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OCTOBER 2010

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## FEATURE ARTICLE

Get to Know the Characters Behind ICD-10-PCS



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The move to ICD-10-PCS from ICD-9 has been long awaited, reports Darnacea Harris, MHA, RHIT, CCS. The new coding classification is a multi-axial, seven-character alphanumeric code structure that provides unique codes for each procedure, she notes. The structure is based on individual letters and numbers, called values that occupy seven spaces of the code, called characters. Procedure codes are seven characters long. Each represents an aspect of the procedure. A character can have one of 34 different values assigned. Gone are vague code descriptors that caused confusion and inconsistency in code assignment. Instead, ICD-10-PCS offers a structure that is logical and consistent.

## DOC2DOC



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### **2011 OIG Workplan is Here. Don't Expect the Pain to Go Away**

The Office of the Inspector General (OIG) has published the 2010 plan for Fiscal Year 2011. Why should you care? Because these are the issues that get passed to Medicare Administrative Contractors (MAC) and Recovery Auditor Contractors (RAC) and private payor auditors.

## TALKING POINTS



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### **2011 Medicare Physician Fee Schedule – Proposed Final Rule Keynotes**

The proposed ruling contains policy proposals that will impact physician and non-physician practitioner (NPP) services paid under the MPFS, as well as other Medicare Part B payment policies that address Ambulance, Lab, End Stage Renal Disease services and Part B Drug coverage.

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### **Some New, Some Not So New Codes Among 2011 CPT® Updates**

The time has arrived for the 2011 CPT updates. Based upon MedAssets' review and analysis of these codes, there only appears to be 343 CPT code changes for 2011.

## MODIFIERS CORNER



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### **Using Modifiers to Report Reduced or Cancelled Procedures**

Modifiers 73 and 74 are used when reporting outpatient procedures that have been cancelled, interrupted, discontinued or terminated and anesthesia was either provided or it was intended to be used during the procedure.

ALSO...

FAQs, MedAssets Events and Presentations, Crossword Puzzle

## Get to Know the Characters Behind ICD-10-PCS

The move to ICD-10-PCS from ICD-9-CM has been long awaited and much anticipated. The level of detail needed to classify diagnostic and procedural specificity far exceeds the language needed for ICD-9-CM – code sets that have been in use in the United States since 1979. Codes listed in ICD-10 are geared toward improving quality of care data, more complete understanding of complications and to better track outcome of care.

ICD-10-PCS adds more specificity to procedure classifications and provides a better system for expansion. The ICD-10-PCS coding classification is based on a multi-axial, seven character alphanumeric code structure that provides unique codes for each procedure. Gone are the eponyms and vague code descriptors that caused confusion and inconsistency in code assignment. Instead, ICD-10-PCS offers a structure that is logical and consistent.

The structure is based on individual letters and numbers, called values that occupy seven spaces of the code, called characters. All procedure codes in ICD-10-PCS are seven characters in length, and each character represents an aspect of the procedure. The diagram below describes the seven characters that represent a complete code in the Medical and Surgical section of ICD-10-PCS

Each character can have one of 34 different values assigned. These values can be numbers 0 through 9 and any of the alphabet (except I and O). The letters I and O are not used so as not to be confused with the numbers 1 and 0. The values for each character depend on the clinical procedure performed, and the section (or category in ICD-9-CM) where the procedure exists. In the ICD-10-PCS code 02103D4, for example, the '0' in character one has a different meaning than the '0' in character four. The differences are better illustrated in the diagram below.

The following provides a general description of each character and its purpose.

### Character 1 – Section

This is the first character in an ICD-10-PCS code. This character identifies the broad procedure category, or section, where the code is found. (In ICD-9-CM this would be the category). There are 16 sections of ICD-10-PCS. For example, the first character in all Medical and Surgical codes is always '0,' the first character in all obstetric codes is always '1,' and so on.

### Character 2 – Body Systems

Body systems specify the general clinical body system of the procedure. For example, the female reproductive system is represented by the value 'U,' the endocrine system is represented by the value 'G,' and procedures on the heart and great vessels are represented by the value '2.' There are 30 values that represent body systems.

CHARACTER 1	CHARACTER 2	CHARACTER 3	CHARACTER 4	CHARACTER 5	CHARACTER 6	CHARACTER 7
SECTION	BODY SYSTEM	ROOT OPERATION	BODY PART	APPROACH	DEVICE	QUALIFIER
0	2	1	0	3	D	4
MEDICAL AND SURGICAL	HEART AND GREAT VESSELS	BYPASS	CORONARY ARTERY, ONE SITE	PERCUTANEOUS ENDOSCOPIC	INTRALUMINAL DEVICE	CORONARY VEIN

### Character 3 – Root Operations

The root operations identify the reason, or objective of the procedure. There are 31 precisely defined root operations that are grouped with procedures having similar attributes. Root operations represent a significant change from ICD-9-CM procedure guidelines. ICD-10 coding guidelines for multiple procedures, for example, define specific conditions for coding multiple procedures (ICD-10-PCS root operation guideline B3.3 – multiple procedures).

Examples of root operations include the following:

Bypass	Creation	Excision
Extirpation	Insertion	Occlusion
Removal	Supplement	Transfer

### Character 4 – Body Part

This character defines the specific anatomic site where the procedure was performed. This is different from Character 2 where the general body system is identified. There are 34 possible values for each body system. Within the body part 'H' – skin and subcutaneous tissue and breast, there are 17 body parts. Examples include breast, right, abdominal wall, and subcutaneous tissue, thorax.

### Character 5 – Approach

In ICD-10-PCS, the approach refers to the technique used to reach the site of the procedure. There are only seven different approaches:

1. Open
2. Percutaneous
3. Percutaneous Endoscopic
4. Via Natural or Artificial Opening
5. Via Natural or Artificial Opening Endoscopic
6. Via Natural or Artificial Opening Endoscopic with Percutaneous Endoscopic Assistance
7. External

The three components associated with the approach character are the access location, method, and type of instrumentation. There are two general types of access locations, skin or mucous membranes and external orifices. Every approach, other than external

must include one of these access locations. External openings can be natural (e. g. via mouth) or artificial (e.g. colostomy stoma).

### Character 6 – Device

The device character specifies devices that remain after the procedure is completed. There are four general types of devices, and all devices fall within these types. These include the following:

- Biological or synthetic material that takes the place of all or a portion of a body part (e.g., skin grafts and joint prosthesis)
- Biological or synthetic material that assists or prevents physiological function ( e.g., IUD)
- Therapeutic material that is not absorbed by, eliminated by or incorporated into a body part (e.g., radioactive implant)
- Mechanical or electronic appliances used to assist, monitor, take the place of or prevent a physiological function (e.g., cardiac pacemaker, orthopedic pins)
- Specific guidelines within ICD-10-PCS direct the coder, where devices and root operation match. When no device is used within a procedure, a placeholder value is assigned.

### Character 7 – Qualifier

Qualifiers hold the seventh position in the ICD-10-PCS code. This character contains unique values for individual procedures. The qualifiers provide definition for aspects of the procedure that cannot be defined elsewhere, but need to be identified. In the obstetrics section, for example, qualifiers identify the type of extraction (low forceps, etc.) the type of cesarean section (classical, etc.) or the type of fluid removed during a drainage procedure (amniotic fluid).

The development goal of ICD-10-PCS was to incorporate completeness, unique definitions, expandability, multi-axial codes, standardized terminology and structural integrity. Maximum functionality and flexibility is achieved with the use of consistent characters and values, allowing for improved data collection and analysis.

Consistency in character definition allows for meaningful comparisons of data and

analysis across a wider field of data possibilities. The improved structure and specificity make ICD-10-PCS much easier to use than ICD-9-CM. More extensive knowledge of anatomy and physiology, the clinical process of a procedure, and the purpose of devices are needed for coders to properly assign codes in ICD-10-PCS. Coders will need to spend time reviewing anatomy and procedural processes, and organizations will need to improve the clinical documentation provided by providers. ■

### About the Author

Darnacea Harris MHA, RHIT, CCS, has over 20 years experience in the coding, compliance and reimbursement industry, and has previously held such positions CCA 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.

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## 2011 OIG Workplan is Here Don't Expect the Pain to Go Away

*Bad docs, bad docs what you gonna do,  
what you gonna do when they come for  
you. (Sung to the tune of Bad Boys!)*

On Oct. 1, 2010 The Office of the Inspector General (OIG) published the 2010 plan for Fiscal Year 2011. Why should you care? Because these are the issues that get passed to the Medicare Administrative Contractors (MAC) and Recovery Auditor Contractors (RAC) and private payer auditors.

Below are new or continued issues from the 2009 plan:

### Payments for Diagnostic X-Rays in Hospital Emergency Departments

Medicare claims AND medical records will be reviewed for diagnostic x-rays performed in ERs to determine appropriateness of payments. There are concerns about the potential overuse of diagnostic imaging services and interpretations. Physicians are paid under the Physician Fee Schedule for radiology services, and in 2007 the Medicare program paid approximately \$207 million to physicians for radiology services provided in emergency departments.

### Medicare Incentive Payments for E-Prescribing

Incentive payments made in 2010 to eligible professionals for their 2009 e-prescribing activities will be reviewed. OIG will assess whether any payments for e-prescribing were made in error.

### Place of Service Errors

Physician coding of place of service on Medicare Part B claims for services performed in ASCs and hospital outpatient departments will be reviewed.

The proper coding by physicians of POS for services provided in ASCs and hospital outpatient departments will be reviewed.

This issue continues to be a hot button for the OIG. Reimbursement for certain procedures is higher when a physician performs them in the office than when she/he performs them in an ambulatory surgical center or hospital outpatient department.

### E&M Services during Global Surgery Periods

The OIG will review industry practices related to the number of E&M services provided by physicians and reimbursed as part of the global surgery fee. The OIG will determine whether industry practices related to the number of E&M services provided during this period have changed since the global surgery fee concept was developed in 1992.

### Medicare Payments for Part B Imaging Services

- The OIG will focus on the practice expense components, including the equipment utilization rate.
- The OIG will determine whether payment reflects the actual expenses incurred and whether the utilization rate reflects current industry practices.

### Physician Reassignment of Benefits

- The OIG will review extent to which physicians reassign their benefits to other entities.
- The OIG will examine the extent to which physicians are aware of their reassignments.

### Medicare Providers' Compliance with Assignment Rules

The OIG will examine extent to which providers comply with assignment rules and determine if and to what extent beneficiaries are inappropriately billed in excess of amounts allowed by Medicare.

### Accuracy and Completeness of the NPI

The OIG will determine whether providers are including NPIs on claims as required.

### Medicare Billings with Modifier GY

The OIG will review the appropriateness of the use by physicians and other providers of Modifier GY on claims for services that are not covered by Medicare. The GY modifier is used in coding for services that are statutorily excluded or do not meet the definition of a covered service.

Although providers are not required to provide beneficiaries with an Advance Beneficiary Notice for such services, beneficiaries are liable for all charges associated with these services. The OIG is concerned that beneficiaries may be unknowingly acquiring large medical bills. Of note: Medicare denied over \$820 million in modifier GY claims in fiscal year 2010, and the OIG

wants to further research “patterns and trends for physicians’ and suppliers’ use of modifier GY.”

### Physician Self-Referral for DME

The Office of Audit Services (OAS) will be examining whether to allow claims from DME suppliers in which physicians hold ownership interests to determine whether the claims are permitted under the Physician Self Referral (Stark) Law.

### Physicians Visits to Hospice Patients

If you as a physician have an employment arrangement with a hospice, the Part A hospice benefit should pay for part of your services. The OIG wants to make sure physician visits to hospice patients aren’t being double billed – once to Part A and once to Part B.

There are also areas affecting the hospital that may require your documentation assistance:

### Hospital Admissions With Conditions Coded Present-on-Admission

For certain diagnoses specified by CMS, hospitals receive a lower payment amount if the specified diagnoses were acquired in the hospital. So your assistance is required in the documentation to assist the coders in accurately identifying the conditions present on admission.

### Adverse Events

In December 2008, the OIG issued three reports regarding its investigation into the occurrence of adverse events. The terms “Never Events,” or “serious reportable events,” refer to a subcategory of adverse events that the National Quality Forum (NQF) deemed “should never occur in a health care setting” such as, for example, surgery on the wrong limb. Although the OIG reviewed never events last year, it has now expanded its review to include adverse events. In 2010, the OIG will continue its focus on the following:

- Adverse events among Medicare beneficiaries in inpatient hospital settings
- Methods for identifying adverse health care events
- Implementation of Medicare’s Policy for Hospital Acquired Conditions (HACs)

- Responses by Medicare Oversight Entities
- Public Disclosures of Adverse Event Information

Documentation is required to help the hospital in the coding and therefore defense of “hospital-acquired” as this affects reimbursement. In the example of HACs, CMS will deny higher Medicare reimbursement for related care.

### Coding and Documentation Changes Under the Medicare Severity Diagnosis Related Group System

The OIG will review the impact of the October 1, 2007, implementation of the Medicare Severity Diagnosis Related Group (MS-DRG) system. CMS revised its hospital inpatient reimbursement system to improve recognition of severity of illness and resource consumption, as recommended in a March 2005 MedPAC report. As a result, the number of DRGs has increased from 538 to 745. It is up to you as doctors to provide the documentation in the chart to meet the severity of illness assignment by the coder so that “upcoding” is justified.

So what is the underlying thread that ties all the above? That is correct proper documentation. You must document medical necessity. Depending on how you document will affect the outcome of audits and therefore reimbursement.

### Medical Learning Network: Get Connected

If not already familiar with documentation there are two articles in MLN (Medical Learning Network) Matters published on September 23rd that offer education to providers. For those of you who do not know what MLN Matters are all about they are articles published by the Centers for Medicare & Medicaid Services (CMS) designed to inform the physician, provider and supplier community about the latest changes to the Medicare Program.

The new articles are titled SE 1027 – with the intent on addressing medical necessity for inpatient hospitals and SE 1028 which addresses medical necessity and validation of inpatient DRGs. Depending on how you document will affect the hospital getting reimbursed if at all when they are audited.

Please make sure that all documentation tools such as assessments, flow sheets, checklists etc. in the office, as well as in the hospital, are completed as applicable. If a field is not applicable, do not leave it blank. I know that it is tedious but please fill in N/A.

This shows a reviewer that the question was reviewed and answered. Blank fields will be interpreted as being inaccurate by the reviewer. So, please make sure that you review your notes, and if an entry contradicts previous documentation please explain the contradiction. Or if there is a change in the patient’s condition, note the change in your documentation.

CMS advises that all inpatient admissions must have the principal diagnosis specifically identified by the attending physician. You as the provider are attesting to the medical necessity and the severity of illness. You are being reminded that the principal diagnosis is the condition established after study to be chiefly responsible for the admission and this should be documented on the discharge summary. You are also being advised on what constitutes a secondary diagnosis and these also must be documented by the attending as seen MLN SE 1028.

Secondary diagnoses are those that have been:

- Clinically evaluated or
- Diagnostically treated or
- Therapeutically treated or
- Cause an increase in LOS or nursing care

Per MLN SE 1024, submission of incomplete or illegible records can result in denial of payment for billed services.

### What’s in it for You?

Do you think CMS is trying to push you into the ever popular and “cheap” electronic medical record?

So what does this mean for you? Yes, it translates as a heavier administrative burden. More charts, more internal chart dives to make sure that they are accurately coded, and this all translates as more man hours for staff or the extra added burden of hiring more temporary or permanent qualified help.

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## 2011 Medicare Physician Fee Schedule Proposed Final Rule Keynotes

*ED. NOTE: The Medicare Physician Fee Schedule (MPFS) Proposed Final Rule was published in the Federal Register on July 13, 2010. The Centers for Medicare and Medicaid Services (CMS) accepted comments through Aug. 24 and will respond to all comments in the final ruling scheduled for release by Nov. 1, 2010. This is the final installment in a two-part series on this timely subject.*

The proposed ruling is a 1,200+ plus page document containing a multitude of policy proposals that will impact physician and non-physician practitioner (NPP) services paid under the MPFS, as well as other Medicare Part B payment policies that address Ambulance, Lab, End Stage Renal Disease services and Part B Drug coverage. In the following paragraphs, we have attempted to capture a number of significant changes being proposed for 2011 as follows:

- Sustainable Growth Rate (SGR)
- Rebasing of RVU Components
- Equipment Utilization Rates
- Stark Law Changes – In-Office Ancillary Services Disclosure
- Potentially Misvalued Codes
- Multiple Procedure Payment Reduction
- Expansion of Medicare Preventive Services and Access to Primary Care
- Physician Quality Review Initiative (PQRI) and Electronic Prescribing (eRx) Incentives

The MPFS Proposed Rule is anything but light reading but if you're ready to dive in, it can be reviewed from the CMS website at CMS-1503-P (Published July 13, 2010) - PDF Version [57MB] or CMS-1503-P (Published July 13, 2010) - Text Version.

### Sustainable Growth Rate (SGR)

The proposed rule focuses on a 6.1 percent payment cut to take place in January 2011. The SGR, which serves as a foundation for calculating physician payments, has been considered a flawed system, partly because Congress has stopped across-the-board decreases each year since 2002. In 2010, Congress acted to suspend the projected 21.3 percent cut and replaced it with a 2.2 percent increased rate. Unless Congress blocks the proposed cuts, we can expect to see drastic reductions in the MPFS payments for 2011.

### Practice Expense (PE) and Malpractice (MP) – Rebasing of RVU Components

2011 is the second year of the four-year phase in period utilizing the Physician Practice Information Survey (PPIS) data conducted by the American Medical Association (AMA). CMS plans to continue with the phase-in by using a 50/50 blend of older practice expense data in conjunction with the current PPIS data. The phase in period will be fully implemented by 2014.

As an attempt to recognize increased physician practice expenses, CMS projects an increase in PE RVUs which is based on the impact of the PPIS data and revision to the Medicare Economic Index (MEI). The MEI is a weight portion of physician practice costs and is used in the SGR formula that determines physician payment updates.

The rebasing process is revising the MEI by selecting a base year in which determines the expense categories. For 2011 the proposed rule states that CMS is proposing to rebase the MEI to calendar year (CY) 2006 opposed to using CY 2000 data for the base in 2010.

Malpractice RVUs are reviewed and adjusted at least every five years, and the latest review was completed in 2010. CMS also proposes an increase in MP RVUs, and in order to preserve budget neutrality with realigning PE and MP RVUs. CMS plans on off-setting the increases by revising the work RVU weight component of the Medicare payment calculation process.

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**The MPFS Proposed Rule is anything but light reading but if you're ready to dive in, it can be reviewed from the CMS website at CMS-1503-P (Published July 13, 2010).**

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**The written notice must be written in a manner that is easily understood, and a patient signature is required.  
Once reviewed and signed, it should be retained by placing the notice in the medical record.**

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### Equipment Utilization

CMS proposes an estimate of 75 percent usage for the cost of radiological diagnostic equipment priced at over \$1 million, such as Computed Tomography (CT), Computed Tomography Angiography (CTA), Magnetic Resonance (MRI) and Magnetic Resonance Angiography (MRA). The estimate is based on a cost per minute projection that is incorporated into the utilization of equipment equation. 2011 proposal decreases the usage amount for expensive equipment from the 2010 implementation of 90 percent. The usage assumption reflects an estimate of how often equipment is used during business operating hours.

### In-Office Ancillary Service Self-Referrals

Changes to the Affordable Care Act (ACA) will require physicians making in-office self-referrals for certain radiology services such as MRI, CT and PET scans, to inform their patients, in writing, at the time of the referral of alternate locations in which the services can be received. CMS issued proposed regulations that are to include a written list of suppliers that contains name, address, and telephone number of suppliers that furnish the same services within a 25-mile radius of the area of the referring physician's office.

The written notice must be written in a manner that is easily understood, and a patient signature is required. Once reviewed and signed, it should be retained by placing the notice in the medical record. In addition, CMS proposes that where there are no other qualifying suppliers within the radius a written list does not need to be issued. Also, "providers of services" such as hospitals are not required to be included on the list.

### Potentially Mis-valued Codes under the Physician Fee Schedule

Provisions of the Patient Protection and Affordable Care Act of 2010 (PPACA) requires review of potentially mis-valued services in several areas. Contractors may be used to identify and analyze codes and families of codes which have substantial changes in practice expense, services that have been the fastest in growth or services containing new technologies.

Other areas of concern are multiple codes that are frequently reported together in conjunction with a single service and also codes that have low RVUs that are often billed multiple times in one setting. The Secretary is mandated to have a validation process in place, and CMS has requested comments on how they should go about establishing the validation process in which will be further discussed in the final rule after receiving input.

### Multiple Procedural Reduction Rule

For this provision of the ACA, CMS is proposing to increase the requirements of the Multiple Procedure Payment Reduction (MPPR) by applying the reduction to specific imaging services furnished on the same day in the same session, regardless of imaging modality. The reduction will apply to CT, CTA, MRI, MRA, and ultrasound procedures performed within the same family of codes or across code families similar to surgical procedures that do not group procedures by body area. Currently the MPPR applies full payment for the technical component (TC) of the highest paid procedure and a 25 percent reduction in payment for each additional procedure. CMS is proposing to change to a 50 percent reduction for each additional procedure. The change will also affect cardiac CT and CTA as well as speech pathology and physical therapy services.

### Expansion of Medicare Preventive Services and Access to Primary Care

Several provisions in the recent healthcare reform legislation offer increased funding for primary care and prevention services. In an effort to improve preventive services offered to Medicare beneficiaries, the proposed rule states that in 2011 CMS would eliminate deductibles and coinsurance payments for most preventive services. CMS will cover an annual wellness visit that will expand on the current Initial Preventive Physical Examination (IPPE or "Welcome to Medicare Visit"). Currently the IPPE is a one-time visit that must be scheduled within the first year that the patient becomes eligible for Medicare benefits. The proposed wellness visit is intended to open up opportunities for the beneficiary to not only establish but to also develop a patient and physician relationship and prevention plan.

Other areas of the ACA provision address policy and payment rate updates for primary care services provided by physicians and NPPs paid under the MPFS, as well a payment incentive program for primary care providers. For rural areas designated as Health Professional Shortage Areas (HPSAs), physician assistants (PAs) will be allowed to order post-hospital extended care services in skilled nursing facilities and certified nurse midwives will be paid for their services under the MPFS at the same rate as physicians.

### Physician Quality Reporting Initiative (PQRI)

In 2010, participating professionals reporting quality measures were eligible for an incentive payment of 2.0 percent of the estimated total allowed charges for all covered professional services furnished during the designated reporting period. In 2011, CMS is proposing a one percent incentive payment that will drop to 0.5 percent incentive payments beginning in

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**A significant change proposed in 2011 will reduce the requirement of reporting each measure from 80 percent to 50 percent of patients receiving services in which the measure applies.**

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2012 through 2014 and penalties will begin in 2015 for those who do not participate in submitting quality data.

Eligible practitioners (EPs) reporting claims-based individual measures or measure groups are required to report at least three measures for services provided. A significant change proposed in 2011 will reduce the requirement of reporting each measure from 80 percent to 50 percent of patients receiving services in which the measure applies. CMS anticipates that this change will allow more providers to successfully participate. EPs that have less than three measures to report may report one or two measures and still be able to meet the 50 percent requirement.

For reporting measures through qualified registries or electronic health records (EHRs), EPs will still be required to report on 80 percent of the patients receiving services. The 80 percent requirement also continues to apply for reporting group measures through registries. Currently when reporting by a Group Practice, only groups of 200 or more practitioners can participate in this reporting method. CMS proposes to launch a pilot program that will allow group practices with two or more EPs to participate in 2011. Smaller group practices with between two and 200 EPs must report three to six individual measures and one or more measure groups.

### **PQRI Maintenance of Certification Programs (MOC)**

Additional incentives are being proposed for EPs that submit data through a qualified Maintenance of Certification Program (MOC). For 2011 an additional 0.5 percent incentive payment is being proposed for EPs that meet the requirements of submitting their data through a MOC program.

Participating EPs are required to qualify for a maintained board certification status by having such data submitted on their behalf through a MOC Program, and participating in a MOC Program, practice assessment is required more often.

### **PQRI Reporting Periods**

Similar to the reporting periods used in 2010, CMS proposes the following alternatives for PQRI reporting:

- 12-month reporting period for claims-based and registry-based reporting (Jan. 1, 2011–Dec. 31, 2011) or 6-month reporting period for claims-based and registry-based reporting (July 1, 2011–Dec. 31, 2011)
- 12-month reporting period for EHR-based reporting
- 12-month reporting period for the Group Practice Reporting Option (GPRO)

### **Electronic Prescribing (eRx) Incentive Program**

CMS also proposes changes to the Electronic Prescribing incentive program that will establish an incentive payment for successful e-prescribers, however will exclude those EPs who receive a payment under the Electronic Health Records (EHR) Incentive Program from receiving a separate payment. The proposal will allow fewer than 200 physician practice members to participate in the eRx program.

### **In Summary**

The MPFS Final Rule with comments is anticipated for release by Nov. 1, 2010, and it remains to be seen how Congress handles the proposed payment cuts. Based on that action is how the SGR will affect the MPFS payment calculation process for 2011. Once finalized, the proposed policies outlined in this article are to apply for services furnished Jan. 1, 2011 unless otherwise specified.

We will all need to stay tuned and see how it plays out. ■

### **About the Author**

Susan Cinquino, CPC is a Quality Review Analyst with MedAssets. She brings more than 26 years of healthcare experience in various areas that include coding and compliance, revenue cycle management, physician education, consulting services, practice management and healthcare administration for private, professional and facility-based practices.



## TALKING POINTS

By Shelley V. Nave, RHIA, CPC-H and Renee T. Guilbeau, RHIA, CIRCC

## Some New, Some Not So New Codes Among 2011 CPT® Updates

### Are you ready?

The time has arrived for the 2011 CPT updates. MedAssets is committed to assisting its clients through the process of updating their chargemaster (CDM). Let us begin with a brief overview of 2011 CPT codes updates. According to Appendix B in the 2011 CPT Manual, the American Medical Association (AMA) has approved 420 CPT code changes for 2011 (Please see the table below for a complete breakdown of all the category updates). Based upon MedAssets' review and analysis of these codes; there only appears to be 343 (excludes the two reinstated Category III codes) CPT code changes for 2011.

The majority of these codes are additions (new codes) occurring in the "Surgery" section. We have reviewed the codes listed as "new" and many of these codes were effective in calendar year 2009 and

2010. Therefore, these codes may already be established in your CDM and are not technically "new" codes for 2011. These codes will appear as "new" codes in the 2011 CPT Manual because they were not listed as "new" codes in the previous year(s) CPT Manual.

Based on our review of the "new" codes, there appears to be 151 codes that are "new" for 2011. Three of these (0260T, 0261T, and 90654) are not listed in Appendix B, but they are listed on the AMA website as new codes for 2011 and will appear in the 2012 CPT Manual. Please note, Evaluation and Management (E/M) CPT code 99365 is listed as a "new" code in Appendix B, but according to the AMA it will not be an active CPT code for 2011.

The surgery section also contains the most revised codes for 2011. Although, the AMA

Appendix B has listed 97 revisions, after further review only 85 appear to be "true" revisions. "True" revisions are when the CPT code description has been changed and the change substantially alters the intent of the CPT code. The other revisions include grammatical (e.g., commas, capitalization, changing the word three to the number 3), changes that do not change the intent of the CPT code.

For 2011, the "Medicine" section has the largest number of deleted codes. These will require deactivation/inactivation in the chargemaster. Remember, deleted codes will become invalid codes and will no longer be available for use effective Jan. 1, 2011. The Appendix B listed 110 codes deleted for 2011; however, after further analysis, it appears that there are only 107 deleted codes for 2011. Included in the 2011 Appendix B are two deleted Category

### SUMMARY OF CHANGES - APPENDIX B

\* denotes numbers are included in the number of new codes

CATEGORY	NEW CODES	REVISED CODES	DELETED CODES	RE-SEQUENCED CODES	RECYCLED/ REINSTATED CODES
Evaluation & Management (99201-99499)	3	0	0	3*	0
Surgery (10040- 68899)	64	54	32	6*	0
Radiology (70010-79999)	5	5	8	0	0
Pathology/Laboratory (80048-89399)	16	7	13	3*	0
Medicine (90281-99199) & (99500-99607)	40	23	41	2*	0
Category II (0001F - 7025F)	31	6	2	0	0
Category III (0019T - 0259T)	52	2	14	1*	0
<b>TOTAL</b>	<b>211</b>	<b>97</b>	<b>110</b>	<b>15*</b>	<b>2</b>

II codes (1127F and 1128F) and one deleted Category III code (0140T) that were actually deleted on 12/31/2009.

In 2010, the AMA began a new CPT code numbering methodology by resequencing codes. Resequencing is a method of displaying a CPT code outside of its numerical CPT code range. The CPT codes are resequenced based on its description and relations with another code rather than by its number. The AMA has continued this numbering methodology by adding 15 new resequenced CPT code for 2011.

For example, new evaluation and management (E/M) subsequent observation care codes, 99224, 99225 and 99226 are resequenced and might be displayed in the 2011 CPT manual after the Subsequent Hospital Care codes (99231 – 99233) instead of being displayed following Initial Hospital Care E/M codes (99221- 99223).

Resequenced CPT codes may be identified in red font within the subcategories to provide guidance as to where to locate the resequenced CPT code within that subcategory. A list of resequenced codes can also be found in Appendix N of the CPT Manual.

Also published in the 2011 Appendix B are two reinstated/recycled Category III codes. Reinstated/recycle codes are formerly deleted codes that have been recycled or reinstated. The published reinstated codes are 0058T, cryopreservation; reproductive tissue, ovarian; and 0059T, cryopreservation; oocyte(s). The facility will need to determine whether to reactivate these reinstated codes or if it will be necessary to create a new charge. Also note, according to the AMA, these reinstated codes are retroactive with an effective of Jan. 1, 2009.

This quick glance into the 2011 CPT updates does not end here. MedAssets would like to invite you to participate in one of our 2011 CPT Codes Update Webinars that will provide additional information on the CPT changes for 2011. To register, please [click here](#). ■

#### About the Authors

Shelley V. Nave, RHIA, CPC-H, is a Coding and Chargemaster Analyst with MedAssets integrity Services. In this role she provides coding and reimbursement guidance. Prior to joining MedAssets Shelley was Director of Health Information Management for five years for an acute care hospital

in Georgia. Shelley is a member of the American Academy of Profession Coders, American Health Information Management Association, and the Georgia Health Information Management Association.

Renee T. Guilbeau, RHIA, CIRCC, has been employed with MedAssets for more than five years. Prior to this position she was an APC Coordinator & Outpatient Coding Supervisor for 5 years. She 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.

#### REFERENCE

AMA 2011 DATA FILES – APPENDIX B

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## 2011 OIG Workplan is Here (continued)

The denials pointed out in MLN SE 1028 are not always correct, and in some cases have been appealed successfully. If you are flagged for an audit, remember that you are the provider and the folks auditing your charts are not clinicians. They are coders who have great coding knowledge but have not gone to medical school to attain what you have attained.

So if you are audited and cited, remember that the best defense is an offense. ■

#### 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 NH for the Fraud and Abuse Division.

## Using Modifiers to Report Reduced or Cancelled Procedures

*ED. NOTE: The last two modifiers presented in this three-part series are used when reporting outpatient procedures that have been cancelled, interrupted, discontinued or terminated, and anesthesia was either provided or it was intended to be used during the procedure.*

The definitions for Modifiers 73 and 74 are rather lengthy as you can see from reading the information presented below. The underlined text, however, shows the differences between the two definitions:

**73 Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia:** Due to extenuating circumstances or those that threaten the well being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73.

**74 Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia:** Due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure

after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74.

### Similarities: Between 73 and 74

Both modifiers are appropriate for reporting the following:

- Discontinued outpatient hospital or ASC procedures
- Surgical or diagnostic procedures that were cancelled or terminated by the physician due to extenuating circumstances or those that threaten the well being of the patient
- A procedure that either required or usually required anesthesia or a procedure planned to be performed under anesthesia due to patient needs
- The patient was in or had been moved to the room or surgical suite where the procedure requiring anesthesia was to be performed

Modifiers 73 and 74 should NOT be reported with:

- Procedures that are electively cancelled
- Procedures where anesthesia is not planned
- A patient visit where a procedure was planned, but was cancelled prior to the patient being prepped or prior to the patient being moved to the room or surgical suite where the procedure requiring anesthesia was to be performed

Note: It is not appropriate to report a procedure that was not provided to the patient; however, if other services besides a procedure were provided (during the visit for a planned procedure that was cancelled prior to the patient being prepped, sedated or taken to the procedure room), it may be appropriate to report an E/M code to capture these services if no CPT/ HCPCS code exists to describe the services provided. The facility might report a visit code based on the hospital's own coding guidelines, which must reasonably relate the intensity of hospital resources used to the E/M level reported. The services provided should be medically necessary and documented in the patient record.

### Key Points

There are a few key points that make a difference when deciding whether to report Modifier 73 or 74 for a terminated or cancelled procedure where anesthesia was planned.

### Anesthesia

The main difference between these modifiers is whether the administration of "anesthesia" occurs prior to the termination of the procedure.

As we discussed in part one of our article, anesthesia for the purpose of these modifier assignments includes the following: local, regional block(s), moderate sedation/ analgesia ("conscious sedation"), deep sedation/analgesia, or general anesthesia. This definition was clarified in CMS Transmittal 442 issued in January 2005,

to include “moderate sedation/analgesia (“conscious sedation”), deep sedation/analgesia.”

Prior to the clarification by CMS, hospital claims data showed that discontinued procedures:

- Performed using moderate or conscious sedation were often not reported with Modifiers 73 or 74. Many facilities were reporting Modifier 52 for discontinued colonoscopies. According to the CMS clarification, discontinued procedures that were planned with moderate or conscious sedation should be reported with either Modifier 73 or 74. These would be procedures such as biopsies, minor surgery or endoscopies. Based on guidance from CMS and CPT Assistant, it appears that in these types of cases when the sedation was started but the procedure was not initiated, it would be appropriate to report the procedure code appended with Modifier 73. Surgical Procedures versus Non-Surgical Procedures

When Modifiers 73 and 74 were first introduced, certain types of procedures were not allowed to be reported with these modifiers.

Previous Medicare guidance stated that Modifiers 73 and 74, and sometimes Modifier 52 as well, did not apply to radiology services. Then in 2007, the OPSS Final Rule announced they had amended the title and additions subsections of Section 419.44 in the 42 Code of Federal Regulations (CFR), where payment policy for interrupted procedures resides, for 2008. This change deleted the word “surgical,” leaving the term to read “procedures” so that all procedures performed in hospital outpatient departments would now apply. They also revised §419.44(b) changing “Terminated” to “Interrupted.”

\*Currently the Medicare Claims Processing Manual (chapter 4, §20.6) states “Modifiers -73, and -74 apply only to certain diagnostic and surgical procedures that require anesthesia,” but in subsection 20.6.4 they simply refer to the use of

modifiers 73 and 74 with “a procedure requiring anesthesia.”

Unfortunately, §20.6.6 ‘Modifiers for Radiology Services’ still instructs facilities to use Modifier 52 for radiology procedures that are “reduced,” without mentioning whether the radiologic procedures they are referring to are performed with or without anesthesia. This section states: “When a radiology procedure is reduced, the correct reporting is to code to the extent of the procedure performed. If no HCPCS code exists for the service that has been completed, report the intended HCPCS code with Modifier 52 appended.” Since they only mention Modifier 52, we might assume that they are referring to radiologic procedures where anesthesia is not planned in this reference.

#### Multiple Procedures

During a patient visit multiple procedures may be planned but not all of them completed.

- Any completed procedures should be reported.
- Any of the planned procedures that were not started would not be reported.
- If none of the planned procedures are completed, but the patient was prepped and taken to the procedure room, then it would be appropriate to report the procedure code for the first planned procedure.
  - If the procedure was not initiated and/or anesthesia was not started prior to the termination of the procedure append Modifier 73
  - If the procedure was initiated and/or anesthesia started prior to the termination of the procedure append Modifier 74

#### By-Passing Edits Frequency Edits

These modifiers will allow procedures with frequency limitations to bypass the Medicare Common Working File (CWF) edits. For example incomplete screening colonoscopies performed under conscious sedation may be reported with Modifiers 73 and 74 and the CWF will not apply the frequency limitations.

G0105 - Colorectal cancer screening; colonoscopy on individual at high risk

G0121 - Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

#### Missing Device Edits

For Medicare reporting by hospitals paid under the OPSS, HCPCS codes for devices are required to be reported on claims for certain procedures that use those devices. When the procedure is reported without a required device or a device is reported without the required procedure, the claim is returned to the provider. These “procedure-to-device” and “device-to-procedure” edits are bypassed when an interrupted procedure is reported with the appropriate modifier for the interrupted procedure.

#### Examples

Reviewing examples can help us to understand the regulations and guidance. The scenarios below have previously been published in AHA Coding Clinic for HCPCS.

#### 2nd Qtr 2008

##### Question

##### Incomplete colonoscopy

A patient is admitted to undergo a diagnostic colonoscopy for abdominal pain. After administration of anesthesia, the colonoscope was inserted and passed into the rectum and advanced into the sigmoid colon. Several attempts were made to pass the sigmoid colon, but these attempts were unsuccessful. The colonoscope was removed and a pediatric colonoscope was inserted but again the scope could not advance past the sigmoid colon. A small polyp was found in the rectosigmoid junction, which was removed by snare cautery.

How should this encounter be reported?

##### Answer

It would be appropriate to report CPT code 45385, Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique, for the procedure performed.

Because the procedure was started, it would be appropriate to append Modifier 74 to indicate that the entire colon was not examined.

#### Question

Diagnostic thoracentesis

A patient with left pleural effusion presents for diagnostic thoracentesis. The patient's skin was prepped for the thoracentesis and a local anesthetic was given. The needle was inserted into the pleural space, however, pleural plaque was encountered and the thoracentesis could not be performed. The needle was inserted into two different interspaces and pleural plaque was again encountered. At this point, the procedure was cancelled. How should this encounter be reported?

#### Answer

It would be appropriate to assign CPT code 32421, Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent, with Modifier 74 appended. Modifier 74 is appended in this scenario since local anesthesia was given but the procedure was not completed.

### 3rd Qtr 2007

#### Question

A patient presented for a Computed Tomography (CT) guided biopsy and/or drainage of an abscess of the right psoas muscle. Demerol and Versed were administered intramuscularly. The patient was taken to the CT scanner, where combined CTs of the abdomen and pelvis were performed. After review of the scans done (with and without contrast), no abscess was visible. The biopsy and/or drainage were not performed. Would the correct code for this procedure be CPT code 20206 with Modifier 74 assigned to this case?

#### Answer

Report CPT codes 74170, Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections and 72194, Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections, without any modifiers appended since CTs of both abdomen and pelvis were performed.

Since the procedure wasn't started, it would be inappropriate to report CPT code 20206, Biopsy, muscle, percutaneous needle, with Modifier 74, Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia, as the procedure was not performed.

#### Question

In the outpatient surgical center of our hospital, a cervical epidural steroid injection was attempted three times but was unsuccessful. The patient had been taken to the procedure room, prepared for the procedure, and given local anesthesia. The needle was inserted several times but could not reach the C5-C6 space, and the procedure was finally aborted.

Would it be appropriate to report the CPT code for the cervical epidural steroid injection and append Modifier 74?

#### Answer

Report CPT code 62310, Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography) of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic, with modifier 74, for the attempted but not completed cervical epidural steroid injection.

All attempts would be included in the reporting of one unit of the single CPT code.

### 4th Qtr 2006

#### Question

A patient presents as an outpatient for an endoscopic polypectomy. Anesthesia was administered and the colonoscopy was begun however because of poor colon preparation the colon could not be examined adequately and the procedure was aborted. What is the correct code assignment if the intended procedure was an endoscopic polypectomy? Would it be appropriate to append a Modifier 74 to the procedure code?

#### Answer

Report CPT code 45383, Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique, with Modifier 74, for the intended procedure which was not completed.

The scenarios below have previously been published in CPT Assistant.

### September 2003

#### Question

Example: A 70-year-old male patient is brought to the operating room for an elective repair of a recurrent inguinal hernia. The usual surgical preparation and positioning has occurred. Prior to the administration of general anesthesia, the patient complains of radiating chest pain with the cardiac monitor reflecting S-T segment changes. Due to the possibility of an evolving cardiac event, the procedure is cancelled.

#### Answer

Rationale: Under these circumstances, the intended service that was prepared for, but cancelled, can be reported with its usual procedure code and Modifier '73' appended. For this case, CPT code 49520 with the Modifier 73 appended would be reported. This modifier is not intended for physician or other qualified healthcare provider reporting. The Modifier 73 is also not used to depict the elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient.

#### Question

Example: Subsequent to making the incisional port entry for a planned laparoscopic cholecystectomy on a 66-year-old female patient, the anesthesiologist detects ventricular fibrillation on the cardiac monitor. Ventilation continues while defibrillator pads and paddles are brought into the surgical field. Upon the second defibrillation effort, the arrhythmia abates, but ventricular irritability is present. The procedure is cancelled pending further cardiac consultation/stabilization.

**Answer**

Rationale: Under these circumstances, the procedure started but was terminated. This can be reported with its usual procedure code number with the Modifier '74' appended (ie, CPT code 47562 with the Modifier '74' appended).

**Summary**

Since there have been many changes and revisions to the guidelines pertaining to Modifiers 73 and 74, be careful to pay attention to the most recent guidance when assigning these modifiers.

Procedures that are cancelled by the physician, after the patient was prepared for the procedure and taken to the room where it was to be performed, but before the administration of the planned anesthesia, are reported by facilities with Modifier 73 and receive 50 percent of the APC payment for the planned service. CMS has stated that this type of cancellation occurs infrequently and feels the hospitals realize significant savings when the cancellation is prior to initiation of the procedure.

Procedures that are terminated by the physician, after the patient was prepared for the procedure and taken to the room where it was to be performed and after the

administration of the planned anesthesia or after the procedure has been initiated, are reported by facilities with Modifier 74 and receive 100 percent of the APC payment for the planned service. CMS has stated that they believe the costs a facility might incur for procedures that were cancelled after initiation (of the procedure/and/or anesthesia) could be as significant as the costs of a completed procedure.

CMS has stated that their goal is to make sure hospitals understand and report modifiers for reduced, terminated and cancelled procedures correctly, in order for the hospitals to receive the appropriate payment for the services they provide.

**About the Author**

Sandy Palmer, RHIT, is a Coding and CDM Analyst for MedAssets, Integrity Services. Her expertise includes inpatient and out patient facility coding with a specific emphasis on the Outpatient Prospective Payment System (OPPS). 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****Federal Register**

November 01, 2005 - OPPS Section 03 - Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates - B. Interrupted Procedure Payment Policies (Modifiers -52, -73, and -74)

**100-04 Claims Processing Manual Section 020**

Chapter 04-Part B Hospital, Section 20 - Reporting Hospital Outpatient Services Using Healthcare Common Procedure Coding System (HCPCS)

**CMS Medlearn Matters MM4017**

September 2005, 'Billing for Devices Under the Hospital Outpatient Prospective Payment System (OPPS)'

**CMS Program Memorandum AB-03-114**

Publish Date August 2003, Claims Processing and Payment of Incomplete Screening Colonoscopies

**HCPCS Coding Clinic**

Vol 8 No 2, 2nd Qtr 2008, 3rd Qtr 2007, 4th Qtr 2005, 3rd Qtr 2001

**CPT Assistant**

May 2010 and September 2003

## 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** For CPT 36571, can I bill 76000 for the fluoroscopy, or should I always use 77001? Could you please give reference for your answer? Would this procedure need a C-code for the device on the bill?

### MedAssets Response

Based on the CPT Guidelines and CCI Manual references below, when fluoroscopy is performed with central venous access insertion CPT code 36571, it would not be appropriate to report CPT 76000. Additionally, a facility CCI edit for code pair 36571 (column 1) with 76000 (column 2) indicates that 76000 should only be reported on the same date if performed for a different primary procedure.

CPT 36571 is a device-dependent procedure, as indicated in the MedAssets Notes in the CodeBase display, for this code. By selecting the Syringe icon you can view the device codes required for 36571. At least one of these two asterisked device codes is required when reporting 36571, including the following:

C1751 – Catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis)

C1788 – Port, indwelling (implantable)

CPT Guidelines for Central Venous Access Procedures, available in KnowledgeBase, state: “When imaging is used for these procedures, either for the gaining access to the venous entry site or for manipulating the catheter into final central position, use 76937, 77001.”

NCCI Manual, Chapter 1 also available in KnowledgeBase, states: “Since CPT code 77001 describes fluoroscopic guidance for central venous access device procedures, CPT codes for more general fluoroscopy (e.g., 76000, 76001, 77002) should not be reported separately.”

**Q** On an outpatient bill (131) for diagnostic services provided at a hospital outpatient department paid under OPSS, would we need to place a TC modifier on our claim?

### MedAssets Response

The technical component modifier TC is not used for facility reporting. The technical/professional component (TC/PC) concept applies to physician professional service reporting on the CMS-1500 claim form and not to OPSS hospital reporting on the CMS-1450 (UB-04).

CPT and HCPCS procedures eligible for Modifier TC are reflected in the Medicare Physician Fee Schedule (MPFS). Generally, this modifier is used when performing only the technical component of a service. The description for the TC Modifier is found in CodeBase under Modifiers. This modifier is flagged for professional use only.

## Trade Shows & Events

### Metropolitan Chicago Healthcare Council (MCHC) Webinar

Oct. 27 • 10 to 11:00 a.m. CST • [www.mchc.com](http://www.mchc.com)

*The Effects of Healthcare Reform on Supply Chain Management*

Presented by Nick Sears, M.D., Chief Medical Officer, MedAssets

### National Association of Healthcare Administrative Management (NAHAM) Webinar

Oct. 27 • Noon to 1:00 p.m. EST

[www1.gotomeeting.com/register/972799713](http://www1.gotomeeting.com/register/972799713)

*Lean Management: Increase Efficiency and Improve Quality in Healthcare*

Presented by Kenneth Thomson, Senior Vice President, Client Engagement, MedAssets

### eClinical Works National Users Conference

Oct. 29 - Nov. 2 • Kissimmee, FL • Booth 237

[www.eclinicalworks.com](http://www.eclinicalworks.com)

### Georgia HFMA Fall Institute

Nov. 3-5 • Savannah, GA

[www.georgiahfma.org](http://www.georgiahfma.org)

*Value-based Purchasing and Pay for Performance: The New Reimbursement Challenges*

Presented by Nick Sears, M.D., Chief Medical Officer, MedAssets

### Healthcare Finance News (HFN) Webinar

Nov. 4 • 1:00 to 2:00 p.m. EST

[www.bulldogsolutions.net](http://www.bulldogsolutions.net)

*Prepare Now for a Rational and Sustainable Pathway to New Healthcare Payment Systems*

Presented by Francois deBrantes, CEO, Bridges to Excellence and PROMETHEUS Payment and Stephanie Alexander, President, Performance Analytics, MedAssets

### HFMA MAP Event

Nov. 7 - 9 • San Diego, CA • Booth TBD

[www.hfma.org/seminars](http://www.hfma.org/seminars)

### 2010 HPS Conference and Trade Show

Nov. 10 • Lansing, MI • Booth TBD

[www.hpsnet.com](http://www.hpsnet.com)

*Becoming a Winner in the Post-Healthcare Reform Environment*

Presented by Ryan Wheeler, Regional Vice President, Revenue Cycle Technology, MedAssets

### Metropolitan Chicago Healthcare Council (MCHC) Webinar

Nov. 10 • [www.mchc.com/eweb](http://www.mchc.com/eweb)

*Effectively Capturing Supply Revenue Through Corporate Standardization*

Presented by Lee Brooks, Senior Director, Product Management, MedAssets and Kathy Schwartz, Director, Supply Revenue Operations, MedAssets

### ASCP Senior Care Pharmacy '10

Nov. 10-13 • Orlando, FL • Booth 825

[www.ascpannual.com](http://www.ascpannual.com)

### New Mexico HFMA Conference

Nov. 11-12 • Albuquerque, NM • Booth TBD

[www.nmhfma.org](http://www.nmhfma.org)

### Southeast Missouri Chapter of ACHE Educational Meeting

Nov. 18 • Cape Girardeau, MO

[moheg.ache.org/x34.xml](http://moheg.ache.org/x34.xml)

*Managing Your Clinical Supply Chain – Panel Discussion*

Presented by Gina Thomas, RN, BSN, MBA, CMRP, Vice President, Customer Management, MedAssets and other panelists

### HFMA Virtual Tradeshow

Dec. 1-2 • [www.hfma.org/virtualconference](http://www.hfma.org/virtualconference)

### ASHP Midyear Clinical Meeting

Dec. 5-9 • Anaheim, CA • Booth 253

[www.ashp.org/Midyear2010](http://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](#).

### Laboratory Coding & Billing Updates

Tuesday, October 26

11:00 a.m. PDT

### 2011 Outpatient Prospective Payment System (OPPS) Final Rule

December 1, 6, 8, 13, 15, 20, 21

January 5, 11, 19

(check registration schedule for various times)

### 2011 CPT Code Updates

December 2, 9, 16

January 6

(check registration schedule for various times)

# CCFN CROSSWORD OCTOBER 2010

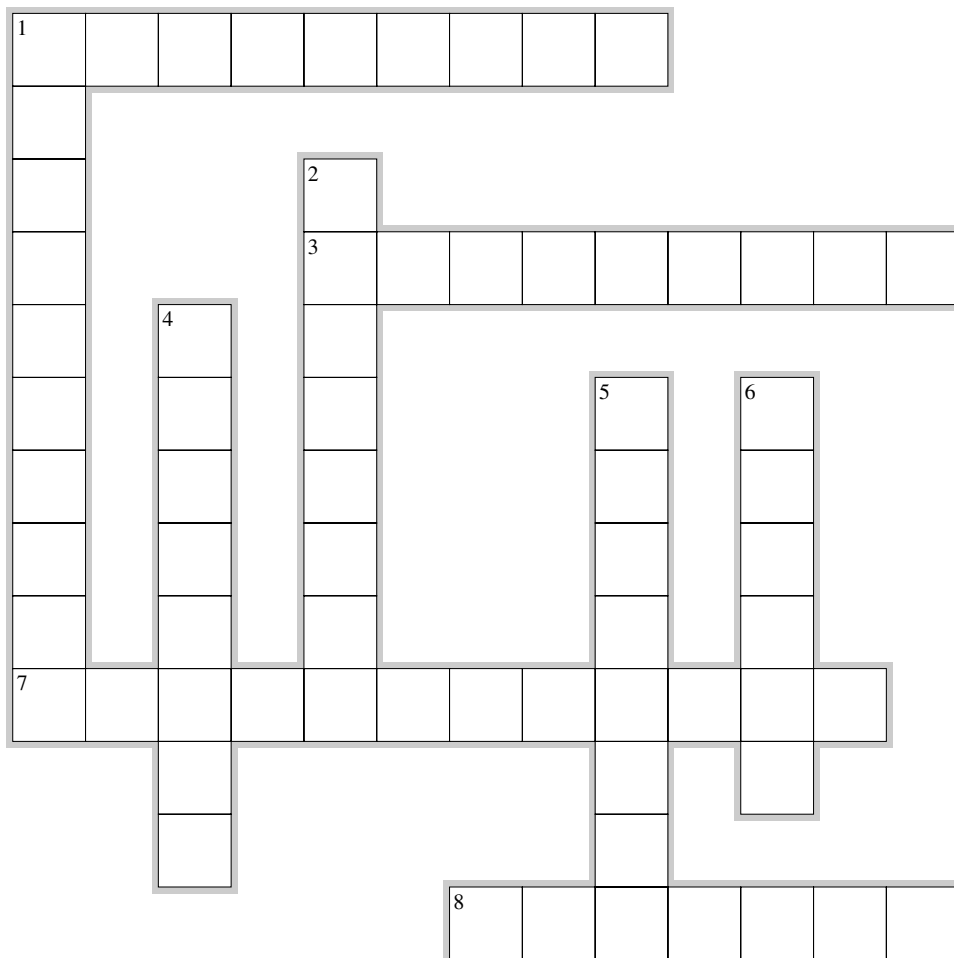
By Nikita Ashford, MBA/HCM, CPC-H, CPhT

## Across

- The device character specifies devices that remain after the procedure is \_\_\_\_.
- The root operations identify the reason, or \_\_\_\_ of the procedure.
- The development goal of ICD-10-PCS was to incorporate completeness, unique definitions, expandability, multi-axial codes, \_\_\_\_ terminology and structural integrity.
- There are 30 values that represent body \_\_\_\_.

## Down

- The ICD-10-PCS structure is based on individual letters and numbers, called values that occupy seven spaces of the code, called \_\_\_\_.
- The letters I and O are not used so as not to be \_\_\_\_ with the numbers 1 and 0.
- In ICD-10-PCS, the \_\_\_\_ refers to the technique used to reach the site of the procedure.
- There are 16 \_\_\_\_ of ICD-10-PCS.
- In Character 4 – Body Part, there are 34 possible \_\_\_\_ for each body system.



ANSWERS  
ACROSS 1. COMPLETED 3. OBJECTIVE 7. STANDARDIZED 8. SYSTEMS  
DOWN 1. CHARACTERS 2. CONFUSED 4. APPROACH 5. SECTIONS 6. VALUES

### Tell Us What You Think

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### CCFN STAFF CREDITS

- Q. Warner**  
VP, Integrity Services
- Shelley V. Nave, RHIA, CPC-H**  
MedAssets Integrity Services  
Coding and Chargemaster Analyst
- Regina Haas**  
Director, Marketing Communication
- Tara O'Neill**  
Art Director
- Chuck Buck**  
Creative Consultant

- CONTRIBUTING WRITERS
- Nikita Ashford, MBA/HCM, CPC-H, CPhT**
- Susan Cinquino, CPC**
- Renee T. Guilbeau, RHIT, CIRCC**
- Darnacea Harris MHA, RHIT, CCS**
- Denise M. Nash MD, CCS, CIM**
- Shelley V. Nave, RHIA, CPC-H**
- Sandy Palmer, RHIT**

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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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