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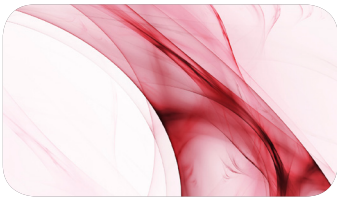
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2011 Changes to the Payment System for ESRD Patients Receiving Dialysis

The Medicare Improvements for Patients and Providers Act (MIPPA) Section 153(b) requires implementation of an End Stage Renal Disease (ESRD) bundled prospective payment system (PPS) effective Jan. 1, 2011, reports Paul Paulson, CHN, CNOR, in this month's edition of CCFN. The ESRD PPS replaces the current composite payment system and its methodologies for the reimbursement of separately billable outpatient related services. The ESRD PPS will provide a single payment to ESRD facilities, i.e., hospital based providers of services and renal dialysis facilities.

DOC2DOC



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Docs: Get on Board for Incentives

"I have been saying for quite some time that eventually it would be a detrimental move for physicians not to get on the bandwagon for Physician Quality Reporting System (PQRS)," reminds Denise M. Nash, MD, CCS, CIM. "Well, penalties have come to fruition for non-participation in the three incentive programs: PQRS, Electronic Prescribing Incentive Program (eRX) and Electronic Health Record Incentive Program (EHR)."

TALKING POINTS



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New CPT® Time Rules Create More Infusion Confusion

Hospital outpatient departments must be aware of adhering to the drug administration hierarchy, advises Sarah Cobb, BS, CPhT, RMC. Coders need to track intravenous sites, encounters, drug units and the proper documentation of start and stop times.

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ICD-10-PCS: The Root Operation

The root operation identifies the objective of the procedure, explains Darnacea Harris, MHA, RHIT, CCS. All procedures are rolled into the definitions of the root operations that are found in 11 sections of ICD-10.

MODIFIERS CORNER



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Report Modifier FB for No Cost Devices and Radiolabeled Products

When hospitals provide devices or radiolabeled products at no cost to Medicare beneficiaries in the outpatient setting, they must report the procedure and indicate that the device or radiolabeled product was provided without cost, reports Sandy Palmer, RHIT.

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2011 Changes to the Payment System for ESRD Patients Receiving Dialysis

The Medicare Improvements for Patients and Providers Act (MIPPA) Section 153(b) requires implementation of an End Stage Renal Disease (ESRD) bundled prospective payment system (PPS) effective Jan. 1, 2011.

The ESRD PPS replaces the current composite payment system. It also replaces methodologies for the reimbursement of separately billable outpatient related services, which include laboratory tests, training, support services and pharmaceuticals. The ESRD PPS will provide a single payment to ESRD facilities, e.g., hospital-based providers of services and renal dialysis facilities.

The per-dialysis treatment base rate for adult patients is subsequently adjusted to reflect differences in the following variables:

- Wage levels among the areas in which ESRD facilities are located;
- Patient-level adjustments for case mix;
- Outlier adjustment (if applicable);
- Facility-level adjustments;
- Training add-on (if applicable);
- Adjustments specific to pediatric patients (dialysis patients that are under the age of 18); and
- Budget neutrality adjustment during the transition period.

The facility-level adjustments also include an adjuster for facilities treating with a low volume of dialysis treatments. ESRD facilities will receive an adjustment to their ESRD PPS base rate when: the facility furnished less

than 4,000 treatments in each of the three cost report years preceding the payment year; and has not opened, closed, or received a new provider number due to a change in ownership during the three years preceding the payment year. Included in the case-mix adjusters are those variables that are currently used in basic case-mix adjusted composite payment system, which is age, body surface area (BSA) and low body mass index (BMI).

In addition to those adjusters that are currently used, the ESRD PPS will also incorporate adjustments for six comorbidity categories and an adjustment for the onset of renal dialysis. These include the following:

1. Gastrointestinal bleeding
2. Bacterial pneumonia
3. Pericarditis
4. Hereditary hemolytic and sickle cell anemia
5. Monoclonal gammopathy (in the absence of multiple myeloma)
6. Myelodysplastic syndrome

The adjustment for comorbidity in the event that there is more than one category on the claim will be adjusted to the highest paying comorbidity category.

Dialysis facilities that are treating patients with higher acuity levels, and therefore higher resource consumption as measured through their utilization of services beyond a specified threshold, will be entitled to outlier

payments. The facility-level adjustments include adjusters to reflect urban and rural differences in area wage levels using an area wage index developed based on Core Based Statistical Areas (CBSAs).

Facilities that are certified to provide training services will receive an add-on payment amount of \$33.44 per treatment, which is adjusted by the geographic area wage index to account for an hour of nursing time for each training treatment that is furnished. Services not included in the PPS that remain separately payable, including blood and blood processing, preventive vaccines, and Telehealth services, are not considered outlier services.

Pediatric Payments

The pediatric payment model applies to all dialysis patients who are under the age of 18. The per-treatment base rate, as it applies to pediatric patients, is the same base rate used for adult patients and is also adjusted by the area wage index. Due to the lack of statistical robustness, the base rate for pediatric patients is not adjusted for case-mix based on specific comorbidities. Instead, the pediatric payment adjusters are increased by 10.5 percent to reflect higher total payments for pediatric composite rate and separately billable services. The pediatric model also incorporates separate adjusters based on two age groups, under 13 and 13 – 17 years old, and dialysis modality, hemodialysis or peritoneal dialysis. Treatments furnished to pediatric patients qualify for a training add-on

Effective Jan. 1, 2011, all ESRD-related laboratory services are included in the ESRD PPS base rate. Any lab service not related to the treatment of ESRD must include Modifier AY to indicate the item or service is not for the treatment of ESRD.

payment when applicable, and are eligible for an outlier adjustment. Pediatric dialysis treatments are not eligible for the low volume adjustment.

Effective Dates of Services

Effective for dates of service beginning Jan. 1, 2011, after the beneficiary's Part B deductible is met, the Medicare Administrative Contractors (MACs) pay 80 percent of the ESRD PPS base rate. They also pay all applicable adjustments (or the blended payment amount if the facility chooses to transition) for each outpatient maintenance dialysis treatment furnished to the ESRD beneficiary in the ESRD facility or at the beneficiary's home.

Effective Jan. 1, 2011, all ESRD-related laboratory services are included in the ESRD PPS base rate. Any lab service not related to the treatment of ESRD must include Modifier AY to indicate the item or service is not for the treatment of ESRD. ESRD-related drugs and biologicals that are currently separately paid under the basic case-mix composite rate payment system are now considered in the calculation of any applicable outlier payment under the ESRD PPS. In the event that an ESRD-related drug or biological was furnished to an ESRD beneficiary for reasons other than for the treatment of ESRD, the provider may submit a claim for separate payment using Modifier AY.

With the implementation of the ESRD PPS, ESRD-related Erythropoietin (EPO) is included in ESRD PPS payment amount and is not separately payable on Part B claims with dates of service on or after Jan. 1, 2011, for other providers. The exception is a hospital billing for an emergency or unscheduled dialysis session. Vaccines remain separately payable under the ESRD PPS.

The Medicare Improvements for Patients and Providers Act (MIPPA) eliminates Method II home dialysis claims. All home dialysis claims must be billed by a renal dialysis facility and paid under the ESRD PPS.

A list of drugs and biologicals as well as a laboratory test included in the PPS payment for ESRD beneficiaries can be located in the following CMS document: <https://www.cms.gov/transmittals/downloads/R2094CP.pdf>.

Summary of Changes

1. ESRD-related pharmaceuticals are packaged into the PPS
2. ESRD-related laboratory test are packaged into the PPS
3. Method II billing for home dialysis patients has been eliminated
4. Pediatric payment adjusters are increased by 10.5 percent to reflect higher total payments for pediatric composite rate and separately billable services
5. Add-on payments are made for home training sessions
6. ESRD PPS will also incorporate adjustments for six comorbidity categories and an adjustment for the onset of renal dialysis
7. ESRD facilities will receive an adjustment to their ESRD PPS base rate when the facility furnished less than 4,000 treatments in each of the three cost report years preceding the payment year and has not opened, closed, or received a new provider number due to a change in ownership during the three years preceding the payment year

8. If the renal dialysis facility needs to report a drug or lab test, which was furnished to an ESRD beneficiary that was not related to the treatment of ESRD, they must include the Modifier AY to indicate the item or service is not for the treatment of ESRD
9. ESRD-related EPO is packaged into the PPS payment
10. Blood and blood processing, preventive vaccines, and Telehealth services continue to be separately payable

About the Author

Paul Paulson CHN, CNOR, currently serves as a Senior Review Analyst within MedAssets' Charge Capture Audit group. Paul has over 35 years in the healthcare industry and has worked as a dialysis nurse, operating room nurse and critical care nurse specialist. Paul has served MedAssets and its customers for more than eight years in various roles from mapping consultant to manager for initial projects in the mapping department to charge master consultant in the compliance department. Paul remains active in his clinical profession and continues to maintain his nursing certifications by attending seminars and taking classes. He maintains certifications in Dialysis, Critical Care, and Surgery. ■

REFERENCES

<https://www.cms.gov/transmittals/downloads/R2094CP.pdf>



Docs: Get on Board for Incentives

I have been saying for quite some time that eventually it would be a detrimental move for physicians not to get on the bandwagon for Physician Quality Reporting System (PQRS). Well, penalties have come to fruition for non-participation in the three incentive programs: PQRS, Electronic Prescribing Incentive Program (eRx) and Electronic Health Record Incentive Program (EHR).

To begin, here's how Medicare defines the eligible professional (EP) as well as the eligibility to participate:

For PQRS and eRx, Medicare defines the eligible professional (EP) as

1. Physicians: defined as a doctor of medicine or osteopathy, a doctor of oral surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry or a chiropractor;
2. Practitioners: defined as a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist (and anesthesiologist assistant), certified nurse midwife, clinical social worker, clinical psychologist, registered dietician, nutrition professional or audiologist; and
3. Therapists: defined as a physical therapist, occupational therapist or qualified speech-language therapist.

Moreover, the participation in the eRx Incentive Program is extended to those professionals having prescribing authority. However, Medicare professionals may not earn incentives under the eRx and EHR Incentive Program at the same time.

For the Medicare EHR program, the EP is defined as a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry or a chiropractor.

For the Medicaid EHR program, EPs are defined as physicians, nurse practitioners (NPs), certified nurse midwives (CNMs), dentists, and physician assistants (PAs) who practice in a Federally Qualified Health Center (FQHC) or rural health clinic (RHC) that is led by a PA.

But, there is more regarding the qualifications for providers. Please note the following for Medicare and Medicaid:

- Medicare: must be enrolled as a Medicare provider and bill Medicare under an individual NPI – this excludes FQHC providers
- Medicaid: must also be enrolled as a Medicaid provider AND at least 30 percent of patient volume must be Medicaid
- If in an FQHC or RHC, the 30 percent can also include "needy individuals," i.e. free care, CHIP, or sliding fee
- Pediatricians can qualify for a lesser amount and qualify with only 20 percent Medicaid volume
- Volume can be the entire practice if reflective of individual and auditable

NOTE: Hospital-based EPs are not eligible to receive payments through either the Medicare or Medicaid EHR program.

Incentive Programs

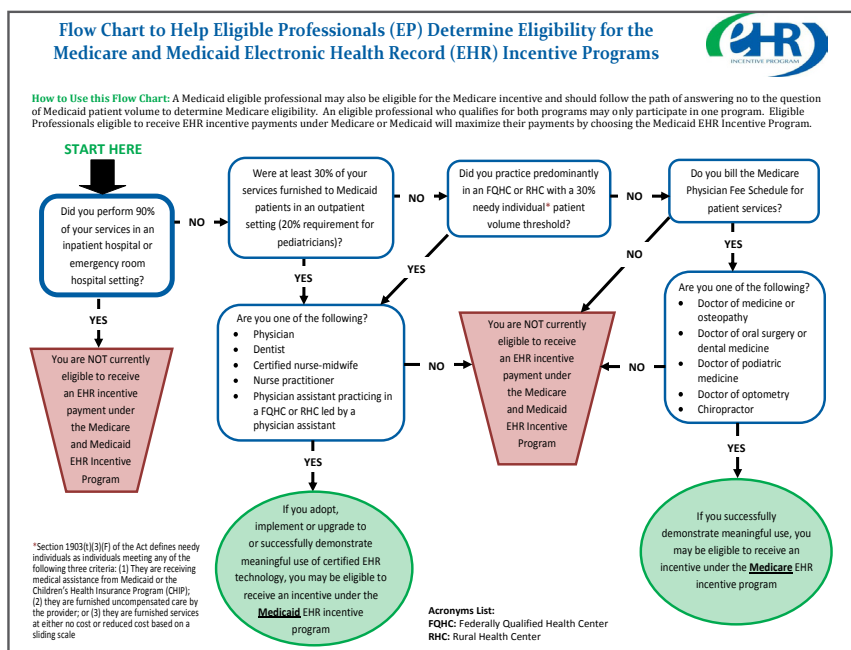
The PQRS incentive program is available until 2014. Beginning in 2015, EPs not "satisfactorily" reporting PQRS measures will be subject to payment adjustments. The penalty will be 1.5 percent in 2015 and will increase to two percent in 2016.

The eRx incentive payments are available until 2013. Beginning next year (2012), adjustments to payments equal to one percent of the Medicare Physician Fee Schedule (PFS) allowed charges will be incurred. This will increase to 1.5 percent in 2013 and two in 2014.

The EHR incentive program that began this year (2011) will run through the next five years (2016) for Medicare and the next six years (2017) for Medicaid participation. Those EPs choosing to participate in the Medicare EHR program beginning in 2015 will not see an incentive.

The incentive payment is subject to an annual limit, equal to 75 percent of the EPs allowed charges and need to be submitted not later than two months after the end of the calendar year. Payment adjustments will initiate in 2015 for those EPs not adopting certified EHR technology. Qualified vendors for EHR technology, PQRS and eRx incentive programs can be found at: <https://www.cms.gov/PQRI/Downloads/QualifiedEHRVendorsforthe2011PhysicianQualityReportingandRx121310.pdf>.

EPs need to elect to participate in the EHR program for either Medicare or Medicaid but not both. Before 2015, an EP may switch between programs one time after the first incentive payment is initiated.



https://www.cms.gov/EHRIncentivePrograms/downloads/eligibility_flow_chart.pdf

Payment Schedule

If you think this is confusing, take a look at the proposed payment schedule. Here's what you really receive from Medicare and Medicaid:

Medicare

- Calculated each year
- Payment = 75 percent of allowable Medicare charges up to \$24,000, or \$18,000
- Amounts are tiered down over time
- Payment is made over five years
- Max payment only available if EP first qualifies by October 2012
- Penalty starting at one percent in 2015 if EP is not meaningful user by that time
- Expect to pay income tax on any payment

Medicaid

- Payable over six years; need not be consecutive
- Payment based on 85 percent of "net average allowable cost" (\$25,000 in first year and \$10,000 thereafter); this number assumes \$54,000 and no more than \$29,000 contributed from a non-governmental outside source to offset these amounts. Actual documentation requirements set up by each state; EP may need to show \$3,750 in cost in/ prior to year one and \$1,500 in years two through six
- Max payment available until 2016
- No penalties if EP does not meet meaningful use by then
- Expect to pay income tax on any payment

Can EPs participate in multiple incentive programs?

- CMS eRx incentive – only if the EP chooses Medicaid for EHR incentives
- PQRI – yes, for both Medicare and Medicaid
- BUT, only one EHR incentive program

You may have to employ an accountant to decipher and keep track of all the "extra earnings."

About the Author

Denise M. Nash, MD, CCS, CIM, is the Medical Director and Product Owner for Episodes of Care for MedAssets. Denise has over 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. ■

REFERENCES

Additional information on PQRS, eRx and EHR can be found at these links:
http://www.cms.gov/PQRI/01_Overview.asp
<http://www.cms.hhs.gov/ERXincentive>
http://www.cms.hhs.gov/Recovery/11_HealthIT.asp

Trade Shows & Events

MARCH 13 - 16

ASHE International Summit and Exhibition on Health Facility Planning, Design & Construction

Tampa Bay, FL • Booth: 221 • View [Website](#)

MARCH 21

2011 Spring IDN Summit & Expo

Orlando, FL • View [Website](#)

"GPO Players in Healthcare Reform" presented by Michael Berryhill, Executive Vice President, Strategic Sourcing Solutions, MedAssets and other panelists

MARCH 23 - 25

The National Pay for Performance Summit

San Francisco, CA • Booth: 212 • View [Website](#)

MARCH 23 - 25

HFMA Arizona Chapter 2011 Spring Conference

Chandler, AZ • Booth: TBD • View [Website](#)

APRIL 7

HFMA Hudson Valley NY Chapter 2011 Annual Institute

Tarrytown, NY • Booth: TBD • View [Website](#)

APRIL 13 - 16

AONE 44th Annual Meeting and Exposition - The American Organization of Nurse Executives

San Diego, CA • Booth: 918 • View [Website](#)

APRIL 18

2011 South Central Ohio Healthcare Supplier Diversity Symposium

Cincinnati, OH

Keynote Session. presented by John Bardis, Chairman, President and CEO, MedAssets

APRIL 28 - 30

Healthcare Coalition of Texas Physician/Trustee/CEO Conference

San Antonio, TX • View [Website](#)

MAY 11 - 14

ASCs 2011

Orlando, FL • Booth: TBD • View [Website](#)



New CPT® Time Rules Create More Infusion Confusion

Layered with multiple regulations to follow, coding drug administrative services can be a challenge even for the most experienced coder. At times, this area of coding is not always as straightforward as we prefer.

Hospital outpatient departments must be aware of adhering to the drug administration hierarchy. In addition, coders need to keep track of intravenous sites, encounters drug units, and the proper documentation of start and stop times. It's no wonder this topic has notoriously been referred to as the "infusion confusion" of coding.

In order to report drug administrative services, you must first have a firm understanding of the drug administrative hierarchy. The basics of the drug administrative hierarchy are outlined in the 2011 CPT Manual. These basics state that:

"The initial code should be selected using a hierarchy whereby chemotherapy services are primary to therapeutic, prophylactic and diagnostic services which are primary to hydration services. Infusions are primary to pushes, which are primary to injections."

Based on this information, drug administrative services are not reported in the actual order they were administered. Rather, they are reported in the order of the drug administration hierarchy. To help clarify the hierarchy see the detailed

illustration to the left.

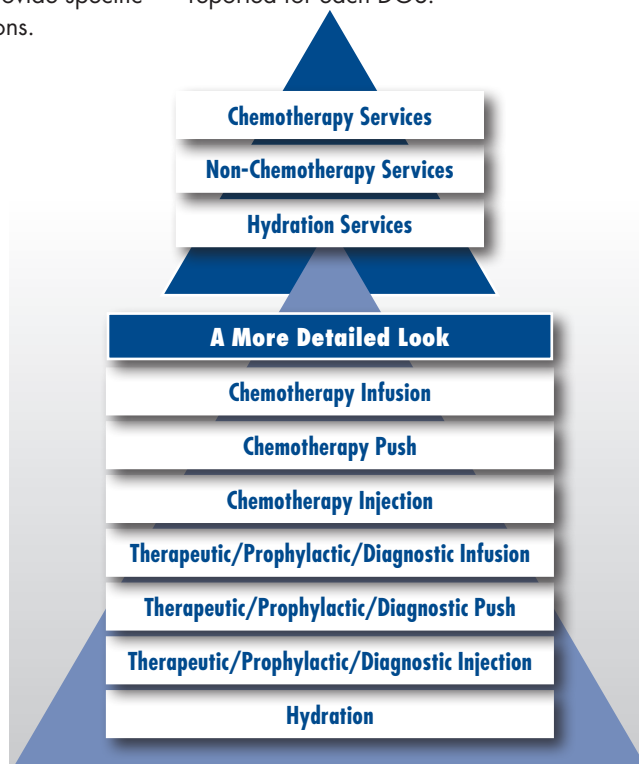
Additionally, Medicare requires that only one initial drug administration service be reported during a patient encounter, unless there is a separate and distinct second intravenous access site. This initial code is determined based on the hierarchy of the drug administration services.

Just when you think you have the drug administration hierarchy figured out, the rules change again. This year there was a "Time" section added to the Introduction of the 2011 CPT manual. In this introduction, on page xii, the guidelines provide specific examples for reporting infusions.

The manual states:
"Some services measured in units other than days extend across calendar dates. When this occurs a continuous service does not reset and create a new first hour. For example, if intravenous hydration (96360, 96361) is given from 11 PM to 2 AM 96360 would be reported once and 96361 twice. However, if instead of a continuous infusion, a medication was given by intravenous push at 10 PM and 2 AM, as the

service was not continuous, both administrations would be reported as initial (96374). For continuous services that last beyond midnight, use the date in which the service began and report the total units of time provided continuously."

This section of the manual essentially states that an initial drug administrative service code is not required for each date of service. If the service were continuous, an initial code would only be reported for the first DOS. In contrast, if the service were not continuous, an initial code would be reported for each DOS.





The examples given in the CPT Manual are appreciated, but the information may be too simple for a specific scenario you may be questioning. In actuality, drug administrative services vary from patient to patient and may be more complex than what is outlined in the manual.

Take for example, a scenario in which a patient is administered a continuous infusion on day one that extends to the next calendar day. While that infusion is still being administered the following calendar day, the patient receives an additional infusion of a different drug.

Based on the Time section of the CPT Manual, MedAssets would recommend reporting an initial code for the continuous infusion that extends into the second day with the appropriate add-on code for the additional hours, in addition to a sequential infusion code for the second infusion of a different drug given the next day.

Although these time regulations were recently published in the 2011 CPT Manual, the regulations are not truly new, as they already apply to observation services. The Claims Processing Manual, Chapter 4, Section 230.2, states: *“Drug administration services are to be reported with a line item date of service on the day they are provided. In addition, only one initial drug administration service is to be reported per vascular access site per encounter, including during an encounter where observation services span more one calendar day.”*

With all this being said, there are some exceptions to the rule. There may be instances when it would be appropriate to report an additional initial infusion code.

For example,

- an intravenous push that was administered at a different vascular access site
- a patient leaves the facility and returns later in the day to receive an additional infusion

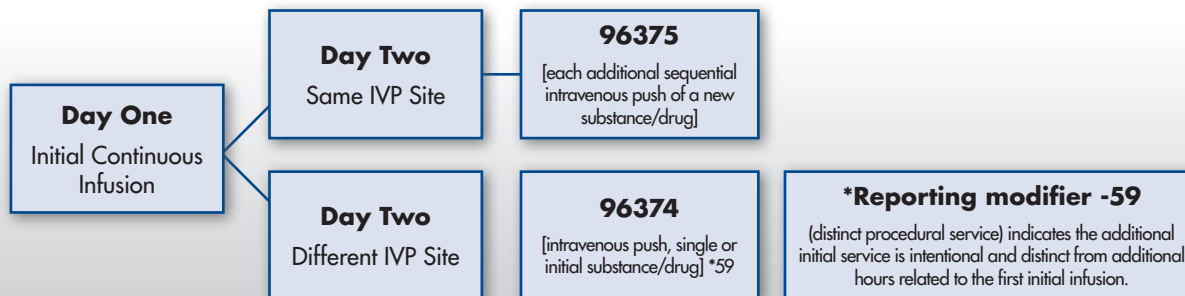
In these cases, reporting Modifier 59 (distinct procedural service) indicates the additional initial service is deliberate and distinct from additional hours related to the first initial infusion.

In recent years, coding for drug administration services has remained a topic of confusion, even for the most skilled coder. The root cause of this confusion can be attributed to constant changes in the drug administration coding guidelines. Furthermore, unlike most other procedures, different and multiple scenarios vary from patient to patient. The specifics of a particular scenario determine how the drug administration service should be coded.

The drug administration hierarchy can help guide the coder to the appropriate initial code. It is also imperative, however, that coders of drug administrative services study and understand the coding guidelines to conquer and defuse the confusion of coding drug infusions.

About the Author

Sarah Cobb, BS, CPhT, RMC, is a Registered Medical Coder and Nationally Certified Pharmacy Technician. As a healthcare professional, Sarah has over 10 years of pharmacy experience. Currently, Sarah 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 degree in biology and is currently pursuing her CPC-H certification. ■





TALKING POINTS

By Darnacea Harris, MHA, RHIT, CCS

ICD-10-PCS: The Root Operation

Character 1	Character 2	Character 3	Character 4	Character 5	Character 6	Character 7
SECTION	BODY SYSTEM	ROOT OPERATION	BODY PART	APPROACH	DEVICE	QUALIFIER

As discussed in previous editions of *Coding and Compliance Focus News*, ICD-10-PCS provides an improved system for code expansion and allows for greater specificity in procedure classifications.

ICD-10-PCS is a classification system built on characters. The code is seven characters, and each character has a definition and a purpose. The third character of ICD-10-PCS is the Root Operation.

The root operation identifies the objective of the procedure. In ICD-9-CM, the root operation would be equivalent to the procedure or how the procedure was indexed. What may be confusing is that many of the terms used in the procedure section of ICD-9-CM, eponyms and shortcuts, for example, have been removed from ICD-10-PCS. Although these terms have been excluded, the procedures still exist.

Now, all procedures are rolled into the definitions of the root operations, and coders will need to assign root operations based on the actual procedure performed. For example, colonoscopy is not considered a root operation and will not have a specific term assigned to the procedure. A colonoscopy is actually a visualization of the colon in ICD-10-PCS, and the third character of the ICD-10-PCS code (root operation) is *Inspection*.

Root operations are found in 11 sections of ICD-10. The section that contains the most root operations is the Medical and Surgical Section, which contains 31 different root operations. These root operations are arranged by groups with similar attributes, and each root operation has a precise definition. The root operations for the Medical and Surgical Section are the following:

Medical and Surgical Section Root Operations	
Alteration	Inspection
Bypass	Map
Change	Occlusion
Control	Reattachment
Creation	Release
Destruction	Removal
Detachment	Repair
Dilation	Replacement
Division	Reposition
Drainage	Resection
Excision	Restriction
Extirpation	Revision
Extraction	Supplement
Fragmentation	Transfer
Fusion	Transplantation
Insertion	

Other sections of ICD-10-PCS are represented by fewer root operations. The two root operations in the Obstetrics section, for example, are Labor and Delivery. Other procedures on pregnant women, such as episiotomy, are coded in the Medical and Surgical section.

Other Sections of Root Operations	
Section	Number of Root Operations
Obstetrics	2
Placement	7
Administration	3
Measurement and Monitoring	4
Extracorporeal Assistance and Performance	3
Extracorporeal Therapies	10
Osteopathic	1
Other Procedures	1
Chiropractic	1

Procedure	ICD-9-CM index	ICD-10-PCS Index	ICD-10-PCS Code
Laparoscopic Cholecystectomy	Cholecystectomy	Resection	0FT44ZZ
EGD with gastric biopsy	Biopsy	Extirpation	0DB68ZX
Transurethral endoscopic laser ablation of prostate	Ablation	Destruction	095KXZZ
Nonexcisional debridement of skin ulcer, right foot	Debridement	Extraction	0HDMXZZ
Hysteroscopy with D&C, diagnostic	Hysteroscopy/Curetage	Extirpation	0UDB8ZY

To search a root operation, an understanding of the actual procedure performed is required. Root operations are based on the objective of the procedure. Rather than indexing a Caldwell-Luc operation in ICD-9-CM, Volume 3, ICD-10-PCS would index the procedure as Drainage-Sinus-Maxillary.

A comprehensive understanding of the definition of the Caldwell-Luc operation is required for proper code assignment. ICD-10-PCS defines the components of a procedure separately from the procedure, and are assigned based on the available characters. Remember, ICD-10-PCS is a classification system built on characters. The only component of a procedure specified in the root operation is the objective of the procedure.

Above are several examples of procedures and how they are indexed in ICD-9-CM compared to the root operation in ICD-10-PCS.

Similar to ICD-9-CM, guidelines are followed to assign procedure codes in ICD-10-PCS. Guidelines cover such concepts as combination procedures, multiple procedures, redo of procedures, discontinued procedures and others. Coders should read and understand the guidelines for correct code assignment.

Guideline for Discontinued Procedures reads:

B3.4. If the intended procedure is discontinued, code the procedure to the root operation performed. If a procedure is discontinued before any other root operation is performed, code the root operation 'Inspection' of the body part of the anatomical region inspected.

Example: Ureterscopy with unsuccessful extirpation (Taking or cutting out solid matter in a body part) of ureteral stone is coded to Inspection of ureter.

As complex as ICD-10-PCS appears, understanding root operations and the basic guidelines associated with the character's assignment, provides a foundation for optimal code assignment. Coders should begin to refresh anatomy and physiology knowledge, and better understand how procedures are performed. Managers should ensure appropriate resources are available and detailed clinical documentation processes are in place.

About the Author

Darnacea Harris MHA, RHIT, CCS, is an AHIMA approved ICD-10-CM/PCS Trainer with more than 20 years experience in the coding, compliance and reimbursement industry. Darnacea has held previous positions including Charge Capture Audit Rules Manager, Assistant Director HIM, HIM Manager, Coding Manager, and Consultant. She has also held teaching positions at several colleges and universities where she taught coding, billing, HIM and supporting courses. ■

Report Modifier FB for No Cost Devices and Radiolabeled Products

The use of implantable medical devices has become a widespread, costly and confusing part of providing medical care. This is a result of manufacturers often providing replacement devices or credit for a device that is under warranty and needs to be replaced due to failure or recalls of the manufacturer or FDA.

Hospitals, when reporting procedures under the OPSS to Medicare, are required to report device category codes (C-codes) for implanted devices used in conjunction with those procedures. Device to Procedure edits flag procedures that are reported without a required device category code, and Procedure to Device edits flag for devices that are reported without an appropriate procedure code.

These devices include those with current pass-through status (status indicator (SI) of "H") as well as devices with an expired pass-through status (SI "N"). Medicare edits also require hospitals to report HCPCS codes for radiolabeled products used during diagnostic nuclear medicine scans.

When hospitals provide these devices or radiolabeled products at no cost to their Medicare beneficiaries in the hospital outpatient setting, they must have a process in place to report the procedure and also indicate that the device or radiolabeled product was provided without cost. This may include free samples or trial diagnostic radiopharmaceuticals received free of charge.

Modifier FB was first introduced for use with no cost devices in 2006. The description was revised in 2007 to include "full credit

received for replaced device." Beginning Jan. 1, 2011, Modifier FB may also be used to bypass a radiolabeled product edit, although no change has been made to the description of this modifier which currently only describes no cost devices:

Modifier FB Description

1/1/2006 – 12/31/2006

Item provided without cost to provider, supplier or practitioner (examples, but not limited to: covered under warranty, replaced due to defect, free samples)

Modifier FB Description

1/1/2007 – Current

Item provided without cost to provider, supplier or practitioner, or full credit received for replaced device (examples, but not limited to, covered under warranty, replaced due to defect, free samples)

Reporting the Procedure

Since APC rates for procedures that regularly require an implantable medical device are based in part on the cost of the device, CMS created Modifier FB for OPSS reporting. Modifier FB was originally appended to the HCPCS code for the no cost device. This requirement changed Jan. 1, 2007. Currently, Medicare states that hospitals must append Modifier FB to the procedure code when they furnish a device or radiolabeled product during a procedure, and:

- The device or radiolabeled product is supplied without cost from the manufacturer, or
- The hospital receives full credit for the item from the manufacturer.

Hospitals must append FB to the procedure code (not the device or radiolabeled product code). Modifier FB should be reported with the CPT® or HCPCS procedure codes assigned with status indicators of S, T, X or V only. The reason these devices and radiolabeled products (diagnostic radiopharmaceuticals) may have no cost includes, but is not limited to, warranty, replacement, recall, defect issues or free samples.

Reporting the device or radiolabeled product

The charge for the no cost device or radiolabeled product used should be reported one of two ways:

1. Report a token charge less than \$1.01 (usually \$1.00) in the "Covered" charge field for the no cost item:

This includes circumstances where the cost of the device being replaced (A) and the cost of a replacement device (B) will be different. When the cost of a replacement device (B) is less than the cost of the device being replaced (A), and there is no cost to the hospital that is performing the device replacement, then hospitals should report the device, as stated above, with a token charge.

Additionally, when the manufacturer supplies a device or radiolabeled product with no cost to the hospital for other reasons (not a replacement), hospitals should report the item as stated above with a token charge. This might include clinical trials where a Category B IDE device is provided at no cost or when free samples are provided.

- Report the difference between a credited and replacement device in the "covered" charge field

If the replacement device (B) is an upgrade and more costly than device (A) (for which the hospital receives a credit), then the difference is reported in the "covered" charge field. Modifier FB is still appended to the code for the procedure in which the device is implanted.

Example provided in a CMS FAQ (January 2010):

The hospital receives a credit for device A that is being replaced:..... \$4,000

The hospital's usual charge for device A is:\$8,000

The hospital pays for device B for which the usual charge is: \$10,000

(The hospital should charge the difference between the usual charges for devices A and B, \$10,000 minus \$8,000)

The hospital should bill this difference in the "covered" charge field:.....\$2,000

Additional examples showing proper and improper claims using Modifier FB can be found in CMS Transmittal R1103CP (Reporting and Payment of No-Cost Devices Furnished by OPSS Hospitals - effective Jan. 1, 2007), including the following types:

- Claim 1 – Free ICD Device
- Claim 2 – Credit for Device Upgrade
- Claim 3 – Multiple Procedure Discount
- Claim 4 – Terminated Procedure along with free device
- Claim 5 – FB Modifier on Free Device Line

Payment for Procedures with No Cost Devices or Radiolabeled Products

Although Medicare states that hospitals must append Modifier FB to the procedure code when they furnish a no cost device during a surgery, only certain combinations of procedure codes and device codes trigger the OCE adjustment that reduces the payment for the procedure. Effective Jan. 1, 2009:

- The procedure code must map to one of the APCs subject to the adjustment and is reported with Modifier FB
- The claim must list a device HCPCS code which is on the list of devices subject to the adjustment
- The OCE will apply an existing full offset payment to the APC rate when Modifier FB is reported with the procedure code, and a no cost device is reported on that claim

For diagnostic radiopharmaceuticals reported with Modifier FB, the payment for the diagnostic nuclear medicine scan will be reduced by the full policy-packaged offset amount. Reported token charges for devices, no cost devices and full credit devices are not used in rate setting for device-dependent APCs.

For further information related to payments when Modifier FB is reported, see the CMS Claims Processing Manual, Chapter 4, 61.3.4 - Medicare Payment Adjustment.

On an annual basis, CMS publishes the tables that identify applicable devices or radiolabeled products, procedures and the procedure offset amounts related to reporting no cost devices with Modifier FB. The current versions of these tables are available on the CMS Website under the Hospital Outpatient Regulations and Notices section.

In summary

Providers should pay attention to device-to-procedure, procedure-to-device and radiolabeled product edits. You need to know when to:

- Report a no cost device with a token charge or an upgraded replacement device with the difference between the original and the replacement charge; and
- Append Modifier FB to a device requiring procedure code or diagnostic nuclear medicine procedure.

Next month we will discuss the uses for the counterpart to Modifier FB, Modifier FC, "Partial credit received for replaced device."

About the Author

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REFERENCES

CMS Documents | Transmittals

<http://www.cms.gov/HospitalOutpatientPPS/99/OPPSTransmittals.asp#TopOfPage>

- R2141CP** - January 2011 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- j. Reporting of Outpatient Diagnostic Nuclear Medicine Procedures
 - k. Implementation of the FB modifier for Diagnostic Radiopharmaceuticals
 - l. Payment Offset for Pass-Through Diagnostic Radiopharmaceuticals

R804CP - January 2006 Update of the Hospital Outpatient Prospective Payment System (OPPS): Summary of Payment Policy Changes, OPSS PRICER Logic Changes, and Instructions for Updating the Outpatient Provider Specific File (OPSF) 7. Modifier-FB; Item Provided Without Cost to Provider, Supplier or Practitioner (Examples, but not limited to: Covered Under Warranty, Replaced Due to Defect, Free Samples)

CMS Documents | 100-04 Claims Processing Manual

Chapter 04-Part B Hospital - <http://www.cms.gov/manuals/downloads/clm104c04.pdf>

- 20 - Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS)
- 60 - Billing for Devices Eligible for Transitional Pass-Through Payments and Items Classified in "New Technology" APCs
- 61 - Billing for Devices under the OPSS

Chapter 32 - Billing Requirements for Special Services
<http://www.cms.gov/manuals/downloads/clm104c32.pdf>

- 68.4 – Billing Requirements for Providers Billing Routine Costs of Clinical Trials Involving a Category B IDE

CMS Documents | OPSS Final Rules

<http://www.cms.gov/HospitalOutpatientPPS/HORD/list.asp#TopOfPage>

2008 - OPSS Final Rule - IV
OPSS Payment for Devices - pages 66746-66747

Device, Radiolabeled & Offset files 2011

2011 OPSS Final Without Cost or With Credit Device Information

This file includes tables 25 and 26 which are also available in the set of Preamble Tables

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 I'm a little confused about an edit that I'm getting. I checked your CPT/CCI editor and it states:

Column 2 codes are components of the comprehensive column 1 codes Comprehensive Codes

(Column 1) Component Codes

(Column 2) CCI Modifier

97598

97597

Modifier not permitted with code pair

My problem lies with 97597 not being billed with the 97598. The 97598 is an add-on code to 97597 where it cannot be billed without the primary charge.

To me this does not make sense. What is your opinion?

MedAssets Response

For 2011, CPT code 97598 is now an add-on code that must be reported with 97597 per CPT instructions. However, the existing facility NCCI edit for this code pair in which 97597 is a component of Column 1 code 97598 and cannot be billed using any modifier is still in effect.

CMS establishes the NCCI edits and the AMA develops CPT codes and instructions. At times there are discrepancies in this guidance, or the guidance is not yet updated. In addition, the facility NCCI edits (currently version 16.3) are always one quarter behind the physician professional edits (currently version 17.0).

In an Errata to the physician edits version 17.0 published January 20, the 97598/97597 edit was marked as deleted. This update has been made in KnowledgeSource. Version 17.0 will be effective for hospital use on April 1st and at that point should no longer include the edit for 97598/97597.

However, based on the information below from the introduction to the CCI Policy Manual directing practitioners to the CMS guidance when there is a discrepancy between CMS and CPT, we recommend contacting your FI /MAC regarding how they want you to report these codes given that the existing CCI edit restricts reporting the add-on code (97598) with the primary procedure (97597).

From the CCI Policy Manual: "I. CPT Manual and CMS Coding Manual Instructions CMS often publishes coding instructions in its rules, manuals, and notices. Physicians must utilize these instructions when reporting services rendered to Medicare patients.

The CPT Manual also includes coding instructions which may be found in the "Introduction", individual chapters, and appendices. In individual chapters the instructions may appear at the beginning of a chapter, at the beginning of a subsection of the chapter,

or after specific CPT codes. Physicians should follow CPT Manual instructions unless CMS has provided different coding or reporting instructions.

The American Medical Association publishes CPT Assistant which contains coding guidelines. CMS does not review nor approve the information in this publication. In the development of NCCI edits, CMS occasionally disagrees with the information in this publication. If a physician utilizes information from CPT Assistant to report services rendered to Medicare patients, it is possible that Medicare Carriers (A/B MACs processing practitioner service claims) and Fiscal Intermediaries may utilize different criteria to process claims."

Q In an outpatient facility setting, if a drug dosage (specifically HCPCS J1645) is wasted as a result of patient refusal, is it appropriate to charge the patient for the drug or not?

MedAssets Response

The pharmacy item would not be charged to the patient since it was not administered. CMS directs that supplies and services not provided to a patient may not be billed. This would include unused drugs, or drugs wasted as a result of patient refusal.

The Medicare General Information, Eligibility and Entitlement Manual Chapter 1, Section 20.3.1 states:

"Fraud is defined as making false statements or representations of material facts in order to obtain some benefit or payment for which no entitlement would otherwise exist. These acts may be committed either for the person's own benefit or for the benefit of some other party. In order to prove that fraud has been committed against the Government, it is necessary to prove that fraudulent acts were performed knowingly, willfully, and intentionally.

Examples of fraud include, but are not limited to, the following:

- Billing for services that were not furnished and/or supplies not provided. This includes billing Medicare for appointments that the patient failed to keep; ...
- Falsely representing the nature of the services furnished. This encompasses describing a non-covered service in a misleading way that makes it appear as if a covered service was actually furnished"

Based upon this information, it would be inappropriate to report the pharmacy item that was not administered to the patient.

Resource: Medicare General Information, Eligibility and Entitlement Manual Chapter 1: www.cms.hhs.gov/manuals/downloads/ge101c01.pdf

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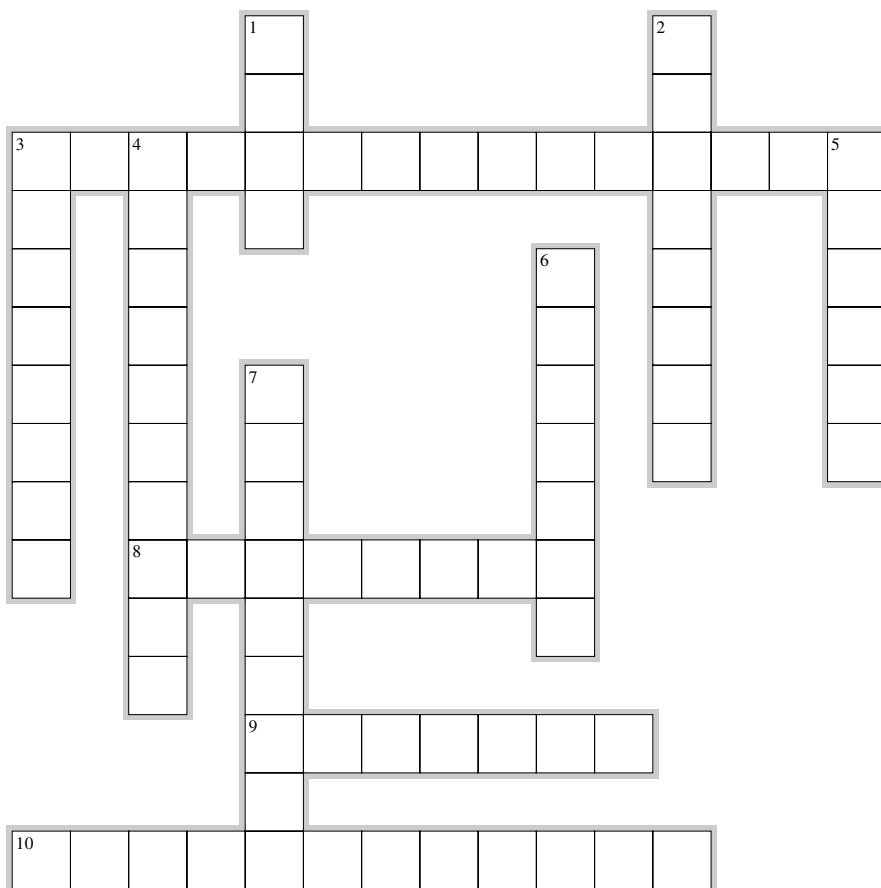
By Toueria Morris, CPC-H

Across

3. ESRD related laboratory test and ___ are packaged into the PPS.
8. Pediatric dialysis treatments are not ___ for the low volume adjustment.
9. When a facility needs to report a drug or lab test that was furnished to an ESRD beneficiary that was not ___ to the treatment of ESRD, they must include the modifier AY to indicate the item or service is not for the treatment of ESRD.
10. This is one of the six comorbidity categories that the ESRD PPS will incorporate in addition to those adjusters that are currently used.

Down

1. All claims must be billed by a renal dialysis facility and paid under the ESRD PPS for ___ dialysis.
2. Blood, blood products and ___ are separately payable under the ESRD PPS.
3. Add-on ___ are made for home training sessions.
4. If the ESRD facility furnished less than 4,000 treatments in each of the three cost report years preceding the payment year and has not opened, closed, or received a new provider number due to change in ownership during the 3 years preceding the payment year, they will receive an ___ to their ESRD PPS base rate.
5. The ESRD PPS will provide a ___ payment to ESRD facilities, i.e., hospital based providers of services and renal dialysis facilities.
6. Dialysis facilities that are treating patients with higher acuity levels will be entitled to ___ payments.
7. What payment model applies to all dialysis patients that are under the age of 18?



ANSWERS
 ACROSS 3. PHARMACEUTICALS 8. ELIGIBLE 9. RELATED 10. PERICARDITIS
 DOWN 1. HOME 2. VACCINES 3. PAYMENTS 4. ADJUSTMENT 5. SINGLE 6. OUTLIER 7. PEDIATRIC

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CCFN provides a discussion of coding practices for educational purposes only. MedAssets has made every effort to ensure the accuracy of the contents herein. Official coding guidelines are maintained by the Central Office on ICD-9-CM of the American Hospital Association.



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