconotide for intrathecal infusion) have been approved for pass-through status under the OPPS. Payment rates will be available in the October 2005 update of OPPS Addendum A and Addendum B at http://www.cms.hhs.gov/providers/hopps/ on the CMS website.

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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.

Do you have a specific coding question or topic that you would like to see addressed in our next newsletter? You may fax your question to (615) 661-5147 or go to "contact us" on our website at www.hmi-corp.com. We would like to hear from you.

Ultrasound Stimulation For Nonunion Fractures

Effective August 1, 2005 CMS lifted its requirement of at least one surgical intervention prior to treating nonunion fractures using ultrasound stimulation for services performed on or after April 27, 2005. CMS has covered ultrasonic osteogenic stimulators as medically reasonable and necessary for the treatment of nonunion fractures excluding the skull, vertebrae and tumor-related fractures. Fracture nonunion has been based on two sets of radiographs separated by a minimum of 90 days that demonstrate no clinical evidence of fracture healing. Coverage has been further limited by requiring that patients must have failed at least one surgical intervention for treatment of the nonunion. However, fresh fractures and delayed unions remain noncovered. Hospitals should be aware that they can not bill for the Ultrasonic Osteogenic Stimulator. Hospitals may only instruct patients on how to use the Ultrasonic Osteogenic Stimulator and **not** provide the device itself. Hospitals should report this service using CPT code 20979.

For further guidance, go to:
http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3836.pdf