By now your 2013 CPT books have been ordered and hopefully delivered. CMS published the OPPS Final Rule. While the HCPCS Level II books are not expected until mid-December, CMS has published the lengthy OPPS Final Rule along with the long-HCPCS description file(s). This edition of Chargemaster Corner is dedicated to several departments of the facility’s chargemaster anticipated to present several operational challenges

This year’s required coding changes are numerous and predicted to impact the facility’s chargemaster rather dramatically. Highlights of these changes are provided in this month’s edition of Chargemaster Corner.

Revised Instructional Notes in 2013
A new paragraph has been added under the section entitled “Instructions for Use of the CPT Codebook”, page x. The fourth paragraph explains that other healthcare providers, e.g. physician, qualified health care professional or individual is not all “inclusive” and not intended to indicate that other professionals may not report the service.

Since the OPPS was implemented in 2000, hospitals have struggled when interpreting CPT code descriptions and the specific reference to “physician performed”. Facilities have been instructed in the past by CMS to report the CPT code that describes the service provided, and the reference to “physician” was to be ignored. Hospitals are again reminded that the healthcare professional performing the service/procedure may report the associated CPT code, provided the service was within the professional’s scope of practice/licensure. Many of the code descriptor revisions can be attributed to the standardization of the above procedure description and is not anticipated to require chargemaster revisions.

The new 2013 CPT book does contain some notable changes. Green-colored sentences and paragraphs again represent new or changed information and readers should familiarize themselves with any notable new instructions. While the specific CPT code may not have changed, instructional notes included in the printed text may have changed, thereby impacting the use of that specific code.

Appendix B, Summary of Additions, Deletions, and Revisions, is the primary source for all “CPT” code changes for 2013. HCPCS codes are published by the Center of Medicare and Medicaid Services (CMS) four times annually, effective dates January 1, April 1, July 1 and October 1. There are over 900 CPT and HCPCS code revisions for 2013; however, not all will be impacting the charge document.

Therapy Services in 2013
CMS discussed the need to implement a reporting system to collect and analyze data for Medicare beneficiaries’ use and outcomes for therapy services. This data will be used to develop an improved payment system for rehabilitation/therapy services. The payment system would pay appropriately and similarly for efficient and effective services furnished to beneficiaries with similar conditions and functional limitations that have potential to benefit from services furnished.

To accomplish the data collection, CMS is requiring claims for therapy services to include nonpayable G-codes and modifiers which would highlight the beneficiary’s functional limitations (a) at the outset of the therapy episode, (b) at specified points during treatment, and (c) at discharge from the outpatient therapy episode of care. In addition, the therapist’s projected goal for functional status at the end of treatment would be reported on the first claim for services and periodically (every ten therapy sessions) throughout an episode of care. The new G-codes would be applicable for physical, occupational and speech-language-pathology services and would also include the present rehab modifiers of –GN, –GO and –GP. These new HCPCS codes would be reported by all hospitals (including CAH facilities), SNFs, rehabilitation agencies, CORFs, home health agencies as well as private offices and would be reported on the same claim form as the payable rehabilitation CPT codes, contain a minimal charge of a penny ($0.01), and include not only the GN, GO or GP modifier but also one of the related severity modifier (two modifiers per G-code).

Medicare is implementing these G-codes effective January 1, 2013 with a 6-month testing period. Claims that do not comply with the data reporting requirements will be returned beginning July 1, 2013. It is advisable for providers to check with their individual MACs prior to submitting these rehabilitation nonpayable codes to make sure the MAC’s claim processing systems have been modified to accept these codes.

For a more in-depth discussion, the facility is encouraged to download the 2013 Professional Final Rule and review this section, beginning on or around page 226. There is no time...
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like the present to begin analyzing the operational impact, documentation requirements and staff education. These G-codes are numerous and while the chargemaster can accommodate these codes, determining how they will be structured, specific modifiers and the use of these codes is a decision not only to be made by the rehabilitation services but all the entire revenue cycle team.

Other than the above nonpayable HCPCS “G” codes, the only CPT code changing for rehabilitation services is the deletion of CPT 29590 Denis-Browne splint strapping is deleted. Used to correct equinovarus deformity (clubfoot), it is thought the use of Denis-Brown splint strapping is no longer a current treatment method.

Cardiac Cath/Cardiology
One noticeable change when coding coronary interventions in 2013 will be the recognition of five major coronary arteries: 1) left main, 2) left anterior descending, 3) left circumflex, 4) right main, and 5) ramus intermedius artery. Transmittal 1136, effective January 1, 2013, introduces two additional modifiers, e.g. LM (left main coronary artery), and RI (ramus intermedius coronary artery). There will be five modifiers in 2013, corresponding with the five main coronary arteries, LM, LD, LC, RI and RC.

Coronary artery branches are further clarified. The new instructional notes state up to two coronary artery branches of the left anterior descending (diagonals), left circumflex (marginal), and right (posterior descending, posterolaterals) coronary arteries are recognized. As a reminder, for coding purposes, the left main and ramus intermedius coronary arteries do not have recognized branches. Percutaneous coronary interventions up to two branches of a major coronary artery are reported. If an intervention is performed in a third branch of the same major coronary artery, a separate code is not reportable.

Six (6) CPT codes have been deleted in 2013, replaced with eight (8) new codes which have been created and reported based on hierarchy and intensity of services, ranked from the lowest to the highest. As providers begin to utilize these new codes, they will recognize similarities with the new cardiac interventions with those for lower extremity interventions.

When utilizing a drug eluting stent (DES), Medicare requires the use of HCPCS G0290 Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel or G0291 Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel. Both G0290 and G0291 are deleted in 2013, replaced with nine new HCPCS codes specific for the placement/use of a DES. It is interesting to note that Medicare replicated these new procedure descriptions with those of new CPT codes 92928, 92929, 92933, 92934, 92937, and 92938. Therefore, the chargemaster can be structured with descriptions to differentiate coronary interventions utilizing an intracoronary stent versus a drug-eluting stent.

Diagnostic Radiology
Several procedures underwent descriptor revisions within the radiology chargemaster. Cervical spine x-rays will be reported based on the number of views performed. CPT 72040, Radiologic examination, spine, cervical, 3 views or less; 72050, Radiologic examination, spine, cervical 4 or 5 views; 72052, Radiologic examination, spine, cervical 6 or more views contain welcomed descriptors reflective of current physician ordering practices.

Fluoroscopy, CPT 76000/76001, descriptors have been revised to include the “physician or other qualified health care professional” noted in numerous code descriptor revisions in 2013. It is interesting that CPT 76001 Fluoroscopy, physician time more than 1 hour, assisting a nonradiologic physician (eg, nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy) will not be reportable by hospitals in 2013 due to the status indicator change from “N” (Packaged Service) to “B”. Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).

Common ordering practices seem to promote the overuse and abuse the 3D rendering CPT codes 76376-76377. CPT codes 76376, 76377 will require “concurrent supervision” of image post-processing 3D manipulation of volumetric data set and image rendering. With this revision it is felt documentation must be contained in the record to support the “concurrent” supervision requirement is met.

Description revision for ultrasound infant hips is pertinent to the inclusion of “physician or other qualified health care professional” in the 2013 code description. It is interesting the computer-aided detection codes, 77051-77052, no longer contain the “physician” must provide the further review for interpretation.

Wound Clinic
When utilizing a wound vac on patient wounds, CPT codes 97605 Negative pressure wound therapy (eg, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters and 97606 Negative pressure wound therapy (eg, vacuum assisted drainage
collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters are reported and payable. CMS created two new G-codes for wound vacuum drainage systems, but with a slightly enhanced description including the device, assessment, dressings and instructions. These codes also contain a status indicator “T” and would be reimbursed at a higher payment rate. Review of both the HOPPS and Physician Final Rules fail to find reporting directions for providers to follow when applying and utilizing this specific type of wound therapy. Providers are encouraged to continue monitoring Medicare transmittals and other communiqué as it is hoped additional reporting instructions will be provided prior to January 1, 2013. These new codes are as follows:

HCPCS G0456, Negative pressure wound therapy, (eg vacuum assisted drainage 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

HCPCS G0457, Negative pressure wound therapy, (eg vacuum assisted drainage 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.

One can see the added component with these new HCPCS codes specifically “mechanically-powered device including the provision of cartridge and dressings.

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 “Inside Track to ICD-10” 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 Central” 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.optumcoding.com/NonProd/2952/

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

And be sure to check the Optum conference agenda for the 12th annual Optum Essential’s conference November 26-29 at The Bellagio Las Vegas. The 2013 OPPS Updates will be discussed, 2013 CPT/HCPCS updates for the Chargemaster, ICD-10-CM/PCS Updates and educational sessions as well as Anatomy and Physiology focused sessions. There is something for everyone!! Check out the above website for the detailed conference schedule, speakers and other sessions to prepare you for ICD-10-CM implementation and 2013 reporting challenges!! See you there.

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