Coding & Billing for Prospective Payment Systems

July 2013 Update of Hospital OPPS

New Data Reporting Requirements on Home Health Prospective Payment System

Implementation of CME Ruling 1455-R
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, remote chargemaster services, interim chargemaster coordinator coverage, remote contract coding, and on-site education/training of clinical staff and physicians. Our twenty-three 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.
Implementation of CME Ruling 1455-R (Medicare Program; Part B Billing in Hospitals)

On June 10, 2013 CMS rescinded Transmittal 1243 and released Transmittal 1247 as a one-time notification regarding Ruling 1455-R. This transmittal sets forth the requirements for contractors to implement CMS Ruling 1455-R “until such time as the operating instructions and necessary system change in CR 8185 can be fully implemented”. All other language contained in the initial transmittal will remain the same and is effective for claims processed after July 1, 2013.

To read Transmittal 1247 and MLN Matters MM8277 go to:


CMS released Transmittal 2718 on June 7, 2013 with the changes to and billing instructions for various payment policies effective July 1, 2013. The following is a summary of those changes.

1. Changes to Device Edits for July 2013

To obtain the most current listing for device edits go to: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/

2. New Service

One new payable service is being implemented effective July 1, 2013 as follows:

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
<th>Payment</th>
<th>Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9736</td>
<td>Lap ablate uteri fibroid rf</td>
<td>Laparoscopy, surgical, radiofrequency, ablation of uterine fibroid(s), including intraoperative guidance and monitoring, when performed</td>
<td>T</td>
<td>0131</td>
<td>$3,487.15</td>
<td>$1,001.89</td>
</tr>
</tbody>
</table>
3. New Long Descriptor for C9734

CMS has added a new long descriptor for HCPCS code C9734 to indicate it must be performed with magnetic resonance (MR) guidance.

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Short Descriptor</th>
<th>Long Descriptor</th>
<th>SI</th>
<th>APC</th>
<th>Payment</th>
<th>Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9734</td>
<td>U/S trtmt, not leiomyomata</td>
<td>Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance</td>
<td>S</td>
<td>0067</td>
<td>$3,300.64</td>
<td>$660.13</td>
</tr>
</tbody>
</table>

4. Deletion of HCPCS Code C1879

Effective June 30, 2013 CME will be deleting temporary HCPCS code C1879 (tissue marker, implantable) as it is described by HCPCS code A4648 (Tissue marker, implantable, any type). Providers should report the use and cost of implantable tissue markers with HCPCS code A4648 only.

5. Category III CPT Codes

Effective July 1, 2013 there are six new Category III CPT Codes that are now separately payable under OPPS. The payment rates for these services can be found in Addendum B of the July 2013 OPPS Update that will be posted at [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html)
6. Billing for Drugs, Biologicals, and Radiopharmaceuticals

A. Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective July 1, 2013.

The updated payment rates effective July 1, 2013 are found in the July 1, 2013 Addendum A and Addendum B which are not available online at the time of this newsletter. Once CMS updates their files it can be found at the following website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html

B. Drugs and Biologicals with OPPS Pass-Through Status Effective July 1, 2013

CMS has granted OPPS pass-through status to two drugs and biological effective July 1, 2013. It is noted that HCPCS code C9131 is a new code effective July 1, 2013.

C. Flublok (Influenza virus vaccine)

On January 16, 2013 the FDA approved Flublok as an influenza virus vaccine. Effective July 1, 2013 CMS has assigned it to HCPCS Q2033 (Influenza Vaccine, Recombinant Himagglutinin Antigen, for Intramuscular Use (Flublok)) with the OPPS status indicator of “L” (Influenza Vaccine; Pneumococcal Pneumonia Vaccine). For all claims prior to July 1, 2013 it should have been reported with an unlisted CPT/HCPCS vaccine code.

D. Fluarix Quadrivalent (Influenza virus vaccine)

On December 14, 2012 the FDA approved Fluarix Quadrivalent and is described by CPT code 90686 (Influenza virus vaccine, quadrivalent, split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use), however, due to the timing of this approval CMS was unable to assign CPT code 90686 to a separately payable status.

As part of the July 2013 update CMS is revising the status indicator for 90686 to “L” Influenza Vaccine; Pneumococcal Pneumonia Vaccine) with an effective date of January 1, 2013. For all claims prior to January 1, 2013 the appropriate code to report Fluarix Quadrivalent would be an unlisted CPT/HCPCS vaccine code.
E. New HCPCS Codes Effective July 1, 2013 for Certain Drugs and Biologicals

CMS has created two new HCPCS codes for reporting certain drugs and biological (other than new pass-through drugs and biological as discussed earlier) to be used in the hospital setting effective July 1, 2013.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
<th>APC</th>
<th>Status Indicator Effective 7/1/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2050*</td>
<td>Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10 mg</td>
<td>7046</td>
<td>K</td>
</tr>
<tr>
<td>Q2051**</td>
<td>Injection, Zoledronic Acid, Not Otherwise Specified, 1 mg</td>
<td>1356</td>
<td>K</td>
</tr>
</tbody>
</table>

*HCPCS code J9002 (Injection, Doxorubicin Hydrochloride, Liposomal, Doxil, 10 mg.) will be replaced with HCPCS code Q2050 effective July 1, 2013. The status indicator for HCPCS code J9002 will change to E, “Not payable by Medicare”, effective July 1, 2013.

** HCPCS code J3487 (Injection, Zoledronic Acid (Zometa), 1 mg) and HCPCS code J3488 (Injection, Zoledronic Acid (Reclast), 1 mg) will be replaced with HCPCS code Q2051 effective July 1, 2013. The status indicators for HCPCS codes J3487 and J3488 will change to E, “Not Payable by Medicare”, effective July 1, 2013.

F. Revised Status Indicator for HCPCS Codes Q4126 and Q4134 Effective July 1, 2013

CMS is changing the status indicator for HCPCS code Q4126 (Memoderm, dermaspan, tranzgraft or integuply, per sq. cm) and HCPCS code Q4134 (Hmatrix, per sq. cm) from “E” (Not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to “K” (Paid under OPPS; separate APC payment) effective with dates of service on or after July 1, 2013. The prices for these codes will be updated quarterly.

G. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2013 through June 30, 2013.

CMS has indicated that the payment rates for two HCPCS codes were incorrectly entered during the April 2013 OPPS Pricer update. The corrected payment rates have been installed in the July 2013 OPPS Pricer and is effective for services provided on April 1, 2013 through June 30, 2013.
Hospital outpatient departments are allowed to bill for new drugs, biologicals, and therapeutic radiopharmaceuticals that are approved by the FDA on or after January 1, 2004 for which pass-through status has not been approved and a C-code and APC payment have not been assigned using the “unclassified” drug/biological HCPCS code C9399 (Unclassified drugs or biological). Drugs, biologicals, and therapeutic radiopharmaceuticals that are assigned to HCPCS code C9399 are contractor priced at 95 percent of AWP.

Diagnostic radiopharmaceuticals and contrast agents are policy packaged under the OPPS unless they have been granted pass-through status. Therefore, new diagnostic radiopharmaceuticals and contrast agents are an exception to the above policy and should not be billed with C9399 prior to the approval of pass-through status but, instead, should be billed with the appropriate “A” NOC code as follows:

1. Diagnostic Radiopharmaceuticals – All new diagnostic radiopharmaceuticals are assigned HCPCS code A4641 (Radiopharmaceutical, diagnostic, not otherwise classified). HCPCS code A4641 should be used to bill a new diagnostic radiopharmaceutical until the new diagnostic radiopharmaceutical has been granted pass-through status and a C-code has been assigned. HCPCS code A4641 is assigned status indicator “N” and, therefore, the payment for a diagnostic radiopharmaceutical assigned to HCPCS code A4641 is packaged into the payment for the associated service.

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>Status Indicator</th>
<th>APC</th>
<th>Short Descriptor</th>
<th>Corrected Payment Rate</th>
<th>Corrected Minimum Unadjusted Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9297</td>
<td>G</td>
<td>9297</td>
<td>Omacetaxine mepesuccinate</td>
<td>$2.53</td>
<td>$0.51</td>
</tr>
<tr>
<td>C9298</td>
<td>G</td>
<td>9298</td>
<td>Injection, ocriplasmin</td>
<td>$1,046.75</td>
<td>$209.35</td>
</tr>
</tbody>
</table>
2. Contrast Agents – All new contrast agents are assigned HCPCS code A9698 (Non-radioactive contrast imaging material, not otherwise classified, per study) or A9700 (Supply of injectable contrast material for use in echocardiography, per study). HCPCS code A9698 or A9700 should be used to bill a new contrast agent until the new contrast agent has been granted pass-through status and a C-code has been assigned. HCPCS code A9698 is assigned status indicator “N” and, therefore, the payment for a drug assigned to HCPCS code A9698 is packaged into the payment for the associated service. The status indicator for A9700 will change from SI=B (Not paid under OPPS) to SI=N (Payment is packaged into payment for other services) and, therefore, the payment for a drug assigned to HCPCS code A9700 is packaged into the payment for the associated service.

To read Transmittal 2718 go to:

To read MLN Matters MM8338 go to:

To read Transmittal 2717 for the ASC July Payment update to go:

To read MLN Matters MM8328 for the ASC July Payment update go to:
On May 24, 2013 CMS issued Transmittal 2714 to indicate changes to Chapters 12 and 16 of the Medicare Claims Processing Manual to revise instructions regarding the Technical Component (TC) of pathology services furnished to hospital patients. This change request was issued to communicate the changes made in each section so that they contain the up-to-date instruction for the billing of the technical component of physician pathology services furnished to hospital patients. It is noted that effective July 1, 2012 an independent laboratory may not bill for the TC of a physician pathology service furnished to a hospital inpatient or outpatient. It further clarifies that payment will be made under the physician fee schedule for TC services furnished in institutional settings such as Ambulatory Surgery Centers where the TC service is not bundled into the facility payment.

Use of a Rubber Stamp for Signature

On May 17, 2013 CMS issued Transmittal 465 effective June 18, 2013, to clarify the use of a rubber stamp for signature to be in accordance with the Rehabilitation Act of 1973. Please note below the new language that has been added to 3.3.2.4 – Signature Requirements, of the Program Integrity Manual.

**EXCEPTION 4:** CMS would permit use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that they have reviewed the document.


CMS released Transmittal 2730 on June 20, 2013 to update the coding requirements for Laboratory Specimen collections in The Medicare Claims Processing Manual Chapter 16, Section 60.1.4. Effective July 16, 2013, the following HCPCS codes and terminology must be used:

- 36415 – Collection of venous blood by venipuncture
- P9615 – Catheterization for collection of specimen(s).

This update is being released to address questions CMS has received from the laboratory industry. The allowed amount for specimen collection in each of the above circumstances is included in the laboratory fee schedule.

To read Transmittal 2730 go to:

Effective April 3, 2013 with an implementation date of July 16, 2013, CMS will expand coverage of OPT with verteporfin for “wet” AMD. They are also revising the requirements for testing to permit either optical coherence tomography (OCT) or FA to assess response to treatment. These changes are being made to The Medicare Claims Processing Manual, Chapter 32 – Billing Requirements for Special Services.

To read Transmittal 2728 to go:

To read MLN Matters MM8292 go to:
Ambulance Payment Reduction for Non-Emergency Basic Life Support (BLS) Transports to and from Renal Dialysis Facilities

Transmittal 2703 was released by CMS on May 10, 2013 to update changes as required by Section 637 of the American Taxpayer Relief Act of 2012. Effective with transports occurring on and after October 1, 2013 there will be a 10% reduction in fee schedule payments for the non-emergency transport of individuals with ESRD to and from renal dialysis. This includes transports to and from both hospital based and freestanding dialysis treatment facilities. These changes are noted in The Medicare Claims Processing Manual Chapter 15 – Ambulance Section 20.6.


New Data Reporting Requirements on Home Health Prospective Payment System (HHPPS) Claims

Effective with Home Health episodes beginning on or after July 1, 2013, home health agencies must report new codes indicating the location of where the services were provided and indicate if the services were added to the home health care plan by a physician that did not certify the plan of care. The HCPCS codes for the location of services are:

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5001</td>
<td>Hospice or home health care provided in patient’s home/residence</td>
</tr>
<tr>
<td>Q5002</td>
<td>Hospice or home health care provided in assisted living facility</td>
</tr>
<tr>
<td>Q5009</td>
<td>Hospice or home health care provided in place not otherwise specified (NO)</td>
</tr>
</tbody>
</table>


Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

Effective July 1, 2013 the following HCPCS codes will be added to the Home Health consolidated billing therapy code list:

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0456</td>
<td>Negative pressure wound therapy, (e.g., vacuum assisted draining collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session, total wound(s) surface area less than or equal to 50 square centimeters</td>
</tr>
<tr>
<td>G0457</td>
<td>Negative pressure wound therapy, (e.g., vacuum assisted draining collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session, total wound(s) surface area greater than 50 sq. cm.</td>
</tr>
</tbody>
</table>


Effective July 1, 2013 ESRD facilities will be required to append the **JE (Administered via Dialysate)** modifier to all ESRD claims where drugs and biological are furnished to ESRD beneficiaries via the dialysate solution.


Q: We have several clients that are inquiring into the proper way in which to bill for 77417 – Therapeutic radiology port film(s).

A: Per the Medicare Claims Processing Manual Chapter 13, Section 70.3 carriers pay for this TC service on a weekly (five fractions) basis for radiation treatment delivery. Upon additional research with the various carriers it is concluded that this service cannot be billed in multiple units. We have included the links to the Medicare Claims Processing Manual, Noridian Medicare, and Novitas for authoritative guidance. While not an authoritative source, we are also including the link to the American Society for Radiation Oncology (ASTRO) for their opinion regarding the coding and billing of Therapeutic Radiology Port Films.

https://www.astro.org/Practice-Management/Radiation-Oncology-Coding/Coding-Guidance/IGRT.aspx