June 2013 Edition

We will focus on Transmittal 2718, CR 8338, dated June 7, 2013 – July 2013 Update of the Hospital Outpatient Prospective Payment System (OPPS) in this edition of Chargemaster Corner. Be sure to read the full transmittal and MLN Matters articles for further details. The July 2013 OPPS update does impact the facility’s chargemaster, specifically pharmacy, surgical implants, cardiology as well as the billing and HIM coding staff. After review of the complete July OPPS Update, feel free to contact Optum with questions regarding the new rules and regulations.

Changes to Device Edits

New HCPCS code C9736 Laparoscopy, surgical, radiofrequency ablation of uterine fibroid(s), including intraoperative guidance and monitoring, when performed is added to the Device Edits list and can be found under “Device, Radionabeled Product, and Procedure Edits” at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/ on the CMS website.

New long descriptor for C9734 Focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with magnetic resonance (MR) guidance is effective July 1, 2013. HCPCS code C9734 must be performed with Magnetic Resonance Guidance.

Deletion of HCPCS Code C1879 and Use of A4648

CMS will delete HCPCS C1879 Tissue marker, implantable, any type. Consistent with the CMS general policy of using permanent HCPCS codes rather than using temporary HCPCS codes under the OPPS in order to streamline coding, CMS is deleting HCPCS code C1879 (Tissue marker, implantable) on June 30, 2013, because it is described by HCPCS code A4648 (Tissue marker, implantable, any type). Therefore, effective July 1, 2013, when using implantable tissue markers with any services provided in the OPPS, providers should report the use and cost of the implantable tissue marker with HCPCS code A4648 only. Typically used with breast biopsy procedures, the facility may see this implantable device used with other invasive surgical procedures. As with C1879, the revenue code for A4648 should be reported with revenue code 0278, Implantable.

New Category III Codes

For the July 2013 update, CMS is recognizing six Category III CPT Codes the AMA released in January 2013. Of the six, four Category III CPT Codes are separately payable by Medicare:

- 0329T Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report, Status Indicator – E, APC – N/A (Excluded from Medicare coverage)
- 0330T Tear film imaging, unilateral or bilateral, with interpretation and report, Status Indicator – S, APC – 230,
- 0331T Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; Status Indicator – S, APC – 398,
- 0332T Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT, Status Indicator – S, APC – 398,
- 0333T Visual evoked potential, screening of visual acuity, automated, Status Indicator – E, APC – N/A, (Excluded from Medicare coverage)
- 0334T Sacroiliac joint stabilization for arthrodesis, percutaneous or minimally invasive (indirect visualization), includes obtaining and applying autograft or allograft (structural or morselized), when performed, includes image guidance when performed (e.g., CT or fluoroscopic), Status Indicator – T, APC – 208.

Drugs, Biologicals, and Radiopharmaceuticals

In the CY 2013 OPPS/ASC final rule with comment period, CMS stated that payments for drugs and biologicals on Average Sales Price (ASP) will be updated on a quarterly basis as later quarter ASP submissions become available. In cases where adjustments to payment rates are necessary based on the most recent ASP submissions, CMS will incorporate changes to the payment rates in the July 2013 release of the OPPS Pricer. The updated payment rates, effective July 1, 2013 may be found included in the July 2013 update of OPPS Addendum A and Addendum B. As of this date (middle of June), CMS has not published these Addendums so providers will have to recheck back towards the end of the month.
Two new drugs have been granted OPPS pass-through status effective July 1, 2013. These items, descriptions, and APC assignments are as follows:

C9131 Injection, ado-trastuzumab emtansine, 1 mg, APC 9131, Status Indicator – G

Q4122 Dermacell, per square centimeter, APC 1419, Status Indicator - G

For the July 2013 update, the HCPCS Workgroup established HCPCS code Q2033 to describe Flublok. CMS is assigning the OPPS status indicator “L” (Influenza Vaccine; Pneumococcal Pneumonia Vaccine) to HCPCS code Q2033 effective July 1, 2013. Prior to July 1, 2013, the appropriate code to report for Flublok would be an unlisted CPT/HCPCS vaccine code.

Fluarix Quadrivalent (Influenza virus vaccine) was approved by the FDA on December 14, 2012, and is described by CPT code 90686. Because of the timing of the FDA approval, CMS was unable to assign CPT code 90686 to a separately payable status. For the July 2013 update, CMS is revising the OPPS status indicator for CPT code 90686 from “E” (Not Covered by Medicare) to “L” (Influenza Vaccine; Pneumococcal Pneumonia Vaccine) effective January 1, 2013. Prior to January 1, 2013, the appropriate code to report for Fluarix Quadrivalent would be an unlisted CPT/HCPCS vaccine code.

Two new HCPCS codes have been created for reporting certain drugs and biologicals (other than new pass-through drugs and biological previously listed) in the hospital outpatient setting for July 1, 2013. These codes are listed are effective for services furnished on or after July 1, 2013.

Q2050* Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10 mg, APC – 7046, Status Indicator – K

Q2051** Injection, Zoledronic Acid, Not Otherwise specified, 1 mg, APC – 1356, Status Indicator – K

*HCPCS code J9002 (Injection, Doxorubicin Hydrochloride, Liposomal, Doxil, 10 mg) will be replaced with HCPCS code Q2050 effective July 1, 2013. The status indicator for HCPCS code J9002 will change to E, “Not Payable by Medicare,” effective July 1, 2013.

** HCPCS code J3487 (Injection, Zoledronic Acid (Zometa), 1 mg) and HCPCS code J3488 (Injection, Zoledronic Acid (Reclast), 1 mg) will be replaced with HCPCS code Q2051 effective July 1, 2013. The status indicators for HCPCS codes J3487 and J3488 will change to E, “Not Payable by Medicare,” effective July 1, 2013. This is good news for J3488 at least. In June’s Chargemaster Corner it was mentioned that Medicare would no longer reimburse for Zoledronic Acid, J3488. While this is somewhat true, reimbursement will be available by reporting this medication with the new HCPCS Q2051. Unfortunately, the other two HCPCS codes will no longer be covered by Medicare.

The facility’s Wound Center will benefit from the following CMS changes. Effective July 1, 2013, the status indicators for HCPCS code Q4126 (Memoderm, dermaspan, tranzgraft or integuply, per square centimeter) and HCPCS code Q4134 (Hmatrix, 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 Q4126 and HCPCS code Q4134 will be separately paid; however, the specific reimbursement amounts will be published in Addendum B.

Updated Guidance: Billing and Payment for New Drugs, Biologicals, or Radiopharmaceuticals Approved by the FDA But Before Assignment of a Product-Specific HCPCS Code

Hospital outpatient departments are allowed to bill for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which pass-through status has not been approved and a C-code and APC payment have not been assigned using the “unclassified” drug/biological HCPCS code C9399 (Unclassified drugs or biological). Drugs that are assigned to HCPCS code C9399 are contractor priced at 95 percent of AWP.

This transmittal again reminds providers the use of C9399 is for drugs and biologicals only. For new contrast and radiopharmaceutical products, facilities are advised to use the generic HCPCS codes A4641, A9700 or A9698. Diagnostic radiopharmaceuticals and contrast agents are an exception to this transmittal and should not be billed with C9399 prior to the approval of pass-through status. Therefore, new diagnostic radiopharmaceuticals and contrast agents are an exception to the policy and should not be billed with C9399 prior to the approval of pass-through status but, instead should be billed with the appropriate “A” NOC code as follows:

Diagnostic Radiopharmaceuticals – All new diagnostic radiopharmaceuticals are assigned HCPCS code A4641 (Radiopharmaceutical, diagnostic, not otherwise classified). HCPCS code A4641 should be used to bill a new diagnostic radiopharmaceutical until the new diagnostic radiopharmaceutical has been granted pass-through status and a C-code has been assigned. HCPCS code A4641 is assigned status indicator “N” and, therefore, the payment for a diagnostic radiopharmaceutical assigned to HCPCS code A4641 is packaged into the payment for the associated service.
**Contrast Agents** - All new contrast agents are assigned HCPCS code A9698 (Non-radioactive contrast imaging material, not otherwise classified, per study) or A9700 (Supply of injectable contrast material for use in echocardiography, per study). HCPCS code A9698 or A9700 should be used to bill a new contrast agent until the new contrast agent has been granted pass-through status and a C-code has been assigned. HCPCS code A9698 is assigned status indicator “N” and, therefore, the payment for a drug assigned to HCPCS code A9698 is packaged into the payment for the associated service. The status indicator for A9700 will change from SI=B (Not paid under OPPS) to SI=N (Payment is packaged into payment for other services) and, therefore, the payment for a drug assigned to HCPCS code A9700 is packaged into the payment for the associated service.

**Coverage Determinations** – CMS reminds facilities the fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the OPPS is published, it does not imply coverage by the Medicare program, but simply indicates how the product, procedure, or service may be paid if covered by the program. Chargemaster professionals are continually challenged to ensure those HCPCS codes reported in the chargemaster are not only accurate, but the departments understand coverage determinations and requirements for reimbursement. Just because a service or supply item has a HCPCS code does not imply the facility can report that code to Medicare. Obviously some HCPCS codes are payable only when reported by certain providers, e.g. DME, Home Health, and etc. When facilities report these services on the UB-04, FIs/MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, FIs/MACs determine that it is reasonable and necessary to treat the beneficiary’s condition and whether it is excluded from payment.

The “Medicare Claims Processing Manual” (Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)) is updated by this transmittal by revising the Table of Contents and Section 61: 4.1 (Billing for Brachytherapy Sources), and by adding new Section 61.4.5 (Payment for New Brachytherapy Sources). The updated Chapter 4 is included as an attachment to CR8338, and the new Section 61.4.5 (Payment for New Brachytherapy Sources) is as follows. Please note that similar to the above discussed “not otherwise specified” codes for radiopharmaceuticals and contrast, CMS also advised providers to use generic (NOS) codes for new brachytherapy sources, C2698 and C2699.

**61.4.5-Payment for New Brachytherapy Sources** – “Not otherwise specified (NOS) Brachytherapy source codes are available for payment of new Brachytherapy sources for which source codes have not yet been established: C2698 (Brachytherapy source, stranded, not otherwise specified, per source), and C2699 (Brachytherapy source, non-stranded, not otherwise specified, per source). The payment rates for these NOS codes are based on a rate equal to the lowest stranded or non-stranded payment rate for such sources, respectively, on a per source basis (as opposed, for example, to per mCi). Once CMS establishes a new HCPCS code for a new source, the new code will be assigned to its own APC, with the payment rate set based on consideration of external data and other relevant information, until claims data are available for the standard OPPS rate making methodology.”

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**Deadline Looms for reporting Rehabilitation Functional Limitation Data (G-codes)**

Non-payable G-codes and modifiers must be included on claim forms to capture the beneficiary’s functional limitations as of July 1. All practice settings that provide outpatient therapy services must include the information on the claim form, including hospitals, critical access hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, rehabilitation agencies, home health agencies (when the patient is under a home health plan of care), and private offices of therapists, physicians and nonphysician practitioners.

Most facilities have elected to incorporate these non-reimbursed G-codes and modifiers into the physical, occupational and speech department’s chargemasters, reported with the payable CPT codes and respective revenue codes 0420, 0430 and 0440. For those chargemasters recently reviewed, Optum has discovered the facilities have “tested the waters” so to speak, by submitting test claims containing the required G-codes to the FI/MAC to ensure that “all systems are go” in anticipation of the July 1 deadline. Providers report the MACs are also prepared and are accepting these codes. Those facilities that have elected to not include these G-codes into the chargemaster have an electronic solution available through the electronic health record which can select the correct modifier(s) for those selected G-codes.

All providers will know next month that things are working smoothly and successfully. July 1 is right around the corner.

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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.

And be sure to budget and attend the Optum conference agenda for the 13th annual Optum Essential’s conference at The Cosmopolitan, Las Vegas. The 2014 OPPS Updates will be discussed, 2014 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 2014 reporting challenges!! See you there.