May 2012 Edition

This month’s Chargemaster Corner contains the following articles:

- With or Without Anesthesia, When Resources Differ
- Rehabilitation Chargemaster-Do You Have All The Codes?
- Hospital Rehabilitation Services to be Capped!

Hope you find this edition helpful!

With Anesthesia; Without Anesthesia, What Code to Use
Occasionally when researching published and official resources on the correct CPT codes to use or references to support billed services, we find discrepancies among these citations. One is the clear definition of what comprises anesthesia services.

Per Medicare’s definition of anesthesia, Transmittal 442, January, 2005, the following is found:
For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia (“conscious sedation”), deep sedation/analgesia, and general anesthesia.
This reference is included in the Claims Processing Manual, 100-04.

Another reference often used is AHA’s Coding Clinic for HCPCS published by the American Hospital Association. In the 2012 1st Quarter Edition the following question was posed and answered:

QUESTION: When a CPT code contains the language “with anesthesia” or “requiring anesthesia” what type of anesthesia are they referring to?

ANSWER: From a CPT coding perspective, CPT codes that contain the phrases “with anesthesia” or “requiring anesthesia” indicate that the procedure requires the following types of anesthesia: general, regional, or monitored anesthesia care (MAC).

If the anesthesia provided is not general, regional or MAC, then it would be inappropriate to report a CPT code that contains the language “with anesthesia” or “requiring anesthesia” in the code descriptor.

The AHA’s reference excludes moderate/conscious sedation and local anesthesia as a type of anesthesia while Medicare includes these services with CPT codes which contain the statement “with anesthesia” in the description.

Recommendation: When references differ in opinion and guidance, and facilities have quoted these resources in charging, coding and billing policies, the facility’s Revenue Cycle and HIM Coding Professionals should coordinate with clinical departments to ensure the facility’s policies and procedures have rendered their specific opinion and interpretation of these guidelines. This will ensure that all clinical departments are utilizing the same resources and applying them consistently throughout the facility.

Rehabilitation Chargemaster—Are all Reportable Codes Found

When reviewing the clinical departments of physical, occupational and speech therapy services, the facility’s chargemaster is often lacking charge lines that are typically used to separately reportable “strapping” procedures. Located in the 29XXX CPT® code series, these specific CPT codes represent the application of restrictive tape to provide support and palliative relief of an extremity, joint or body region. For example, with the strapping an ankle/foot (CPT 29540) or thorax (CPT 29200) the physician or a medical professional, under the physician's direction, performs strapping with tape on a patient of any age.

CPT Assistant, March 2012 contained the following helpful explanation of which CPT® code should be reported for the strapping services:
Question: May applying Kinesio® tape to the shoulder be reported with the strapping codes?

Answer: Because Kinesio® tape is a supply, its application is included in the time spent in direct contact with a patient to provide either re-education of a muscle and movement or to stabilize one body area to enable improved strength or range of motion. The application of tape is usually performed in conjunction with educating the patient on various functional movement patterns. The tape is applied based on the patient’s specific patterns of weakness or strength. The tape is left in place after instruction related to movements designed for improving strength, range, and coordination is provided and documented.

However, if the purpose of the taping is to immobilize the shoulder, then the strapping codes may be appropriate as those codes describe the use of a strap or other reinforced material applied postfracture or other injury to immobilize the joint. If the taping is performed to facilitate movement by providing support, and the tape is applied specifically to enable less painful use of the shoulder and greater function (ie, restricting in some movement, facilitating others), application of tape in this manner is typically part of neuromuscular re-education (97112) or therapeutic exercise (97110), depending on the intent and the outcome desired. This includes application of Kinesio® tape or McConnell taping techniques.

Therapist’s documentation becomes extremely important when selecting the correct CPT code. The purpose of the strapping/taping should be clearly detailed in the notes and treatment plan to help ensure medical necessity and coverage is met and confirms the facility is receiving the accurate reimbursement.

Separate charges for the Kinesio® tape would be considered as a routine supply when reporting the aforementioned strapping CPT codes. After all, strapping could not be performed without the supply tape itself and facility should consider incorporating the supply costs into the charge for the modality using the supply.

Hospitals’ Therapy Services to Be Capped By Medicare

Therapy services furnished in an outpatient hospital setting have been exempt from the application of the therapy caps; however, MCTRJCA requires Original Medicare to temporarily apply the therapy caps (and related provisions) to the therapy services furnished in an outpatient hospital on/after October 1, 2012, and on/before December 31, 2012. Although claims processing requirements associated with the cap are only applicable to hospitals on/after October 1, 2012 (e.g., the exceptions process using the KX modifier or denying claims without the KX modifier if the cap is exceeded), in calculating the cap beginning October 1, 2012, claims paid for hospital outpatient therapy services since January 1, 2012, will be included.

For dates of service before October 1, 2012, limits apply to outpatient Part B therapy services furnished in all settings except outpatient hospitals, including hospital emergency departments. These excluded hospital services are reported on bill types 12x or 13x, or 85x.

Effective for dates of service on or after October 1, 2012, the limits also apply to outpatient Part B therapy services furnished in outpatient hospitals other than Critical Access Hospitals. During this period, only 12x claims with a CMS certification number in the CAH range and 85x claims are excluded. This information may be found at CMS’ Rehabilitation Transmittal 2457 (link provided).

Hospitals have been exempt from the therapy cap until now. Often felt to be an inequitable reimbursement structure, free-standing therapy centers, physician offices as well as self-employed therapists have been operating under this cap for several years. Thought to be “only a matter of time” until Medicare imposed the same therapy cap to those services provided in the hospital’s outpatient therapy department, Medicare will be implementing the therapy cap for a single quarter, October 1 through December 31, 2012, at least initially.

Critical Access Hospitals will be exempt from the therapy cap and will continue to bill and receive payment when submitted on TOB 12X and 85X.
How will hospitals monitor and keep track of the billed charges to determine when to use modifier KX? This will be a new challenge for most facilities. Billing staff are not the gatekeepers of this requirement, since charges are not monitored or watched proactively by the business office. It will most probably be the responsibility of the therapy department to determine when/if the therapy cap is close to being reached or has been exceeded. If therapists are not apprised of current charge structure for the therapies and modalities performed, charges will need to be shared. This will most probably be aside from the clinical documentation and therapist’s notes and not be included in the patient’s chart. Financial tracking tools are typically not considered a medical document and filed in the medical record, but most certainly can be part of the patient’s financial record, utilized and accessed by those staff impacted by the therapy cap. Still other hospitals do include financial documents in the medical record.

There is still time to explore, research, discuss and be ready to implement this new requirement. But time flies when staff is so busy with other issues and regulatory changes, and therapy directors should keep the implementation of the Medicare therapy payment caps in the forefront. It will be here before we know it.

We hope you enjoy receiving the Chargemaster Corner from OptumInsight. Each month OptumInsight will circulate this newsletter via e-mail to those interested parties who have provided contact information either via e-mail request or who have completed an informational form when attending a number of educational seminars conducted nationwide. Please share this e-mail with your coworkers and encourage them to contact OptumInsight via Chargemaster.corner@gmail.com. Contact information will not be shared with any other organization and used only for means of distributing this monthly newsletter. For direct contact concerning receipt of this newsletter, please e-mail your comments to the above noted e-mail address. Thank you for your interest in this monthly chargemaster newsletter and hope you find it helpful.

OptumInsight Consulting offers a variety of services to assist hospitals in the inpatient and outpatient coding and chargemaster functions including: 1) Focused and comprehensive chargemaster review; 2) continual chargemaster maintenance; 3) CPT® Coding Audits; 4) Chart-to-claim audit; 5) MS-DRG audits; 6) Educational opportunities via audioconference/onsite; 7) Physician audits, 8) ICD-10-CM/PCS Preparation and Education, 9) Denials Management, and 10) Physician educational opportunities. If you wish to receive information about any of the consulting services OptumInsight offers, please forward your inquiry to Joe.Martinez@Optum.com or phone 866-867-4248. OptumInsight – bringing you insight and expertise to your chargemaster reporting challenges. In addition, e-mail your questions and subjects you would like to be included in future articles to: Chargemaster.corner@gmail.com.

Also please remember OptumInsight can assist you in the preparation of ICD-10-CM/ICD-10-PCS. Whether doing a gap analysis, assessing financial risk, chart audits or coder and physician education, OptumInsight is prepared to meet your needs.

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.