Chargemaster Corner

March 2012 Edition

The beginning of next month will usher in the 2nd quarter NCCI, MUE and OPPS updates. To help hospitals wade through the changes facing them over the next few days, March’s edition of Chargemaster Corner will explore these changes with helpful implementation hints. At first glance there doesn’t appear to be that many changes that will impact the facility’s chargemaster, but further inspection promises just the opposite. Let’s explore what faces us in the next few weeks.

NCCI Version 18.1 Update
Since 1996 the Medicare NCCI edits have been included in two separate files: 1) Column One/Column Two Correct Coding edit file, and 2) the Mutually Exclusive edit file. When searching on CMS’ website, many providers found it very cumbersome to search both files individually to determine if CPT code combinations in question generated a CCI edit. Whether contained in one or both files, the provider had to determine if the codes should or should not be reported together, or if a modifier was appropriate.

In order to simplify the use of NCCI edit files, CMS will consolidate the two edit files into the Column One/Column Two Correct Coding edit file. The edits previously contained in the Mutually Exclusive edit file are NOT being deleted but are being moved to the Column One/Column Two Correct Coding edit file.

Providers using a software product or claim scrubber to identify claims containing incorrect CPT code combinations will not be aware of any major change. Vendors will provide software updates and the April 1 updates should be transparent to most users. Effective April 1, 2012, CMS will no longer publish a Mutually Exclusive edit file on its website for either practitioner or outpatient hospital services since all active and deleted edits will appear in the single Column One/Column Two Correct Coding edit file on each website.

There continues to be two separate files for the Mutually Exclusive Edits. As of this date CMS has not indicated any intentions of combining the MUEs into a single file. Although CMS publishes most MUE values on its website, other MUE values are confidential and are for CMS and CMS Contractors’ use only. The latter group of MUE values should not be released since CMS does not publish them.

Codes Impacting the Chargemaster
Transmittal 2418, published March 2, 2012 contains the list of new CPT and HCPCS codes typically originating from the facility’s chargemaster. Pharmacy’s chargemaster will once require a brush-up should the following products be provided:

HCPCS C9288 Injection, centruroides (scorpion) immune f(ab)2 (equine), 1 vile. Centruroides immune (Anascorp) is an antivenom indicated for treatment of clinical signs of scorpion envenomation. This medicine is made from horse proteins that have been immunized with the scorpion’s venom.

HCPCS C9289 Injection, asparaginase erwinia chrysantheni, 1,000 international units (I.U.) was granted FDA approval just recently, November 2011. Also known as simply Erwinia, this drug is a component of a multi-agent chemotherapeutic regimen for the treatment of patients with acute lymphoblastic leukemia (ALL) who have developed hypersensitivity to E. coli-derived asparaginase. Facilities with oncology practices will undoubtedly find HCPCS C9289 a welcome addition to the chargemaster.

HCPCS C9290 Injection, bupivacaine liposome, 1 mg. Exparel (bupivacaine liposome injectable suspension) is a long-acting, sustained-release formulation of bupivacaine HCL, a local anesthetic widely used for treating postoperative pain. Receiving FDA approval in November 2011, Exparel is specifically indicated for administration into the surgical site to produce postsurgical analgesia.

HCPCS C9291, Injection, aflibercept, 2 mg vial. Ophthalmology clinics and practices will welcome this new HCPCS code. Also known as Eylea, this drug offers a new treatment option for adults with wet Age-Related Macular Degeneration. The FDA approved the recommended dose for Eylea to be 2 mg every 4 weeks, followed by 2 mg every 8 weeks. Payment is for the entire contents of the single-use vial, labeled as providing a 2 mg dose of aflibercept. Providers are cautioned to be sure to comply with instructions noted on the FDA-approved label. There may also be a coverage determination issued in the near future to provide payment limitations as well as reporting instructions for this specific drug.

These new HCPCS are all assigned status indicator “G”, Pass-Through Drugs and Biologicals, and will be separately paid under Medicare’s OPPS. Specific payment amounts assigned for each of the new HCPCS will be found when CMS releases the April 1 Addendum B. Should the facility already offer these specific pharmaceuticals to their patients, the chargemaster may have HCPCS C9399 Unclassified
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**New HCPCS for new Procedure**

CMS announced a new fluorescent vascular angiography procedure will be separately payable April 1, 2012. HCPCS C9733, non-ophthalmic fluorescent vascular angiography, will typically be performed in the main operating room setting. Novadaq® Technologies is the developer of real-time imaging systems used in the operating room, and is pleased to see that CMS has established C9733 for facilities to use. Referred to as SPY Imaging, most procedures using this new technology will be performed in the inpatient setting. However, when reviewing the types of procedures which could and are using SPY Imaging technology, wound care, vascular procedures and other minimally invasive surgeries may utilize the equipment in the outpatient setting.

Each year, more than 1 million Americans receive outpatient treatment for vascular diseases alone, including patients with chronic lower extremity ischemia, non-healing wounds, diabetic ulcers, pressure ulcers and peripheral vascular disease. For these patients, visual assessment of blood flow and tissue perfusion during procedures is critical to successful intervention, speedy recovery and reduced possibility of complications.

Infrared technology allows the neurosurgeon performing neurovascular procedures such as aneurysm clipping to directly visualize the blood vessels and actually see the flow of blood inside the vessels. Instead of x-rays, a special microscope with infrared vision is used for the surgery. After exposing the aneurysm or vascular abnormality by conventional microsurgical methods, a dye is injected into the IV site by the anesthesiologist. At this time the infrared video camera is activated. While in the bloodstream the dye fluoresces, or glows, at an infrared wavelength just outside the visible spectrum of light so human eyes cannot observe it.

An ICD-9-PCS procedure code already exists for coders to assign when using this technology for inpatient procedures. Procedure code 88.59 Intra-operative fluorescence vascular angiography, is reportable for Intraoperative laser arteriogram (SPY), SPY arteriogram or SPY arteriography. With the introduction of HCPCS C9733, hospitals and providers can be separately reimbursed when this fluorescent vascular imaging procedure is used in the outpatient setting.

As always, providers are encouraged to check local commercial payers’ coverage policies as well as Medicare MACs to ensure payment.

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**It Is Not Too Early To Begin Planning**

The Three-Day Payment Window is not anything new. Chargemaster Corner has discussed this controversial subject in several past editions. CMS announced the expansion of the three-day payment window in the November 28, 2011 Federal Register (CMS’ Updated Three Day Payment Window) to include hospital-owned physician practices. CMS has delayed the required implementation until July 1, 2012, but modifier PD is available for reporting now. Modifier PD, Diagnostic or related nondiagnostic item or service provided in a wholly owned or wholly operated entity to a patient who is admitted as an inpatient within 3 days, or 1 day, and wholly owned or wholly operated entities should begin to append the modifier to claims subject to the 3-day payment window at that time.

For services on and after July 1, 2012 Medicare will pay the professional component only instead of the global for physicians’ services that are clinically related to an inpatient admission which occurs within three days of the admission, which are furnished and provided in the physician practice owned/operated by the facility where the patient was admitted. Modifier PD will identify claims for related services provided within the three-day payment window of an inpatient admission.

CMS expanded the three-day payment window to apply to all diagnosis and non-diagnostic services provided within this window. This does, of course, include drug therapies, imaging and laboratory services which can be provided in the physician/clinic setting, as well as the pre-operative

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surgical visit that would normally be separate from the global surgical package.

An example of how this new reporting requirement will have on a facility’s operation and cash flow is explored. A hospital owns and operates an orthopedic clinic and sees a Medicare patient for left hip pain. Upon physical exam the physician notes pain with movement and a hip x-ray is ordered and performed in the clinic. X-ray films show a possible hairline fracture but to make sure, the physician would like the patient to get an MRI at the hospital, which cannot be scheduled until the next day. The patient’s MRI showed a much worse fracture than originally thought and patient is scheduled for ORIF the next morning. Patient was admitted and undergoes the planned procedure.

The clinic’s claim must be submitted with modifier PD for all services related to the hospital’s inpatient admission. In this example, both the E&M and left hip x-ray would be reported with this new modifier. Reimbursement for these services will be paid at the professional component rate even though the place of service (POS) was the office (POS 11). This rule does not apply to wholly owned rural health or FQHC clinics.

If the hospital owns or operates a clinic, it is the hospital’s responsibility to notify the clinic of all patients admitted with 72 hours of a physician service as well as the reason for the admission. The clinic should, therefore, hold all claims for three days to determine if any patient receiving services in the clinic were admitted to the hospital for a “clinically related service”.

Begin developing policy and procedures to prepare for this new billing requirement. Designate responsible staff to communicate with clinic personnel if computer systems are not integrated, so that all Medicare patients receiving clinic encounters can be cross-checked with hospital admissions. Hospital billing, coding and case managers as well as clinic staff should be included in educational sessions to ensure the timing of this new rule is properly implemented. Reimbursement specialists and clinic directors should be aware of the payment reductions and working together will help the facility overcome processes and obstacles. The facilities with more than one owned/operated clinic will certainly benefit for the added time to anticipate unplanned reporting obstacles. It’s not too early to start now.

Have you looked on-line for free resources to use when preparing for ICD-10-CM and ICD-10-PCS? OptumInsight’s website has “ICD-10 Coder’s Corner” and provides an overview to the ICD-10 coding system and gives focused spotlight discussions for both ICD-10-CM and ICD-10-PCS. There are even coding scenarios to test your coder’s knowledge. The link for “Coding Resources” contains a list of valuable and official resource website links for guidance and additional information.

Please take time to review the resources found on this site, and bookmark the page as updates and new coding scenarios are posted. You may find the site at:
http://www.optuminsightcoding.com/NonProd/2952/

Under “Coding Central” you will also find an archive for previous Chargemaster Corner articles as well.