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NOVEMBER 2010



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Start the New Year with Updated Modifiers and Code Sets

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CHANGES AHEAD

FEATURED ARTICLE

By Renee T. Guilbeau, RHIA, CIRCC

October 2010 CPT®/HCPCS Quarterly Update

Hard to believe that we have entered the final quarter of this year and it is once again time to discuss CPT/HCPCS updates.

Only one new device pass-through category has been established by CMS effective Oct. 1, 2010: HCPCS code C1749 – Endoscope, retrograde imaging/illumination colonoscope device (implantable) – (APC 1749). This code has been assigned to status indicator (SI) H – Pass-Through Device Categories. Separate cost-based pass-through payment; not subject to copayment. C1749 is associated with two procedural APCs:

- **APC 0143** – Lower GI Endoscopy
- **APC 0158** – Colorectal Cancer Screening: Colonoscopy

For APC 0143 and 0158, no portion of the APC payment is associated with the cost of the endoscopic device, resulting in a device offset of \$0. No deductions will be made from the payment for device code C1749. The reason? The device offset, which is the amount associated with the cost of the device, is included in the APC payment amount for the procedure. The device offset amount is deducted from the pass-through payment for the device.

The following reimbursement for drugs and biologicals provides payment for both the acquisition and pharmacy overhead cost associated with the drug or biological:

Non Pass-Through ASP +4 percent
Pass-Through ASP +6 percent

Updated payment rates are listed in the October 2010 OPPS Addendum A and B. Click on the link provided to view this information: www.cms.gov/McrPartBD_rugAvgSalesPrice/01a19_2010aspfiles.asp#TopOfPage

Five new drug codes are assigned status indicator (SI) G for pass-through payment effective Oct. 1, 2010, under their associated new APCs:

- **C9269** – Injection, C-1 esterase inhibitor (human), Berinert, 10 units (APC 9269)
- **C9270** – Injection, immune globulin (Gammaplex), intravenous, non-lyophilized (e.g. liquid), 500 mg (APC 9270)
- **C9271** – Injection, velaglucerase alfa, 100 units (APC 9271)
- **C9272** – Injection, denosumab, 1 mg (APC 9272)
- **C9273** – Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF in 250 mL of Lactated Ringer's, including leukapheresis and all other preparatory procedures, per infusion (APC 9273)

**Updated payment rates are
listed in the October 2010 OPPS
Addendum A and B**

CMS has opened a National Coverage Determination analysis (NCD) for code C9273 with a final decision forthcoming in 2011. Currently, coverage decisions for Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion (Provenge), are left to the discretion of the FI/MAC.

In the long descriptor for C9273, “all other preparatory procedures,” refers to the transportation process of collecting immune cells during non-therapeutic leukapheresis, sending the cells to a manufacturing facility, and transporting the cells back for administration to the patient.

Incorrect payment rates for three CPT/HCPCS codes in the second and third quarter of 2010 are corrected in the October OPPS 2010 Pricer. Corrected payment rates and minimum unadjusted copayments are listed below:

Effective April 1–June 30, 2010

90476 – Adenovirus vaccine, type 4, live, for oral use – \$72.17/\$14.43 (SI K, APC 1254)

Effective July 1–Sept. 30, 2010

J9264 – Paclitaxel protein bound particles, 1 mg – \$9.21/\$1.84 (SI K, APC 1712)
C9268 – Capsaicin patch 10cm2 – \$25.55/\$5.01 (SI G, APC 9268)

Note: SI K is for non pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals.

MedAssets recommends that you search your data files to determine if you have been appropriately reimbursed for these three codes. If not, contact your FI/MAC with your findings.

Retroactively effective April 1, 2010, CMS has adjusted the SI for code 90670 – Pneumococcal conjugate vaccine, 13 valent, for intramuscular use – for payment at reasonable cost. The SI change is from K (paid under OPPS; separate APC payment) to SI L (Not paid under OPPS, but paid at reasonable cost; not subject to deductible or coinsurance). Again, be sure to verify correct payment for this service.

Effective Dec. 23, 2009, CPT code 90662 – Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use – is assigned SI L for payment at reasonable cost.

OPPS policy requires hospitals to report the radiolabeled product on the claim with the associated nuclear medicine scan. When the radiolabeled product is administered by another facility, the hospital performing the scanning procedure reports the radiolabeled product with the scan.

By arrangement, the hospital performing the scan reimburses the hospital that administered the radiolabeled product the appropriate amount for that product.

Magnetic Resonance Angiography (MRA)

CMS has granted local FIs/MACs the discretion to allow OPSS providers to bill for certain previously non-covered MRA services. Six new HCPCS codes have been created and must be used in place of the two existing CPT codes listed below.

72159 – Magnetic resonance angiography, spinal canal and contents, with or without contrast material(s) – will be replaced by:

- **C8931** – Magnetic resonance angiography with contrast, spinal canal and contents
- **C8932** – Magnetic resonance angiography without contrast, spinal canal and contents
- **C8933** – Magnetic resonance angiography without contrast followed by with contrast, spinal canal and contents

73225 – Magnetic resonance angiography, upper extremity, with or without contrast material(s) – will be replaced by:

- **C8934** – Magnetic resonance angiography with contrast, upper extremity
- **C8935** – Magnetic resonance angiography without contrast, upper extremity
- **C8936** – Magnetic resonance angiography without contrast followed by with contrast, upper extremity

In addition, CMS has changed the assignment of the status indicators (SIs) for CPT codes 72159 and 73225 from SI “E” to SI “B,” which means that these codes are not recognized by OPSS. The six new HCPCS codes listed above have all been assigned SI “Q3,” which means that these services will be reimbursed with one composite APC payment.

Providers may want to verify with their local FI/MAC participation in this program before updating their chargemaster.

Billing Observation on Condition Code 44 Claims

Condition Code 44 is used when a beneficiary’s status is changed from inpatient to outpatient to report the entire encounter on a hospital outpatient claim. CMS has clarified the reporting of HCPCS code G0378 – Hospital observation service, per hour – with condition Code 44.

CMS clearly states that hospitals may not report observation services under HCPCS Code G0378 for the time period during the hospital stay prior to a physician’s order for observation services.

Medicare provides a helpful example of the appropriate use of G0378 in a Condition Code 44 situation. The example states that a beneficiary is first admitted as an inpatient and receives 12 hours of nursing and monitoring care. The hospital then changes the status of the beneficiary from inpatient to outpatient, the physician has ordered and documented observation care, and all other criteria for billing under Condition Code 44 have been met. With revenue code 0762 on an uncoded line on the outpatient claim, the hospital would bill for the 12 hours of nursing and monitoring care that was provided prior to the change in status. HCPCS code G0378 would be billed for the observation services that followed the change in status.

As in the past reporting of previous CPT/HCPCS changes, you can expect more changes in 2011. For now, however, it’s best to familiarize yourself with these changes, knowing that the only change is change itself.

About the Author

Renee Guilbeau, RHIA, CIRCC, is an analyst for MedAssets and has been with the company for more than five years. Prior to this position she was an APC Coordinator & Outpatient Coding Supervisor for five years. Renee is a Registered Health Information Administrator (RHIA) with an additional credential in Interventional Radiology Cardiovascular Coding (CIRCC). She is a graduate of University of Louisiana at Lafayette. ■

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Accountable Care Organizations: Improving Quality, Lowering Costs

Have you heard about Accountable Care Organizations (ACOs) yet? Managed Care on steroids is a better way of putting this new language. Gone is the verbiage of Per Member Per Month (PMPM) that we were used to in the past and the new language creeping in is “bundled” or “global budget.” But the current idea of the ACO is simply the provision of quality care with a share in the savings.

Is there going to be a “withhold to account” for this year-end cost savings much as we saw with managed care? Only time will tell. Much like a Physician-Hospital Organization (PHO), the ACO would have to be a legal organization that could receive shared savings, and would have to incorporate primary care physicians who solely practice under the ACO.

Health Maintenance Organizations (HMOs) comprise a small percentage of the current market, and health plans in general have focused on negotiating favorable prices within relatively open networks of providers. “Virtual” organizations consist of the various physicians who are associated with local acute care hospitals. These physicians are either directly affiliated with such hospitals through

their inpatient work, or through the care patterns of the patients they serve. These multi-specialty group practices are bunched around local hospitals as an “extended hospital medical staff.”

The premise of an ACO is that this close affiliation improves quality and lowers cost and therefore should be realized by fostering greater accountability on the part of this “extended medical staff.” We did not see this with capitation, as it tended to favor one part of the partnership over the other and did not hold anyone accountable on the services rendered to the patient community.

Where did the ACO idea come from?

The phrase is attributed to Elliot Fisher, MD of Dartmouth Medical School in New Hampshire. Dr. Fisher has led the Dartmouth Atlas Project for the last 30 years. The project documented the variation in care across the United States. The Dartmouth Atlas has focused on both the quality of healthcare as well as its cost. Its findings illustrate that there exists wide variations in the cost of care across the country, and that the regions that spend more per patient do not necessarily obtain better outcomes.

Although the structure of ACOs are still being developed and debated, there are three essential characteristics of ACOs:

1. The ability to provide, and manage with patients, the continuum of care across different institutional settings, including at least ambulatory and inpatient hospital care and possibly post acute care;

2. The capability of prospectively planning budgets and resource needs; and,
3. Sufficient size to support comprehensive, valid, and reliable performance measurement.

In exchange for investing in this reformed healthcare provider structure, the ACO members would share in the savings that resulted from their cooperation and coordination. Thus, ACOs could act as a reform tool by incentivizing more efficient and effective care. This would help to combat the current incentives of overutilization (fee for service model) and overbuilding of healthcare facilities and technology, as well as break down silos that exist in the care of patients today.

There are many payment reform models that go along with the new ACO model and below are Comparison of Payment Reform Models.

Extended medical staff model

www.healthreformwatch.com/wp-content/uploads/2010/03/aco_table.jpg

Extant organizational structures that could be leveraged to create ACOs

www.healthreformwatch.com/wp-content/uploads/2010/03/aco_models_shortell1.jpg

Along with the payment models, the National Committee for Quality Assurance (NCQA) has released ACO Development Guidelines. Within those guidelines are physician-specific guidelines that I have cited below.



The organization has a Web-based physician directory that includes the following physician information to help patients and prospective patients choose physicians.

1. Name
2. Gender
3. Specialty
4. Office locations
5. Languages spoken by the physician or clinical staff
6. Board certification
7. Accepting new patients.

The organization includes the following data in its directory:

- **Name**, including both first and last name of the physician.
- **Gender**.
- **Board certification**, including a list of board certifications as reported by the ABMS and either:
 - A link directly to ABMS to verify current status, or
 - Instructions on how to check the most current board certification status by going to the ABMS Website. Links to DO board certification do not meet the intent of factor 6.
- **Acceptance of new patients** applies to general and internal medicine, family practice, pediatrics, obstetrics/gynecology and high-volume behavioral healthcare.
- **Languages spoken** by the physician or clinical staff (the organization may include office staff but must identify them as such). The organization is not required to include English in the list of spoken languages.
- **Office location**, including physical address and phone number of office locations.

Along with the above physician Web development, NCQA has included reporting criteria to be web displayed on physician performance, a physician report card.

Transparency in reporting

To facilitate understanding of the results, the organization includes detailed explanations of the measures in reports distributed to practitioners. Explanations include:

- The definition of the population included in the denominator
- A description of how individuals are placed in the numerator
- A description of the time period and how it impacts inclusions and exclusions in the numerator and denominator.

NCQA may publicly report whether the organization is transparent in reporting to clients, but does not disclose the details of the organization's methodology.

Examples: Items included in the performance reports may be: physician-ordered services, such as consultations, imaging, and ancillary services, procedures and devices utilization.

So in the end what does an ACO accomplish?

- It's all about margin, not about top line revenue
 - However, a 10 percent margin on \$750 million is better than a 5 percent margin on \$1 billion
- There will be internal winners and losers depending on ability to manage "technical risk" – those that have figured out how to manage internal variation will come out ahead.

Chasing defects is a very different activity than chasing volume – the quality leaders of today should be well-positioned to capitalize on their years of hard work.

And as I was writing this article, Anthem Blue Cross and Blue Shield of New Hampshire and Dartmouth-Hitchcock Medical Center announced that they have created a pilot program that could eventually lead to the creation of a full-fledged accountable care organization. Per Thomas A. Colacchio, MD, "The concept is to bring together the hospital, the physician group practice, and the insurance carrier all with the same goal – to provide high quality, cost-effective care to those we serve."

Of course it makes sense since Dr. Fisher is at Dartmouth.

About the Author

Denise M. Nash, MD, CCS, CIM, is the Medical Director and Product Owner for Episodes of Care for MedAssets. Denise has more than 20 years experience in the healthcare industry. She has worked for CMS in hospital auditing and has expertise in negotiation and implementation of risk contracting for managed care plans. Denise has also worked with individuals as well as physician groups on utilization improvements to improve financial performance for the risk-based contracts. She has worked with both hospitals and physician practices on the legal aspects of adding new services to the respective facilities. Denise is a consultant on compliance/HIPAA at physician practices, hospitals, and insurance plans and has worked for the OIG of New Hampshire for its Fraud and Abuse Division. ■



Taking Steps to Avoid Claim Denials

In healthcare today many hospitals are continuously trying to identify ways to improve operating practices. One of the major reasons hospitals have issues with cash flow is because of a failure to resolve claim denials in a satisfactory time frame.

To improve cash flow, hospitals must improve denial turnaround time, but most importantly, they need to prevent the denial from occurring in the first place. In order to prevent claim denials we must look at whether medical necessity is being met. According to Medicare, medical necessity is defined as “treatment that is deemed reasonable, appropriate and necessary, based on the clinical documentation.”

Areas that hospitals may develop processes to help with claim denials are in Patient Access, Business Office, Central Scheduling, Admitting/Registration and other departments. For it is in these departments that hospitals should obtain all the proper information needed to meet medical necessity prior to rendering services/or treatment.

Another other area within the hospital where good processes are needed is in the Patient Accounting department. Patient Accounting is where the account information can be reviewed after treatment, but before

a claim is submitted to Medicare or other payors for reimbursement. These processes are referred to as Pre-Service Editing and Post-Service Bill Scrubbing.

The Pre-Service Edits steps consist of the following:

- Checking to make sure ordered services are covered by Medicare or other payors. Check to make sure a physician order is present and supports medical necessity before providing the service.
- Making sure employees know how to verify medical necessity and what steps to take when documentation does not support medical necessity, before services are rendered.
- Reviewing and providing the patient with an Advance Beneficiary Notice (ABN), if the procedures will not be covered by Medicare or other private payors and informing the patient that it will be their responsibility to cover the services, if provided.

The Post-Service Scrubbing consist of these steps:

- Processing the UB-04 (CMS – 1450) claim through a bill scrubber
- Sending claims back to the Health Information Management (HIM) department, so that documentation may

be reviewed to support medical necessity or revised the diagnosis codes assigned if appropriate. Codes should never be added or removed from a claim without first reviewing the medical record

- Removing un-billable charges from the claim

These steps can often times be challenging for hospital outpatient departments to address, but are well worth the hassle. For every claim, it is important for hospitals to make certain that processes are put into place on the front end to ensure each service provided is reasonable and meets medical necessity. Medical necessity plays an important role in determining whether a claim for outpatient care is paid.

According to the Social Security Act section 1892(a) (1) (A), Medicare will not cover services that are not considered “reasonable and medically necessary as they relate to the diagnosis or treatment of an illness or injury (within the scope of a Medicare benefit category).” Medical necessity has an impact on both Medicare Part A (outpatient) and B (physician), which can be determined by looking at both the ICD-9-CM (diagnosis) and the CPT®/HCPCS procedure codes. The National Coverage Determination (NCD) and/or Local Coverage Determination (LCD)

**According to Medicare, medical necessity is defined as
“treatment that is deemed reasonable, appropriate and necessary, based on the clinical documentation.”**

policies may be reviewed for medical necessity for specific services and/or procedures. Not every CPT procedure code, however, has a NCD or LCD policy related to medical necessity although, there are many CPT procedure codes linked to ICD-9-CM, also known as code-pairs. Code-pairs identify services that if billed together would meet medical necessity. Code-pairs establish medical necessity at both the national level (CMS) and the local level (FI/MACs).

Within the NCD the Secretary of the Department of Health and Human Services determines whether or not a particular item, service or procedure is nationally covered by Medicare. The LCDs are a guide to assist hospital outpatient services in determining if a particular item, service or procedure is covered by Medicare. But, ultimately, to ensure that medical necessity is met and claims are not denied, providers need to be guided by the components of medical decision-making. This ensures the documentation contained in the medical record is complete and reasonable for the service provided, and complies with coding regulations.

To avoid denials and meet medical necessity, providers should ask the following questions:

- How and to what degree will the service be covered?
- Which ICD-9-CM and/or CPT/HCPCS codes are approved for use?
- Are there modifiers that apply to the procedure?
- Are there any limits as it relates to how many units of service can be billed?
- Are certain providers excluded from providing the service?
- What revenue codes should be used to bill for the service?

Performing the pre-service and post-service steps and asking these types of important questions should help hospital outpatient services ensure that they meet medical necessity and prevent and/or resolve claim denials. ■

About the Author

Jammarrae Summerour, MBA/HCM, CPC, is an Integrity Service Analyst for MedAssets Integrity Services. She is a certified professional coder and a member of the Greater Atlanta Chapter of American Academy of Professional Coders (AAPC). Jammarrae has more than 13 years experience in Health Information Management in areas such as Health Information Technology, Outpatient Coding, Revenue Cycle Management and Staff Management. ■

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www.cms.gov/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf

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Exclusions from Coverage and Medicare as Secondary Payer
 Retrieved October 21, 2010
www.ssa.gov/OP_Home/ssact/title18/1862.htm

Center of Medicare and Medicaid Service (CMS).

Medicare Claims Processing Manual, Chapter 30 Financial Liability Protections
www.cms.gov/manuals/downloads/clm104c30.pdf

Trade Shows & Events

HFMA Virtual Tradeshow

Dec. 1-2 • www.hfma.org/virtualconference

22nd Annual National Forum on Quality Improvement in Health Care

December 5, 2010 • www.ihc.org

Outcome Research on Smart Pumps

Presented by Blane Schilling, M.D., Senior Vice President, Pharmacy, Aspen Healthcare Metrics, a MedAssets company

ASHP Midyear Clinical Meeting

Dec. 5-9 • Anaheim, CA • Booth 253
www.ashp.org/Midyear2010

MedAssets Coding & Compliance Presentations

MedAssets Coding and Compliance Presentations are free to MedAssets clients and employees. For online registration, please [click here](#).

2011 Outpatient Prospective Payment System (OPPS) Final Rule

December 20, 2010
 11:00 AM (EST)

January 5, 2011
 2:00 PM (EST)

December 21, 2010
 2:00 PM (EST)

January 11, 2011
 11:00 AM (EST)

January 19, 2011
 2:00 PM (EST)



TALKING POINTS

By Sarah Cobb BS, CPhT, RMC

The Electronic Prescribing (eRx) Incentive Program

There is still time to take advantage of this monetary incentive

In September of this year, CMS released the new Pub.100-22, Medicare Quality Reporting Incentive programs Manual. Currently, this manual contains two chapters:

Chapter 1 – The Physician Quality Reporting Initiative (PQRI)

Chapter 2 – The Electronic Prescribing (eRx) Incentive Program

The eRx Incentive Program is a quality reporting incentive program that encourages the implementation and use of Electronic Prescribing (eRx) systems. The Electronic Prescribing Incentive Program chapter

focuses on the requirements for this program in order to obtain the associated incentive payment.

This chapter further explains that *“eRx is the transmission of prescription or prescription-related information through electronic media.*

eRx takes place between a prescriber, dispenser, pharmacy benefit manager, or health plan. It can take

place directly or through an intermediary (such as a network).”

The monetary incentive for eligible, successful e-prescribers in 2010 is two percent of their total allowed charges for professional services covered by the Medicare Part B Physician Fee Schedule. This incentive payment will decrease in the coming years. CMS states that the incentive payment will be one percent for 2011 and 2012, and even lower in 2013, which will have an incentive payment of 0.5 percent. Additionally, the eRx incentive payments are paid as a lump sum.

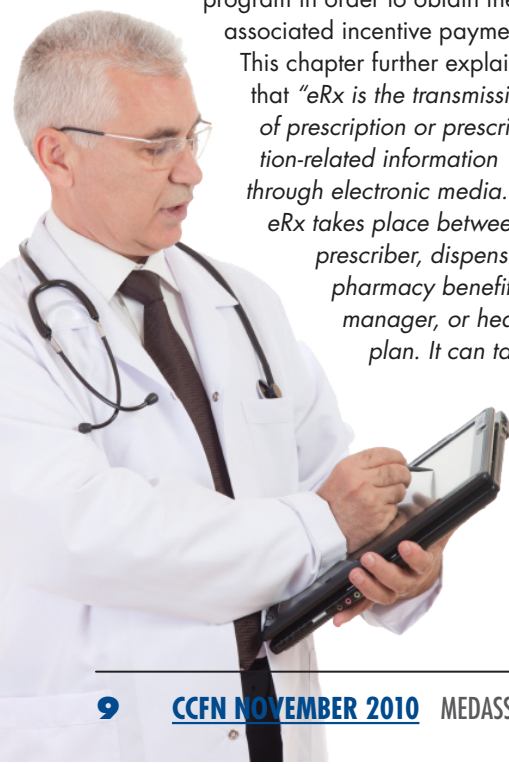
This chapter goes on to state, “The eRx incentive payment amount is calculated based on an EP’s (or group practice’s) total estimated allowed charges for all covered professional services:

1. Furnished during the applicable reporting period;
2. Received into the National Claims History (NCH) file by no later than two months after the end of the reporting period; and,
3. Paid under or based upon the Medicare PFS.”

According to the guidance provided in this chapter, it is not too late to participate in this program and receive the entire incentive for the current year, 2010. The reporting period for the eRx Incentive Program is the entire calendar year from Jan. 1 – Dec. 31, 2010. However, claims processed by the Carrier/MAC may be delivered to the National Claims History file by as late as Feb. 28, 2011.

Eligible Professionals (EPs) for the eRx Incentive Program include physicians, practitioners and therapists. Some professionals are eligible to participate, but are not able to participate as EPs in certain settings in which Medicare PFS billing is processed by Medicare Fls/AB MACs. Also, the eRx incentive does not apply to an EP (or group practice) if an incentive payment is earned under the Medicare EHR incentive program. However, the Medicare EHR incentive program does not begin until 2011. Furthermore, services that are payable under a fee schedule other than the PFS are not included in the eRx Incentive Program.

“eRx is the transmission of prescription or prescription-related information through electronic media. eRx takes place between a prescriber, dispenser, pharmacy benefit manager, or health plan. It can take place directly or through an intermediary (such as a network).”



**2011 NUMERATOR OF THE
ELECTRONIC PRESCRIBING MEASURE**

G8553 [At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system]

**2011 DENOMINATOR OF THE
ELECTRONIC PRESCRIBING MEASURE**

90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

In the Federal Register, CMS has proposed that for 2011, that a successful electronic prescriber is based on the number of times an EP reports "at least one prescription created during the encounter is generated using a qualified electronic prescribing system." The minimum number of electronic prescriptions generated to qualify is 25. This minimum has not changed, and is the same as previous years. The Federal Register also states "for the 2011 electronic prescribing measure, we propose to retain the following numerator G-code from the 2010 electronic prescribing measure's numerator: G8553 (At least 1 prescription created during the encounter was generated and transmitted electronically using a qualified electronic prescribing system.)."

The CPT®/HCPCS codes in the chart above are proposed for the numerator and denominator of the electronic prescribing measure for 2011.

If you are interested in more information, the following links provide general information regarding the 2010 eRx Incentive Program:

CMS has provided the following resources to answer inquiries regarding the PQRI and E-Prescribing (eRx) programs, incentive payments, feedback reports, and IACS registration. www.cms.gov/ERxIncentive/11_HelpDeskSupport.asp#TopOfPage

Pub 100-22 Medicare Quality Reporting Incentive programs Manual, Chapter 2 – The Electronic Prescribing (eRx) Incentive Program:

www.cms.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=1&sortOrder=ascending&itemID=CMS1236946&intNumPerPage=10

Overview of Electronic Prescribing (eRx) Incentive Program: www.cms.gov/ERxIncentive/01_overview.asp

Federal Register, Pages 40039–40718, Tuesday, July 13, 2010: edocket.access.gpo.gov/2010/pdf/2010-15900.pdf

About the Author

Sarah Cobb BS, CPhT, RMC, is a Registered Medical Coder and Nationally Certified Pharmacy Technician. As a healthcare professional, Sarah has more than 10 years of pharmacy experience. Currently, She is a Coding and CDM Analyst for Pharmacy Services with MedAssets. In this position, Sarah is responsible for maintaining the pharmacy content for MedAssets products. Sarah also provides Medicare guidance for billing and coding pharmacy services. Sarah is a graduate of Georgia State University, with a Pre-pharmacy Degree in Biology and is currently perusing her CPC-H certification. ■

Start the New Year with Updated Modifiers and Code Sets

Modifiers and code sets for next year have now been published. The AMA and CMS have both announced new modifiers and some changes to modifier descriptions. We will list the new modifiers and the changes that will be effective Jan. 1, 2011 and the guidance related to their use that has been provided to date.

New Modifiers

2011 CPT modifiers:

4P – HLA-DRB1 4Q – HLA-DRB3
4R – HLA-DRB4 4S – HLA-DRB5
4T – HLA-DQA1 4U – HLA-DPA1

Modifiers 4P – 4U are additions to the genetic modifier set, "Histocompatibility/Blood Typing/Identity/Microsatellite." Appendix I of the 2011 CPT Manual lists the full set of Genetic Testing Code Modifiers.

2011 Level II alphanumeric HCPCS modifiers:

AY – Item or service furnished to an ESRD patient that is not for the treatment of ESRD

Modifier AY will provide a way for providers to report laboratory services, certain drugs and supplies that would otherwise be subject to the consolidated billing requirement for End Stage Renal Disease (ESRD) PPS. www.cms.gov/transmittals/downloads/R2033CP.pdf

AZ – Physician providing a service in a dental health professional shortage area for the purpose of an electronic health record incentive payment

According to CMS One-Time Notification R724OTN, Modifier AZ will allow eligible professionals (EPs) to report claims for services provided in a dental HPSA when the zip code does not fully fall within the

dental HPSA. www.cms.gov/transmittals/downloads/R724OTN.pdf

CS – Item or service related, in whole or in part, to an illness, injury, or of the 2010 oil spill in the Gulf of Mexico, including but not limited to subsequent clean-up activities

DA – Oral health assessment by a licensed health professional other than a dentist

GU – Waiver of liability statement issued as required by payor policy, routine notice

NB – Nebulizer system, any type, FDA-cleared for use with specific drug

PT – Colorectal cancer screening test; converted to diagnostic test or other procedure

We have not seen specific guidance related to the use of modifiers CS, DA, GU, NB or PT.

Changes or Revisions

Modifier descriptions revised effective 1/1/2011:

GA – Waiver of liability statement issued as required by payor policy, individual case

V5 – Vascular catheter (alone or with any other vascular access)

V6 – Arteriovenous graft (or other vascular access not including a vascular catheter)

V7 – Arteriovenous fistula only (in use with two needles)

RB – Replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair

Change to Use of Modifier FB for 2011:

FB – Item Provided Without Cost to Provider, Supplier or Practitioner, or Credit Received for Replacement Device (Examples, but not limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples)

According to the 2011 OPSS Final Rule (CMS-1504-FC), CMS has finalized the proposed requirement that hospitals append modifier FB to nuclear medicine scan procedure codes when the radiopharmaceutical is supplied at no cost to the hospital. The APCs for the applicable procedures are listed in Table 29 "APCs TO WHICH NUCLEAR MEDICINE PROCEDURES ARE ASSIGNED FOR CY 2011." Table 29 is accessible in the Preambles Tables attached to the OPSS Final Rule on the CMS Website.

According to CMS, hospitals should report the diagnostic radiopharmaceutical (in the cases where it is furnished without cost or with full credit) with a token charge of less than \$1.01.

About the Author

Sandy Palmer, RHIT, is a Coding and CDM Analyst for MedAssets, Integrity Services. Her expertise includes inpatient and outpatient facility coding with a specific emphasis on the Outpatient Prospective Payment System (OPSS). She has more than 12 years experience in Health Information Management and is currently responsible for researching and responding to complex facility coding inquiries as well as database maintenance and management. ■

REFERENCES

www.cms.gov/HospitalOutpatientPPS/HORD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1240960&intNumPerPage=10

FREQUENTLY ASKED QUESTIONS

In this section, MedAssets has reviewed and analyzed the questions that are received via our compliance help desk. We offer some of the most frequently asked questions and the MedAssets response for your convenience.

Q Is the only time an Advance Beneficiary Notice (ABN) can be appropriately issued when the service is normally covered but for some reason may not be covered under certain circumstances? In these instances would you have a patient sign an ABN?

Also, would you not issue an ABN to a patient when submitting a claim that has an "items or services" upon which a payment status indicator E has been assigned? Status indicator E codes are excluded and not recognized as a covered benefit. The only reason we are submitting to Medicare with the GY modifier is for the denial.

Do you agree with this statement? Can you explain billing items/services assigned status indicator E vs. ABN with me? I just want to make sure I understand this correctly.

MedAssets Response

ABNs are required (mandatory) for services that are determined to be (non-covered) secondary to being not reasonable and necessary. Services considered not reasonable and necessary are those that are:

- Experimental and investigational
- Not safe and effective
- Have limited coverage based on certain criteria (i.e., medical necessity requirements which must be met such as specific diagnoses and/or other defined criteria)
- Obsolete tests
- Frequency requirements which are not met – number of services exceeds the norm and no medical necessity demonstrated for the extra number of services.

An ABN should be issued when the hospital is providing covered Medicare services to a patient whose condition does not meet the requirements of reasonable and necessary. Hospitals should always follow their internal policies when issuing ABNs.

When billing Medicare for covered services that are not reasonable and necessary, providers must report the appropriate CPT/HCPCS code with the appropriate modifier on the Medicare claim. Applicable modifiers for mandatory ABNs are the following:

GA – waiver of liability statement issued as required by payor policy, individual case: ABN on File – for services which are covered by Medicare but patient does not meet requirements of reasonable and necessary.

GZ – item or service expected to be denied as not reasonable and necessary: ABN NOT on File – for services which are covered by Medicare but patient does not meet requirements of reasonable and necessary.

Assigned payment status indicator E indicate the disposition of outpatient items and/or services not covered or recognized by Medicare:

- Benefit based on statutory exclusion;
- Benefit for reasons other than statutory exclusion;
- Outpatient claims for which an alternate code for the same item or service may be available, or which separate payment is not provided on outpatient claims; and
- Not paid by Medicare when submitted on outpatient claims (any outpatient bill type).

When reporting services assigned SI "E" or non Medicare benefit category, ABNs are not required but can be administered on a voluntary basis for services that are excluded by statute or do not meet the definition of a Medicare Benefit. However, providers should not assume a service is statutorily excluded based on OPPS status indicator E. Statutory exclusion is just one component of status indicator E assignment;

another HCPCS code may be available that more accurately describes the service and is of a non-excluded status and/or is required for use by Medicare regulations. Also, Local Coverage Decisions (LCDs) should be considered for coverage status of the service in question before an accurate ABN administration and ABN modifier decision can be made.

When appropriate, a provider may report the appropriate CPT/HCPCS code with the appropriate modifier. Applicable modifiers for voluntary ABNs are:

GY – item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for Non-Medicare insurers, is not a contract benefit: Non-Covered Service (Services Which Are Statutorily Excluded or Do Not Meet the Definition of Any Medicare Benefit) voluntary ABN NOT on file.

GX – notice of Liability Issued, Voluntary Under Payor Policy: Non-Covered Service (Services Which Are Statutorily Excluded or Do Not Meet the Definition of Any Medicare Benefit) voluntary ABN on file.

For additional information, review the following references:

The Claims Processing Manual, General Billing Requirements – Section 60 – Provider Billing of Non-covered Charges.

The Claims Processing Manual, Financial Liability Protections – Section 80 – Hospital ABNs (Hospital-Issued Notices of Noncoverage – (HINN)

You may also want to review the Advanced Beneficiary Notification Booklet. It is available at www.cms.gov/MLNProducts/downloads/ABN_Booklet_ICN006266.pdf. ■

CCFN CROSSWORD NOVEMBER 2010

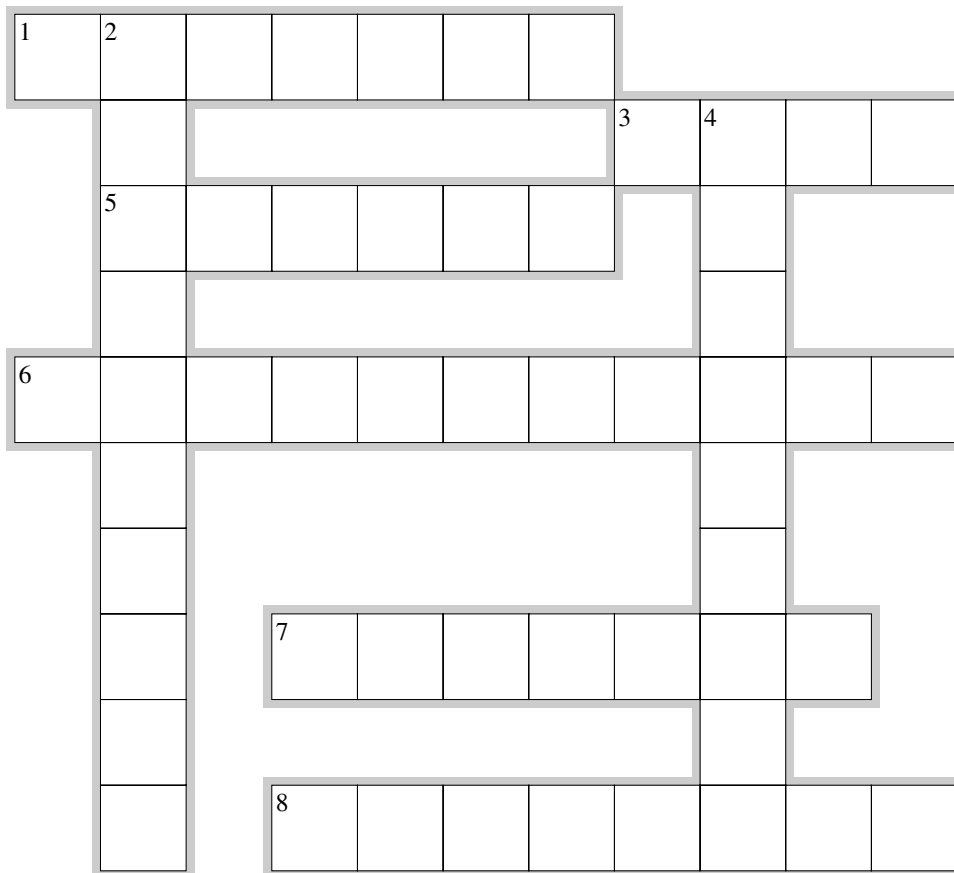
By Toueria Morris, CPC-H

Across

- ___ payment rates are listed in the Oct. 2010 OPPS Addendum A and B.
- How many new drug codes are assigned status indicator "G" for pass-through payment, effective Oct. 1, 2010?
- CMA clearly states that hospitals may not ___ observation services under HCPCS Code G0378 for the time period during the hospital stay prior to a physician's order for observation services.
- HCPCS Code C1749-endoscope, retrograde imaging/illumination ___ device (implantable).
- Condition code 44 is used when a beneficiary's status is ___ from inpatient to outpatient to report the entire encounter on a hospital outpatient claim.
- The device offset amount is ___ from the pass-through payment for the device.

Down

- When the radiolabeled product is administered by another facility, the hospital ___ the scanning procedure reports the radiolabeled product with the scan.
- ___ payment rates for three CPT/HCPCS codes in the second and third quarter of 2010 are corrected in the Oct. OPPS 2010 pricer.



ANSWERS
 ACROSS 1. UPDATED 3. FIVE 5. REPORT 6. COLONOSCOPE 7. CHANGED 8. DEDUCTED
 DOWN 2. PERFORMING 4. INCORRECT

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