Chargemaster Corner

June 2010 Edition

Summer has arrived and so has several new and important changes impacting not only the facility’s chargemaster but also current practices clinical departments use to generate charges for services provided. The month of May came and went and Ingenix didn’t publish a “Chargemaster Corner” so we are loading up this issue with changes looming right around the corner. We hope you find this issue helpful and encourage you to forward Chargemaster Corner to colleagues who may find these enclosed discussions helpful. Thank you for all your continued support, questions and positive responses sent to us in the past.

July Updates
CMS issued several transmittals detailing new HCPCS codes eligible for separate reimbursement. Specific for drugs and biologicals, the following codes will be separately payable for services provided on and after 7/1/2010:

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>Description</th>
<th>APC</th>
<th>SI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9264*</td>
<td>Injection, tocilizumab, 1 mg</td>
<td>9264</td>
<td>G</td>
</tr>
<tr>
<td>C9265*</td>
<td>Injection, romidepsin, 1 mg</td>
<td>9265</td>
<td>G</td>
</tr>
<tr>
<td>C9266*</td>
<td>Injection, collagenase clostridium histolyticum, 0.1 mg</td>
<td>9266</td>
<td>G</td>
</tr>
<tr>
<td>C9267*</td>
<td>Injection, von Willebrand factor complex (human), Willate, per 100 IU VWF: RCO</td>
<td>9267</td>
<td>G</td>
</tr>
<tr>
<td>C9268*</td>
<td>Capsaicin, patch, 10cm2</td>
<td>9268</td>
<td>G</td>
</tr>
<tr>
<td>C9367*</td>
<td>Skin substitute, Endoform Dermal Template, per square centimeter</td>
<td>9367</td>
<td>G</td>
</tr>
</tbody>
</table>

Tocilizumab was recently approved by the FDA and is typically prescribed for treatment of rheumatoid arthritis. Also known as Actemra, when given in combination with methotrexate is providing added relief for patients with moderate to severe RA. The second drug, Romidepsin, was approved by the FDA for treatment of cutaneous T-cell lymphoma. It may also be listed in your chargemaster as Listodax and is reportable per 1 mg. The third drug listed above, C9266, is reportable per 0.1mg, and also may be referred to as Xiaflex. When injected into a Dupuytren’s contracture, it disrupts the generation of collagen which may reduce the contracture and improve range of motion. The Capsaicin patch, trade name Qutenza, provides pain relief following a shingles attack. Normally “patches” would be deemed as self-administerable drug (SAD). Several of those published “J” codes have reimbursement attached, yet CMS still classifies them as SAD. It may be a short period of time before your MAC’s SAD list is updated to include this specific product. The last HCPCS code C9367 was developed for a new biological product used for tissue repair and reconstruction. The dermal template provides support to guide the growth of cells and new tissue within a chronic wound. This product might be used in the wound clinic or surgical services as its uses include partial/full-thickness wounds, pressure ulcers, undermined wounds, surgical wounds, trauma and draining wounds. Revenue code 636 is recommended for each of the new HCPCS codes, effective July 1, 2010.

HCPCS C9262 Fludarabine phosphate, oral, 1 mg will be deleted and replaced with HCPCS Q2025, Oral fludarabine phosphate, 1 mg. Used for the treatment of relapsed B-cell chronic lymphocyte leukemia (CLL), this oral medication would not be considered as a SAD. The charge line currently containing C9262 would simply be updated, replacing the HCPCS with Q2025, continuing with revenue code 636.

Several new surgical CPT codes are available for reporting 7/1/10. Introduced on the AMA’s website the end of last year, Category III codes are updated bi-annual on this specific website. Not printed in the CPT (Current Procedural Terminology) book until the following calendar year, providers have to be aware of these new codes available January 1 and July 1 of each calendar year. Let’s discuss a few of these codes. For a complete list of all new Category III codes, please go to: http://www.ama-assn.org/ama1/pub/upload/mm/362/cptcat3codes.pdf
Chargemaster Corner

Many facilities may actually be performing several of the above procedures already. For instance, HRA (high resolution anoscopy) (0226T and 0227T) is typically performed on individuals who are at risk for genital or anal HPV infections. Similar to a PAP smear of the cervix, a colposcope is typically used, along with acetic acid, lidocaine jelly, cytology fixative, disposable forceps and disposable anoscopes (among other supplies) to obtain the specimen(s) which is then sent to pathology for examination. Up to this point, CPT 46999, Unlisted procedure, anus may have been hard-coded in the facility’s chargemaster (for both professional and technical) if performing this procedure. After July 1, the respective 0226T and 0227T must replace the unlisted CPT codes.

Several new procedures were introduced to report an exciting service offered to patients suffering from loss of facial fat, a condition that creates facial abnormalities such as severely sunken cheeks. The loss of fat can be the result of complications of HIV and/or active antiretroviral therapy, and because of this condition related to this specific disease, Medicare has issued a coverage determination that ICD-9-CM diagnosis codes 042 (HIV) and 272.6 (lipodystrophy) must be on claim for payment. HCPCS C9800 (Dermal injection procedure(s) for facial lipodystrophy syndrome (LDS) and provision of Radiesse or Sculptra dermal filler, including all items and supplies) is the new procedure for July 1, 2010 which includes both the filler product as well as the injection. Other new HCPCS include Q2026 (Injection, Radiesse, 0.1 ml), Q2027 (Injection, Sculptra, 0.1 ml), and G0429 (Dermal Filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)). Under the hospital OPPS, CMS has assigned HCPCS code C9800 to APC 0135 with a status indicator “T”. Since HCPCS code C9800 describes both the injection procedure and the dermal filler items and supplies, CMS has assigned HCPCS codes G0429, Q2026, and Q2027 to status indicator “B” to indicate that these codes are not recognized by OPPS when submitted on an outpatient hospital Part B bill type 12x or 13x. Please be advised that the same filler products may be used for facial reconstruction due to defects caused by surgery for carcinoma treatment. The above products and C9800 currently are not covered for these specific types of reconstructive procedures.

Transmittal R1980CP also discussed the payment for the administration and product for H1N1 vaccinations/administrations. This discussion provided nothing new, simply reinforced the appropriate codes to report when providing this specific type of flu immunization.

And finally, CMS reiterated the same verbiage again about the importance of reporting charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. Hospitals and providers are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the HCPCS code descriptor.

Documentation for Discarded Drugs and Biologicals

Transmittal 1962, issued April 30, 2010 with an Implementation/Effective Date July 30, 2010 has generated a lot of concern for most facilities. CMS has recognized that at times facilities administer less than the amount provided in a single use vial resulting in some of the drug being wasted/discarded. Some drugs may be available in packaged amounts that exceed the needs of an individual patient. Up to this point, Medicare has not voiced an issue when reporting the HCPCS code and units for the entire vial amount. However, it does appear those days will soon be coming to an end.

Medicare has always encouraged facilities be mindful of drug vial size so that the packaged drug size meets the needs of the patient and there is minimal amount of discard/waste. We are all familiar with this example Medicare has published as an example of when to use and charge for multi-use vial:

Example 1: Drug X is available only in a 100-unit size. A hospital schedules three Medicare patients to receive drug X on the same day within the designated shelf life of the product. An appropriate hospital staff member administers 30 units to each patient. The remaining 10 units are billed to Medicare on the account of the last patient. Therefore, 30 units are billed on behalf of the first patient seen and 30 units are billed on behalf of the second patient seen. Forty units are billed on behalf of the last patient seen because the hospital had to discard 10 units at that point.

Example 2: An appropriate hospital staff member must administer 30 units of drug X to a Medicare patient, and it is not practical to schedule another patient who requires the same drug. For example, the hospital has only one patient who requires drug X, or the hospital sees the patient for the first time and did not know the patient’s condition. The hospital bills for 100 units on behalf of the patient, and Medicare pays for 100 units.

In March’s edition of Chargemaster Corner we discussed the impact of documenting wastage which impacts several clinical departments: Pharmacy, Nursing, Infusion Center, GI Lab, Surgery, Radiology and Cath Lab to name a few.

© Ingenix 2010 Ingenix Provides The Solution For Your Chargemaster Needs June 2010
Chargemaster Corner

Transmittal 1962 states: *When a physician, hospital or other provider or supplier must discard the remainder of a single use vial or other single use package after administering a dose/quantity of the drug or biological to a Medicare patient, the program provides payment for the amount of drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label.*

Here is the operational challenge facing most hospitals today. The medication administration record (MAR) provides the “dosage” the patient was administered. The claim form shows the charge and units billed for the entire vial of medication and often does not correspond or match. It is “assumed” the difference between the MAR dosage and the billed amount represents the wastage, but in Medicare’s world there can not be any assumptions—the discarded medication amount has to be documented in the record. In hospitals where chargemaster reviews were recently completed, several indicated commercial payers were requesting pay-back of drugs not accounted for in the medical documentation, e.g. the wastage. It is only a matter of time until Medicare recognizes the savings and also decides to pursue this cost-saving opportunity. Most hospitals have not worked out the logistics on how to accomplish this documentation requirement. Pharmacy does not document in the patient’s record nor do nurses typically document wastage, only the amount of drug the patient received. Where will the wastage be documented, and by what department? Do radiology reports record the type and amount of contrast used as well as wastage? Cardiac cath also uses contrast where wastage might become a real issue. Once this problem is resolved and all systems are in sync with the medical record containing the discard/wasted amount, then we must overcome the following challenge.

*When processing claims for drugs and biologicals, local contractors may require the use of the modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded. This modifier, billed on a separate line, will provide payment for the amount of discarded drug or biological.*

In your facility, who will be able to review the record to identify discarded amount? How will the JW modifier be appended to the specific drug HCPCS codes? The chargemaster multiplies the specific HCPCS code based on dosage provided to the patient and reports the units based on the entire vial quantity, not just specific for the amount the patient received. Will we need two charge lines in the CDM…one representing the dosage the patient received and the second with the same HCPCS code containing modifier JW to represent the amount of drug wasted? It is doubtful the JW modifier will easily be accommodated by reporting from the chargemaster. Most hospitals are discussing the idea of having nurse auditors or other clinical staff with the knowledge of identifying the wastage performs this validation function and only then applying the modifier. Will all MACs adopt this requirement? CMS states individual contractors “may” require the use of this modifier. Currently communications from two MACs confirm a positive response when questioned on their requirement for use of this modifier. So be aware, it may be coming to a MAC near you sooner than we are ready.

Can you visualize what will be coming once the JW modifier is mandated? Claims data will identify those hospitals having the largest amount of drug and biological wastage when compared to other facilities. Encouraging hospitals to purchase the lowest dosage of a drug to reduce the amount of wastage, as well as pressure placed on drug vendors to package drugs in lower packaged doses will most likely be on the horizon.

If hospitals are forced to use modifier JW, consider the script your business office will need to rehearse when explaining to a patient why they were charged for drugs or biologicals thrown away and not used during their hospital service. Public perception on wastage and why they are being charged for an amount of medication they did not receive will no doubt be difficult to explain. When implementing documentation ques or verbiage for staff to utilize, be careful on using the term “wastage”. To borrow from Medicare’s phrase “discarded” may be somewhat better, but may still not be a popular phrase with the patient population. Perhaps a team approach to include physician representation, compliance, ancillary staff as well as IT/IS may result in a solution to this challenge. Ingenix has not found a hospital that has yet met the documentation challenge of recording discarded drugs. And as such, no facility is prepared on how to report the JW modifier should/when it becomes mandatory. Many facilities state their Pyxis machines record wastage for controlled narcotics, however, this wastage is required to be recorded and kept in pharmacy and is not part of the patient’s medical record. But perhaps these automated functions used for one application can certainly be modified or applied to this new reporting requirement. This would be very helpful if any discarded or wasted drug entered into Pyxis would be reflected in the patient’s medical record.

**Determining Self-Administration of Drug or Biologicals**

It seems drugs, pharmaceuticals and biologicals are the main theme of June’s Chargemaster Corner. When determining whether a drug is or is not a self-administerable, Medicare has stated it is not the route the medication is administered to the patient but rather, the
Medicare interprets and determines if an injectable drug Medicare payment for it”. From coverage and the contractor may not make any 50% of Medicare beneficiaries, the drug is excluded therefore, if a drug is self-administered by more than the time for all Medicare beneficiaries who use the drug. Therefore, if a drug is self-administered by more than 50% of Medicare beneficiaries, the drug is excluded from coverage and the contractor may not make any Medicare payment for it”. This statement is how Medicare interprets and determines if an injectable drug will be or will not be classified as self-administered.

Many hospitals are missing a unique component when identifying their self-administered drugs in their chargemaster. While they may have done a fabulous job identifying all self-administered drugs, many hospitals have also coded “supply” drugs as self-administered drugs. CMS has defined supply drugs as those drugs that are so integral to the treatment or procedure performed that the treatment and/or procedure could not be performed without them. Because such importance is placed on the use of these otherwise self-administered drugs, the APC Final Rule 2003 provided detail and rationale as to why CMS now considers these drugs as “supply drugs.” Facilities that perform cataract procedures use ophthalmic drops to dilate the eyes and prepare the eye for the surgical procedure. These eye drops are often identified as “self administered” in the chargemaster. They qualify as supply drugs, reportable with revenue code 250. Inhalant medications (albuterol, for example) used with respiratory treatments also qualify as supply drugs. Inhalers, however, should remain as self-administerable. CMS further includes topical solutions such as marcaine, lidocaine, antibiotic ointments such as bacitracin placed on a wound or surgical incision at the completion of a procedure as supply drugs. The next question is how to identify those drugs used with a surgical procedure? Pharmacy is the best resource to assist in identifying these “supply drugs”. Some of these topical drugs, for example, may not always be used with a procedure. These same drugs may be used in other clinical settings in which they would be reportable as SAD. What happens then? Most hospitals agree that if 80% of the time these drugs are identified as supply drugs, and 20% of the time they would be self-administered, the facility could deem them as supply drugs. Transmittal 123, Section 50.2, Paragraph C states “For the purposes of applying this exclusion, the term “usually” means more than 50% of the time for all Medicare beneficiaries who use the drug. Therefore, if a drug is self-administered by more than 50% of Medicare beneficiaries, the drug is excluded from coverage and the contractor may not make any Medicare payment for it”. This statement is how Medicare interprets and determines if an injectable drug will be or will not be classified as self-administered.

The 80/20 is definitely stricter in the guideline but can certainly help determine when to assign the specific pharmaceutical as self-administered. Please be reminded that supply drugs would be reported with revenue code 250 and are not the patient’s financial responsibility. While net reimbursement will not be recognized by the facility, those drugs formerly reported as self-administered were never submitted to Medicare as covered charges in the past. And for those facilities attempting to bill the patient and receive payment for these non-covered drugs (and field the angry phone calls) relieve the financial burden from the patient by reclassifying these drugs from SAD to supply drugs.

This transmittal states that should the patient disagree with the facilities identification of self-administered drugs, the beneficiary may appeal the denial. CMS also states the physician or provider may charge the beneficiary for an excluded drug. Each contractor must report to CMS its complete list of injectable drugs determined as self-administered and this list must also be posted on their website.

Hope you enjoy receiving the Chargemaster Corner from Ingenix. Each month this newsletter will be circulated 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 co-workers and encourage them to contact Ingenix 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 CDM newsletter and hope you find it helpful.

Ingenix 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) Educational opportunities via audioconference/onsite; 6) Physician audits, 7) Denials Management, and 8) physician educational opportunities. If you wish to receive information about any of the consulting services Ingenix offers, please forward your inquiry to Joe.Martinez@ingenix.com or phone 866-867-4248. Ingenix – 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.