HMI Corporation
A Subsidiary of Healthcare Provider Services

Coding & Billing for Prospective Payment Systems

October 2013 Update of Hospital OPPS

Influenza Vaccine for 2013-2014 Season

Q & A

HHA Requirements for Certifying Physician

Table of Contents:

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.

155 Franklin Road
Suite 100
Brentwood, TN 37027
Phone: 615-661-5145
Fax: 615-661-5147
Email: info@hmi-corp.com
Website: www.hmi-corp.com

October 2013 OPPS Update

The following summarizes CMS updates to the Outpatient Prospective Payment System (OPPS) for October 1, 2013:

- Code 90685 was effective January 1, 2013, however, the flu vaccine associated with this code was not approved by the FDA until recently. Fluzone (Influenza virus vaccine) was approved by the FDA on June 7, 2013. CMS revised the status indicator for code 90685 from "E" (Not paid by Medicare) to "L" (Influenza Vaccine; Pneumococcal Pneumonia Vaccine) effective June 7, 2013.
- Effective October 1, 2013, the status indicators for HCPCS code Q4135 (Mediskin, per square centimeter) and HCPCS code Q4136 (Ez-derm, per square centimeter) will change from SI "E" (not paid by Medicare when submitted on outpatient claims (any outpatient bill type)) to SI "K" (paid under OPPS; separate APC payment). For the remainder of CY 2013, HCPCS code Q4135 and HCPCS code Q4136 will be separately paid and the prices for these codes will be updated on a quarterly basis.
- The payment rate for J1566 was incorrect in the July 2013 OPPS Pricer. The corrected payment rate is $30.66 (copayment $6.13) and has been installed in the October 2013 OPPS Pricer, effective for services furnished on July 1, 2013 through September 30, 2013.
- New Device Pass-through code C1841 (Retinal prosthesis, includes all internal and external components) has been assigned to status indicator H.
- New Drug/Biological codes C1204 (Technetium Tc 99m tilmanocept, diagnostic, up to 0.5 millicuries) has been assigned to status indicator G with estimated payment rate of $5,578 and C9132 (Prothrombin complex concentrate (human), Kcentra, per i.u. of Factor IX activity) has been assigned to status indicator G with estimated payment $1.92.

Source: CMS Transmittal 2775, August 23, 2013
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2775CP.pdf

ICD-10 Local Coverage Determinations (LCDs)

All ICD-10 LCDs and associated ICD-10 Articles shall be published on the MCD no later than April 10, 2014. Therefore, contractors shall have all changes in the Local Coverage Backend (LCBE) database by April 6, 2014. All other LCDs and Articles (e.g., does not contain ICD-10 information, or Articles not attached to an LCD) shall be published on the MCD no later than September 4, 2014. Therefore, contractors shall have all changes in the LCBE by August 31, 2014. All LCDs and Articles will receive a new LCD/ Article ID number (e.g., LCD ID 1234 will become LCD ID 4567). The new LCD/Article ID number could have an impact on Medicare Administrative Contractors (MACs) local systems; such as changing their Medicare Summary Notice (MSN) to capture the new LCD/Article ID number. The Centers for Medicare & Medicaid (CMS) has determined that although new LCD numbers will be assigned to the ICD-10 LCD policies, the policies shall not be considered new policies. CMS considers this type of update to be a coding revision that does not change the intent of coverage/non-coverage within an LCD. Therefore, if a MAC only translates ICD-9 codes to the appropriate ICD-10 code, the policy does not need to be vetted through their Carrier Advisory Committee or be sent through the public Comment and notice process. However, if a MAC decides to revise more than just the ICD-10 code(s), they shall follow the normal LCD development process outlined in Pub. 100-08, Chapter 13.

Source: CMS Transmittal 1293, September 6, 2013
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1293OTN.pdf

Data Reporting Requirements for Hospice Claims

Medicare hospices shall report line-item visit data for hospice staff providing general inpatient care (GIP) to hospice patients in skilled nursing facilities (site of service HCPCS code Q5004) or in hospitals (site of service HCPCS codes Q5005, Q5007, Q5008). This includes visits by hospice nurses, aides, social workers, physical therapists, occupational therapists, and speech -language pathologists, on a line-item basis, with visit and visit length reported as is done for the home levels of care. It also includes certain calls by hospice social workers (as described in CR 6440, Transmittal 1738, dated May 15, 2009), on a line-item basis, with call and call length reported as is done for the home levels of care. CMS is not changing the existing GIP visit reporting requirements when the site of service is a hospice inpatient unit (site of service HCPCS code Q5006). For all visit/call reporting, only report visits/calls by the paid hospice staff; do not report visits by non-hospice staff.

Hospices shall report the National Provider Identifier (NPI) of any nursing facility, hospital, or hospice inpatient facility where the patient is receiving services, regardless of the level of care provided, when the site of service is not the billing hospice. In compliance with the 837i requirements, the billing hospice must report the name, address, and NPI of the service facility where the service is being performed when the service is not performed at the same location as the billing hospice's location. When the patient has received care in more than one facility during the billing month, the hospice reports the NPI of the facility where the patient was last treated.

Hospices shall report visits and length of visits (rounded to the nearest 15 minute increment), for nurses, aides, social workers, and therapists who are employed by the hospice, that occur on the date of death, after the patient has passed away. Due to system limitations with reporting services after the date of the death, post mortem visits occurring on a date subsequent to the date of death are not to be reported. Visits occurring after death, and on the date of death, would need to be reported using a PM modifier to differentiate them from visits occurring before death. The reporting of post-mortem visits, on the date of death, should occur regardless of the patient's level of care or site of service.
Hospice agencies shall report injectable and non-injectable prescription drugs on their claims. Both injectable and non-injectable prescription drugs should be reported on claims on a line-item basis per fill. Over-the-counter drugs are not to be reported at this time.

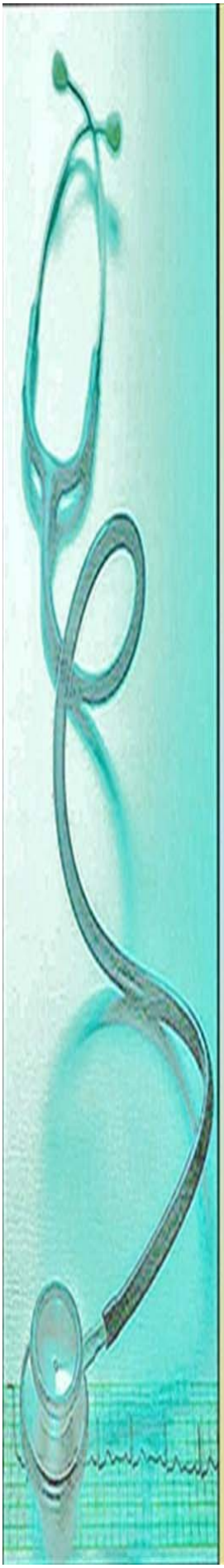
Hospice agencies shall report infusion pumps (a type of DME) on a line-item basis for each pump order and for each medication refill. DME other than infusion pumps, and medical supplies are not to be reported at this time.
CMS is not making any changes to the existing claims requirements for physician billing.

Coding for claims reporting:

- Hospice staff provided GIP visit reporting: Code appropriate visit revenue code + HCPCS for the discipline + Units of 15 minute increments, when site of service = Q5004, Q5005, Q5007, or Q5008.
- Other provider NPI reporting: Other Provider Location Loop 2310 E (Only required on the 5010 Electronic Claim). Required for hospice claims reporting site of service HCPCS Q5003, Q5004, Q5005, Q5006 when not the same as the billing hospice, Q5007 and Q5008.
- Post-mortem visits: Code appropriate visit revenue code + HCPCS for the discipline + PM Modifier + Units of 15 minute increments.
- Injectable drugs: Report on a line-item basis per fill, using revenue code 0636 and the appropriate HCPCS code, with units representing the amount filled (i.e. if says Q1234 Drug 100mg and the fill was for 200 mg, units reported = 2).
- Non-injectable prescriptions: Report on a line-item basis per fill, using revenue code 0250 and the National Drug Code (NDC). The NDC qualifier represents the quantity of the drug filled, and should be reported as the unit measure.
- Infusion pumps: Report on the claim on a line-item basis per pump order and per medication refill, using revenue code 029X for the equipment and 0294 for the drugs along with the appropriate HCPCS.

Source: CMS Transmittal 2747, July 26, 2013

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2747CP.pdf



HOSPICE DEMAND BILLING

The Advanced Beneficiary Notice of Non-coverage (ABN), Form CMS-R-131, is issued by the hospice to Medicare beneficiaries in situations where Medicare payment is expected to be denied. ABN issuance is mandatory when the level of hospice care is determined to be not reasonable or medically necessary as defined in §1862(a)(1)(A) or §1862(a)(1)(C). When a Medicare hospice beneficiary has been receiving covered general inpatient care (GIP) and the hospice determines that continued hospice GIP care is not reasonable and medically necessary, the provider must issue an ABN if the beneficiary wants to continue receiving the level of hospice care that likely won't be covered by Medicare. The beneficiary may indicate on the ABN that Medicare be billed for a determination. Billing instructions for demand bills associated with ABN issuance are provided in CMS Publication 100-4 Claims Processing Manual, Chapter 1 General Billing Requirements, section 60.4.1 Outpatient Billing with an ABN (Occurrence Code 32). The occurrence code 32 is reported on the claim with the date the ABN was provided to the beneficiary. The services in question are submitted as covered services and when billing for both ABN related and non-ABN related services, the hospice appends the GA modifier to the line item(s) related to the ABN. Hospices should be aware Medicare may require suspension of any claims using Occurrence Code 32 for medical review of covered charges associated with an ABN.

Medicare contractors reviewing GIP reported on a hospice claim with an ABN provided may conclude the care is not reasonable and medically necessary. When the Medicare contractor makes the non-coverage determination, they must non-cover the line item(s) on the claim. However, since hospices may be paid the routine home care (RHC) rate in lieu of the denied GIP service, the Medicare contractor must also add a line item for RHC (revenue code 0651) for each denied GIP line. The charges associated with the added RHC line should be the RHC rate the hospice reports on their claim or in the absence of hospice submitted RHC line items, the Medicare contractor shall enter the RHC base rate. Medicare systems shall allow a hospice claim with GIP and RHC reported with the same line item date of service when at least one of the line items is non-covered. Both line items may not be covered.

There are no changes in policy. The following will continue to be applicable:

- Medicare contractors shall allow a hospice claim (type of bill 81x, 82x) with revenue code 0656 and 0651 reported with the same line item date of service when at least one of the line items is non-covered.
- Medicare contractors shall add a covered RHC line for each denied GIP line item denied when an ABN was provided:

1. RHC revenue code 0651
2. Charges associated with the added RHC line shall be the charges associated with RHC reported by the hospice on their claim or in the absence of hospice submitted RHC line items, the contractor shall enter the RHC base rate

Source: CMS Transmittal 2748, July 26, 2013
http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2748CP.pdf

Positron Emission Tomography

On July 11, 2012, the Centers for Medicare & Medicaid Services (CMS) opened a reconsideration of Pub 100-03, the National Coverage Determinations (NCD) Manual, section 220.6, to review coverage of positron emission tomography (PET).

PET is a minimally-invasive diagnostic imaging procedure used to evaluate normal tissue as well as in diseased tissues in conditions such as cancer, ischemic heart disease, and some neurologic disorders.

Section 220.6 of the NCD currently identifies FDG (2-deoxy-2-[F-18] fluoro-D-Glucose (fluorodeoxyglucose)), NaF-18 (fluorine-18 labeled sodium fluoride), ammonia N-13, and rubidium-82 (Rb-82) as the only nationally covered radiopharmaceuticals (also known as radioisotopes or tracers) for certain defined uses in PET. All remaining uses of PET are nationally noncovered. CMS reconsidered section 220.6 of the NCD manual regarding these remaining noncovered uses of PET.

The decision did not change coverage for any uses of PET using radiopharmceuticals FDG (2-deoxy-2-[F-18] fluoro-D-Glucose (fluorodeoxyglucose)), NaF-18 (fluorine-18 labeled sodium fluoride), ammonia N-13, or rubidium-82 (Rb-82). This does not prevent CMS from determining national coverage for any uses of any radiopharmaceuticals in the future, and if such determinations are made, a future determination would supersede local contractor determination.

Effective for dates of service on or after March 7, 2013, local Medicare Administrative Contractors (MACs) may determine coverage within their respective jurisdictions for positron emission tomography (PET) using radiopharmaceuticals for their Food and Drug Administration (FDA) approved labeled indications for oncologic imaging. CMS emphasized the following points:

1. Changing the restrictive language of prior PET decisions will not by itself suffice to expand Medicare coverage to new PET radiopharmaceuticals.
2. The scope of this change extends only to FDA-approved indications for oncologic uses of PET tracers.
3. This change does not include screening uses of PET scanning.

When the local MAC determines that a claim for PET using radiopharmaceuticals for their FDA approved labeled indications for oncologic imaging is noncovered, the following messages shall be used to deny the claim:

- Claim Adjustment Reason Code (CARC) 167: This (these) diagnosis(es) is(are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Medicare Summary Notice (MSN) 15.4: The information provided does not support the need for this service or item.
- If the service is submitted with a GA modifier indicating there is a signed Advance Beneficiary Notice (ABN) on file, contractors shall use group code PR (patient responsibility) and the liability falls to the beneficiary
- If the service is submitted with a GZ modifier indicating no ABN was provided, contractors shall use group code CO (contractual obligation) and the liability falls to the provider.

Source: CMS Transmittal 2750, August 2, 1013 and CMS Transmittal 156, August 2, 2013

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2750CP.pdf

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R156NCD.pdf

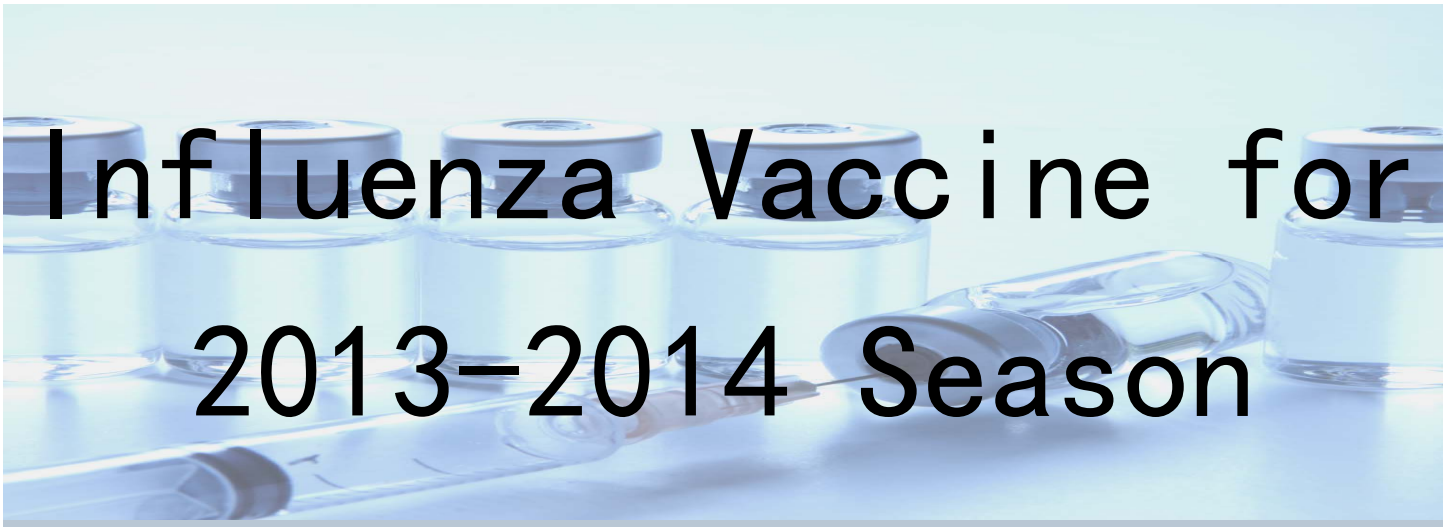
Advance Beneficiary Notice (ABN) Update
ABNs have been required to inform beneficiaries in Original Medicare about possible non-covered charges when limitation of liability applies. The Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296 is being discontinued, and home health agencies (HHAs) will now use the ABN for liability notification. The transmittal serves to provide instructions specific to HHA use of the ABN and will further clarify the current manual instructions on ABN use in Pub. 100-04, Medicare Claims Processing Manual, Chapter 30, Section 50. The instructions also address use of the ABN for outpatient therapy services.

The manual instructions are in effect December 9, 2013 and have been updated as follows:

> "Provider use of the ABN has expanded to include home health agency (HHA) issuance for Part A and Part B items and services. The ABN will replace the Home Health Advance Beneficiary Notice (HHABN), Form CMS-R-296, Option Box 1 issued by HHAs. The mandatory date for HHAs to use the ABN instead of the HHABN, Option Box 1 will be posted on the web link for home health notices found at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html. Information specific to HHA use of the ABN has been added in §50.15.4. The guidelines for ABN use published in this section and the ABN form instructions apply to HHAs unless noted otherwise."
>
> Mandatory use of the ABN has been updated as follows:
>
> "• §1879(g)(1) of the Act (home health services requirements are not met – not confined to the home or no need for intermittent skilled nursing care).
> • §1833(g)(5) of the Act (when outpatient therapy services are in excess of therapy cap amounts and don't qualify for a therapy cap exception – effective January 1, 2013)."
> "When Medicare considers an item or service experimental (e.g., a "Research Use Only" or "Investigational Use Only" laboratory test), payment for the experimental item or service is denied under §1862(a)(1) of the Act as not reasonable and necessary. In circumstances such as this, the beneficiary must be given an ABN."
> "Therapists are required to issue the ABN to beneficiaries prior to providing therapy that is not medically reasonable and necessary regardless of the therapy cap. Statutory changes (described in the section above) mandate ABN issuance when therapy services that aren't medically reasonable and necessary exceed the cap amount. Policies for mandatory ABN issuance for services below the therapy cap remain unchanged. If a beneficiary will be getting therapy services that won't be covered by Medicare because the services aren't medically necessary, an ABN must be issued before the services are provided so that the beneficiary can choose whether or not to get the services and accept financial responsibility for them."
>
> Outpatient Therapy Services exceeding the therapy cap:
>
> "Section 603 (c) of the ATRA amended §1833(g)(5) of the Act to provide limitation of liability protections to beneficiaries receiving outpatient therapy services on or after January 1, 2013, when services are denied and the services provided are in excess of therapy cap amounts and don't qualify for a therapy cap exception. This amendment affected financial liability for certain therapy services that exceed the cap.
>
> Prior to the ATRA, claims for therapy services at or above therapy caps that did not qualify for a coverage exception were denied as a benefit category denial, and the beneficiary was financially liable for the non-covered services. CMS had encouraged suppliers and providers to issue a voluntary ABN as a courtesy; however, ABN issuance wasn't required for the beneficiary to be held financially liable. **Now, the provider/supplier must issue a valid, mandatory ABN to the beneficiary before providing services above the cap when the therapy coverage exceptions process isn't applicable.** ABN issuance allows the provider to charge the beneficiary if Medicare doesn't pay. If the ABN isn't issued when it is required and Medicare doesn't pay the claim, the provider/supplier will be liable for the charges."

Source: Transmittal 2782, September 6, 2013

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2782CP.pdf



Influenza Vaccine for 2013-2014 Season

Payment allowances for the following seasonal influenza virus vaccines: codes 90654, 90655, 90656, 90657, 90661, 90662, 90672, 90673, 90685, 90686, 90687, and 90688, and HCPCS codes Q2033, Q2035, Q2036, Q2037, and Q2038, when payment is based on 95 percent of the Average Wholesale Price (AWP).

The Medicare Part B payment allowances below apply for the indicated effective dates:

Effective 8/1/2013 – 7/31/2014

Vaccine Code	Payment Allowance
90655	17.24
90656	12.39
90657	6.02
90661	pending
90685	23.22
90686	19.40
Q2035	11.54
Q2036	8.57
Q2037	14.96
Q2038	12.44
Q2039	pending*

*Payment allowance determined by the local claims processing contractor

Effective Date Pending – 7/31/2014

Vaccine Code	Payment Allowance
90687	pending*
90688	pending*

*Payment allowances for codes for which products have not yet been approved (including but not limited to codes 90687 and 90688) will be provided when the products have been approved and pricing information becomes available to CMS.

Payment for the following codes may be made if the local claims processing contractor determines its use is reasonable and necessary for the beneficiary, during the effective dates indicated below:

Effective 8/1/2013 – 7/31/2014

Vaccine Code	Payment Allowance
90654	18.91
90662	31.82
90672	24.59

Effective 8/1/2013 – 12/31/2013

Vaccine Code	Payment Allowance
Q2033	pending

Continued on page 10

Influenza Vaccine for 2013-2014 Season, Continued

Effective 1/1/2014 – 7/31/2014

Vaccine Code	Payment Allowance
90673	pending

The payment allowances for pneumococcal vaccines are based on 95 percent of the AWP and are updated on a quarterly basis via the Quarterly Average Sales Price (ASP) Drug Pricing Files.

The Medicare Part B payment allowance limits for influenza and pneumococcal vaccines are 95 percent of the AWP as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department, Rural Health Clinic (RHC), or Federally Qualified Health Center (FQHC). Where the vaccine is furnished in the hospital outpatient department, RHC, or FQHC, payment for the vaccine is based on reasonable cost.

Annual Part B deductible and coinsurance amounts do not apply. All physicians, non-physician practitioners and suppliers who administer the influenza virus vaccination and the pneumococcal vaccination must take assignment on the claim for the vaccine.

Source: CMS Transmittal 2786, September 13, 2013

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2786CP.pdf

HHA Requirements for Certifying Physician

Effective for dates of service on or after July 1, 2014, the home health agency (HHA) must report the National Provider Identifier (NPI) and name of the physician who certifies the patient's eligibility for home health services. The HHA must also continue to report the NPI and name of the physician who signs the patient's plan of care. In most instances, the certifying physician also signs the plan of care. However, the HHA must enter the name and NPI of both the certifying physician and the physician who signs the plan of care. The NPI should be completed for both the attending physician and the other physician fields even if the certifying physician is the same as the physician who signed the plan of care.

Medicare allows a physician (such as a hospitalist) who attends to hospitalized patients, but does not follow them into the community to: 1) Certify the need for home health care based on their face-to-face contact with patients in the hospital; 2) Initiate the orders and a plan of care for home health services, and 3) "hand off" the patients to their community-based physicians to review and sign the plan of care.

Source: CMS Transmittal 2789, September 20, 2013

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2789CP.pdf

State Operations Manual – Interpretive Guidelines for Hospitals

Medicare has updated regulations and procedures in the State Operations Manual. Specifically, Appendix A – Interpretive Guidelines for Hospitals has been updated to address use of patient's own home medications while in the hospital. This guidance should be reviewed in full by pharmacy staff, medical staff, and nursing staff to ensure compliance with procedures and documentation requirements. See link below to review Section A-0412 (updated June 6, 2013), Interpretative Guidelines 482.23 (c)(6)(i) – for hospital program for self-administration of patient's own home medications:

http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

155 Franklin Road
Suite 100
Brentwood, TN 37027
Phone: 615-661-5145
Fax: 615-661-5147
E-mail: info@hmi-corp.com
www.hmi-corp.com
Website: www.hmi-corp.com

Q: CMS proposed a new Status Indicator "J1" (OPD services paid through a comprehensive APC) for 2014. They are proposing to package into the comprehensive APC all integral, supportive, dependent, and adjunctive services provided during the delivery of a comprehensive service. Will this mean we should consider changing the way we report on our claims supplies, medications, or laboratory/diagnostic services?

A: No. While CMS is moving to developing single payments for most all outpatient (and inpatient) encounters, hospitals will continue to individually report all supportive services. The information provided on the claim and hospital cost report demonstrates to CMS your accounting of costs for doing business. They believe this single payment methodology will ensure hospitals seek out opportunities for delivering the most cost-effective medical care to its patients.

Disclaimer: This newsletter was created during the period of the government shutdown. CMS transmittals referenced are subject to further modification. Please check status of transmittals prior to implementing any coding/billing changes.