HIM and the 2016 Chargemaster

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✓ Overview of Significant Payment Revisions for 2016

✓ HIM coding professionals and the Revenue Cycle

✓ Decisions for Chargemaster Structure

✓ Recent Updates Impacting CDM

✓ 2016 Code Updates causing the most challenges
Financial Forecasts

‘Negative pressures that have adversely affected hospitals and health care systems over the past few years will continue in the near future’

Fitch IBCA, Duff & Phelps
www.fitchratings.com
Since August 1, 2000......
What Have We Learned?

• Nobody is doing EVERYTHING right!
• What you are told today ... will change next week!
• The only time left in the day to read program memorandums is between 9 pm and 11 pm
• Lots of money made under APCs
• Medicare’s OPPS is much simpler than we originally thought
• Answers to our billing questions are consistent and accurate
‘We’re drowning in information and starving for knowledge’

—Rutherford Rogers
Chargemaster and HIM Coding Professionals

Industry changes mandated as a means of facility revenue viability
Chargemaster and HIM

Strategic representation on Revenue Cycle Team

- Coding function key to reimbursement
- Strong impact for LCD/NCD diagnoses
- Assistance with denials management
- Decision for hard-coded vs soft-coded CPT codes

Important Charge Capture Knowledge

- Coding Resource
- Coding most/all outpatient encounters
  - Charging processes a second layer of review
Revenue Integrity and HIM

Coders are working out of the box, no longer “just coders” but are vital members of ancillary department’s revenue stream
Revenue Integrity and HIM

- Cardiac Cath Lab
- GI Lab
- Emergency Dept
- Clinic Encounters
- Physician E&M’s
- Injections/Infusions
- Observation Svs
  - Hour Calculations
- Bedside Procedures

- Charge based on documentation
- Supplements Dept’s coding knowledge
- Validates modifier appropriateness
- Researches/validates NCCI edits
Revenue Codes
Without a CPT Code

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Number of Errors</th>
<th>Error Charges</th>
<th>Avg cost Per Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>750 Gastro-Intestinal Serv</td>
<td>948</td>
<td>$12,850</td>
<td>$14</td>
</tr>
<tr>
<td>360 Operating Room Services</td>
<td>724</td>
<td>$65,720</td>
<td>$91</td>
</tr>
<tr>
<td>450 Emergency Room</td>
<td>36</td>
<td>$19,735</td>
<td>$548</td>
</tr>
<tr>
<td>481 Cardiology-Cath Lab</td>
<td>341</td>
<td>$22,463</td>
<td>$66</td>
</tr>
<tr>
<td>410 Respiratory Therapy</td>
<td>720</td>
<td>$43,021</td>
<td>$60</td>
</tr>
<tr>
<td>310 Pathology</td>
<td>805</td>
<td>$67,022</td>
<td>$83</td>
</tr>
<tr>
<td>Total</td>
<td>3574</td>
<td>$230,811</td>
<td>$65</td>
</tr>
</tbody>
</table>
Revenue Integrity and HIM

• Data integrity
  – Validate data transfer

  | HIM Codes | UB-04 Codes |
  | HIM Codes | Electronic Billing Codes |
  | Remittance Codes | Electronic Billing Advice Codes |
CDM and Coding Decisions

- Share Chargemaster with coding staff
  - Eliminates duplicate work
  - Avoids potential double reporting
  - Assures continuity of reporting procedures and proper revenue
HIM Coders/Business Office

• Good Communication Between Departments
  – Manual changing of procedure codes
  – Denials due to incorrect/incomplete codes
  – Denials due to lack of medical necessity
Sources and References

CPT and HCPCS code changes
Sources for 2016 CPT Codes

• 2016 CPT® Changes, An Insider’s View
• Serves as a reference tool to understanding each of the CPT® code changes found in CPT® 2016 codebook. Every new, revised or deleted code, text and guideline change is listed along with a detailed rationale for the change. Immediately know what's new, what's deleted and what changes in 2016
Source for 2016 CPT Coding Changes

• Appendix B
  – Summary of Additions, Deletions and Revisions
    • Source for all changes in today’s presentation specific for coding changes impacting the facility’s chargemaster
Source for 2016 HCPCS Coding Changes

• CMS Addendum B
  – HCPCS Long Descriptions, Short Descriptions
    • http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html
Status Indicators for 2016

• Key to unlocking OPPS payments
  – Billable or Non-billable by hospitals
  – Reimbursed or packaged
    • Chargemaster, HIM and Finance
  – Payable by OPPS or another payment system
    • MPFS, DMEPOS, Laboratory
• Addendum D1
  – Legend of Status Indicators (SI)
Status Indicators for 2016

• Services paid under OPPS
  – Status Indicators G, H, J1, J2, K, N, P, Q1, Q2, Q3, Q4, S, T, and V (X has been removed)

• Services paid under another payment system
  – Status Indicators A, C, F, L, M and Y

• Services not recognized under OPPS but may be recognized by another provider
  – Status Indicator B
Status Indicators for 2016

J1 - Hospital Part B services paid through a comprehensive APC

Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS SI=F,G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services
Status Indicators for 2016

J2 - Hospital Part B Services That May Be Paid Through a Comprehensive APC

Paid under OPPS; Addendum B displays APC assignments when services are separately payable.

(1) Comprehensive APC payment based on OPPS comprehensive-specific payment criteria. Payment for all covered Part B services on the claim is packaged into a single payment for specific combinations of services, except services with OPPS SI=F,G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.
Status Indicators for 2016

J2 - Hospital Part B Services That May Be Paid Through a Comprehensive APC

(2) Packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “J1.”
(3) In other circumstances, payment is made through a separate APC payment or packaged into payment for other services.
Status Indicators for 2016

• Services not paid or covered by Medicare under OPPS
  – Status Indicator E
• Services not paid-code deleted
  – Status Indicator D
• Partial Hospitalization
  – Status Indicator P
    – Paid under OPPS; per diem APC payment
Status Indicators for 2016

• Q1 = Packaged codes “STV”
  • Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator “S,” “T,” or “V”
  – Q2 = T-packaged codes
    • Packaged APC payment if billed on the same date of service as a HCPCS code assigned status indicator “T.”
Status Indicators for 2016

– Q3 = Codes That May Be Paid Through a Composite APC

• Assigned to codes paid through composite APCs based on composite-specific criteria or separately through single code APCs when the criteria are not met

  – Payment is packaged into a single payment for specific combinations of service.
Status Indicators for 2016

– Q4 = Conditionally packaged laboratory tests
– Paid under OPPS or CLFS.

– (1) Packaged APC payment if billed on the same claim as a HCPCS code assigned published status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3.”

– (2) In other circumstances, laboratory tests should have an SI=A and payment is made under the CLFS.
Status Indicators for 2016

- **R** – All blood and blood products
  - Paid under OPPS; separate APC payment.
  - Changed from “K” status indicator (2009)
- **U** – Brachytherapy sources
  - Paid under OPPS; separate APC payment
  - Changed from “K” status indicator (2009)
Reporting Packaged Services

• Packaging and bundling payment for multiple interrelated services into a single payment create incentive for providers to furnish services in the most efficient way by enabling hospitals to manage their resources with maximum flexibility, thereby encouraging long-term cost containment.

• Where there are a variety of supplies that could be used to furnish a service, some of which are more expensive than others, packaging encourages hospitals to use the least expensive item that meets the patient’s needs, rather than to routinely use a more expensive item.
  – OPPS Final Rule, Page 280-281, 2009
Reporting Packaged Services

• Packaging also encourages hospitals to negotiate carefully with manufacturers and suppliers to reduce the purchase price of items and services or to explore alternative group purchasing arrangements, thereby encouraging the most economical health care.

• Packaging encourages hospitals to establish protocols that ensure that necessary services are furnished, while carefully scrutinizing the services ordered by practitioners to maximize the efficient use of hospital resources.
  – OPPS Final Rule, Page 280-281, 2009
Reporting Packaged Services

• “We encourage hospitals to report all HCPCS codes that describe packaged services that were provided, unless CPT or CMS provide other guidance. If a HCPCS code is not reported when a packaged service is provided, it can be challenging to track utilization patterns and resource costs”
  – 2009 Proposed Rule page 155
Transmittal 3471

• Coverage Determination
  – The fact that a drug, device, procedure or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program, but indicates only how the product, procedure, or service may be paid if covered by the program. Medicare Administrative Contractors (MACs) determine whether a drug, device, procedure, or other service meets all program requirements for coverage.
Comprehensive APCs

C-APCs and Packaging
Comprehensive APCs

• In 2015
  – Clinical family of related C-APCs that represent different resource levels of clinically comparable services
    • 25 C-APCs mostly which include procedures with costly medical devices

• In 2016
  – CMS finalized ten new C-APCs including some surgical APCs and a new C-APC for comprehensive observation
Comprehensive APCs

• A Comprehensive APC Payment Policy
  – Services that are typically integral, ancillary, supportive, dependent, or adjunctive to the primary service
    • Diagnostic procedures
    • Laboratory tests
    • Other diagnostic tests and treatments
    • Visits and evaluations
    • Uncoded services and supplies
    • DME as well as Prosthetic and Orthotic items
    • Therapy services (considered outpatient department services and not therapy services)
    • Drugs, biologicals and radiopharmaceuticals
    • Brachytherapy
Comprehensive APCs

• A Comprehensive APC Payment Policy
  – Services that continue to be separately payable or excluded from the C-APC
    • Drugs, biologicals and radiopharmaceuticals with pass-through payment status
    • Drugs which are self-administered
    • Recurring therapy services
    • Ambulance services
    • Diagnostic and screening mammography
    • Annual wellness visit and prevention services such as pneumococcal, influenza, and Hep B vaccines
    • Pap smear screening, prostate screening*, colorectal screening
A Comprehensive APC Payment Policy

- Services that continue to be separately payable or excluded from the C-APC
  - Diabetes outpatient self-management services
  - Bone mass measurements
  - Glaucoma screening
  - Medical nutritional therapy services
  - Cardiovascular screening
  - Diabetes screening
  - Ultrasound screenings for AAA
Observation Services

• In 2015:
  – CMS makes a single payment for non-surgical encounters with:
    • CPT 99284, 99285, 99291, G0384, G0463, G0379
    • 8 hours of observation or more
  – If CPT code reported on same date as observation or 1 day earlier which contains SI “T”, observation payment not eligible
Observation Services

In 2016:
  – CMS makes a single payment for non-surgical encounters with:
    • Any E&M (13 CPT codes) with SI of “J2”
    • 8 hours of observation or more
  – If claim contains CPT code with SI of “T” or “J1”, observation C-APC 8011 will not be paid
    • CPT code with SI of “T” or “J1” will be paid
## Observation Services

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>S.I.</th>
<th>APC</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>ER Visit Level 1</td>
<td>J2</td>
<td>5021</td>
<td>$59.30</td>
</tr>
<tr>
<td>99282</td>
<td>ER Visit Level 2</td>
<td>J2</td>
<td>5022</td>
<td>$109.50</td>
</tr>
<tr>
<td>99283</td>
<td>ER Visit Level 3</td>
<td>J2</td>
<td>5023</td>
<td>$195.98</td>
</tr>
<tr>
<td>99284</td>
<td>ER Visit Level 4</td>
<td>J2</td>
<td>5024</td>
<td>$326.99</td>
</tr>
<tr>
<td>99285</td>
<td>ER Visit Level 5</td>
<td>J2</td>
<td>5025</td>
<td>$486.04</td>
</tr>
<tr>
<td>99291</td>
<td>Critical care first hour</td>
<td>J2</td>
<td>5041</td>
<td>$666.27</td>
</tr>
<tr>
<td>G0379</td>
<td>Direct refer hospital observ</td>
<td>J2</td>
<td>5013</td>
<td>$480.69</td>
</tr>
<tr>
<td>G0380</td>
<td>Lev 1 hosp type b ed visit</td>
<td>J2</td>
<td>5031</td>
<td>$79.22</td>
</tr>
<tr>
<td>G0381</td>
<td>Lev 2 hosp type b ed visit</td>
<td>J2</td>
<td>5032</td>
<td>$76.17</td>
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<tr>
<td>G0382</td>
<td>Lev 3 hosp type b ed visit</td>
<td>J2</td>
<td>5033</td>
<td>$115.20</td>
</tr>
<tr>
<td>G0383</td>
<td>Lev 4 hosp type b ed visit</td>
<td>J2</td>
<td>5034</td>
<td>$196.25</td>
</tr>
<tr>
<td>G0384</td>
<td>Lev 5 hosp type b ed visit</td>
<td>J2</td>
<td>5035</td>
<td>$315.88</td>
</tr>
<tr>
<td>G0463</td>
<td>Hospital outpt clinic visit</td>
<td>J2</td>
<td>5012</td>
<td>$102.12</td>
</tr>
</tbody>
</table>
Observation Services
Comprehensive-APC 8011

- Reimbursement $2,174 (Nat’l Unadjusted)
- Co-Payment $435
  - All injections, infusions, bedside procedures and diagnostic/therapeutic procedures will be packaged
2\textsuperscript{nd} Quarter Update 2016

Latest CPT and HCPCS impacting the CDM

Effective April 1, 2016

All are chargemaster driven
Transmittal 3471

• Drug Testing HCPCS Codes
• HCPCS G0477-G0483 were published on the CMS website after the release of the January 2016 IOCE
  – Unable to include them in the January 2016 IOCE release
  • Status Indicator Q4 (Conditionally packaged laboratory tests)
Drug Testing Reimbursements

CMS has distributed the following announcement directed at providers:

"CMS discovered systems errors affecting claims with new drug testing laboratory codes (HCPCS codes G0477 through G0483) with dates of service on or after January 1, 2016. No provider action is required.

Your Medicare Administrative Contractor (MAC) will correct any claims previously returned to you in error with these codes and reason code **W7006**. CMS will be holding these claims until April 4, 2016."
Transmittal 3471

- Drug Testing Reimbursements
- CPT 83992 *Phencyclidine (PCP)*
  - All CPT codes for drug testings reported to Medicare using G0477-G0483
    - Appears this specific CPT was overlooked
    - Status Indicator Revised from Q4 1/1/16
    - Status Indicator will be revised to B 4/1/16
NCCI Update – April 2016

• Expect the following NEW NCCI edits:
  – 22,402 added (new) NCCI Edit Combinations
  • Added 96361, 96366, 96367, 96368
    – Add-on infusion CPT codes

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>2016 Long Description</th>
<th>SI</th>
<th>Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>96361</td>
<td>Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)</td>
<td>S</td>
<td>$30.87</td>
</tr>
<tr>
<td>96366</td>
<td>Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)</td>
<td>S</td>
<td>$30.87</td>
</tr>
<tr>
<td>96367</td>
<td>Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)</td>
<td>S</td>
<td>$42.31</td>
</tr>
<tr>
<td>96368</td>
<td>Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>
NCCI Update – April 2016

• Expect the following NEW NCCI edits:
  • 576 new NCCI code combinations specific for new drug testing “G” codes
    – HCPCS G0477-G0483
  • 45 NCCI Code Pair Changes

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Indicator</th>
<th>Description</th>
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<tbody>
<tr>
<td>0</td>
<td></td>
<td>not allowed</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>allowed</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>not applicable</td>
</tr>
</tbody>
</table>
NCCI Update – April 2016

Deleted NCCI edits:

– 5,857 NCCI Edits/Code Pairs Deleted
  • Some deleted pairs resulted from CPT and HCPCS code deletions
## Medically Unlikely Edit Updates

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<table>
<thead>
<tr>
<th>HCPCS/CPT Code</th>
<th>Outpatient Hospital Services MUE Values</th>
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<tbody>
<tr>
<td>A9606</td>
<td>203</td>
</tr>
<tr>
<td>C9447</td>
<td>1</td>
</tr>
<tr>
<td>J0596</td>
<td>840</td>
</tr>
<tr>
<td>J0695</td>
<td>60</td>
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<td>J1443</td>
<td>1</td>
</tr>
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<td>J2407</td>
<td>120</td>
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<td>J2547</td>
<td>600</td>
</tr>
<tr>
<td>J2704</td>
<td>200</td>
</tr>
<tr>
<td>J2860</td>
<td>170</td>
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## Medically Unlikely Edit Updates

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</tr>
</thead>
<tbody>
<tr>
<td>76802</td>
<td>Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (&lt; 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>76810</td>
<td>Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (&gt; or = 14 weeks 0 days), transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>76812</td>
<td>Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>76814</td>
<td>Ultrasound, pregnant uterus, real time with image documentation, first trimester fetal nuchal translucency measurement, transabdominal or transvaginal approach; each additional gestation (List separately in addition to code for primary procedure)</td>
<td>N</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
# Medically Unlikely Edit Updates

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>A9576</td>
<td>Injection, gadoteridol, (ProHance multipack), per ml</td>
<td>N</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>J0171</td>
<td>Injection, Adrenalin, epinephrine, 0.1 mg</td>
<td>N</td>
<td>120</td>
<td>0</td>
</tr>
<tr>
<td>J0461</td>
<td>Injection, atropine sulfate, 0.01 mg</td>
<td>N</td>
<td>800</td>
<td>0</td>
</tr>
<tr>
<td>J0583</td>
<td>Injection, bivalirudin, 1 mg</td>
<td>N</td>
<td>1250</td>
<td>0</td>
</tr>
<tr>
<td>J2704</td>
<td>Injection, propofol, 10 mg</td>
<td>N</td>
<td>200</td>
<td>0</td>
</tr>
<tr>
<td>J7512</td>
<td>Prednisone, immediate release or delayed release, oral, 1 mg</td>
<td>N</td>
<td>300</td>
<td>0</td>
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<tr>
<td>Q4117</td>
<td>HYALOMATRIX, per sq cm</td>
<td>N</td>
<td>200</td>
<td>0</td>
</tr>
</tbody>
</table>
Pharmaceuticals HCPCS April Updates
Transmittal 3471

• C9137 Injection, Factor VIII (antihemophilic factor, recombinant) PEGylated, 1 I.U.
  • Brand Name Adynovate
  • Used on-demand (as needed) to control bleeding in patients ages 12 and older with hemophilia A
    – FDA Approval November 2015
    – Revenue Code 0636
    – Status Indicator “G”
Transmittal 3471

- C9138 Injection, Factor VIII (antihemophilic factor, recombinant) (Nuwiq), 1 I.U.
  - Generic Name  Simoctocog alfa
  - Brand Name  Nuwiq
    - FDA Approval September 2015
    - Revenue Code 0636
    - Status Indicator “G”

Transmittal 3471

- C9461  Choline C 11, diagnostic, per study dose
  - FDA Approval September 2012
  - The initial US FDA-approved NDA for Choline C11 Injection is held by The Mayo Clinic in Rochester, Minnesota
  - Revenue Code 0343
  - Status Indicator “G”
Transmittal 3471

- C9470 Injection, aripiprazole lauroxil, 1 mg
  - Brand name: Aristada
  - FDA Approval: 10-05-15
  - Approved to treat adults with schizophrenia
  - Revenue Code: 0636
  - Status Indicator: “G”
Transmittal 3471

• C9471 Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg
  – Brand Name
  – FDA premarket Approval August 2015
  – Revenue Code 0636
  – Status Indicator “G”
Transmittal 3471

- C9472 Injection, talimogene laherparepvec, 1 million plaque forming units (PFU)
  - Brand Name  Imlygic
  - FDA Approval October 2015
  - Revenue Code 0636
  - Status Indicator “G”
Transmittal 3471

- **C9473** Injection, mepolizumab, 1 mg
  - Brand Name: Nucala
  - FDA Approval: November 2015
  - Revenue Code: 0636
  - Status Indicator: “G”

- **C9474** Injection, irinotecan liposome, 1 mg
  - Brand Name: Onivyde
  - FDA Approval: October 2015
  - Revenue Code: 0636
  - Status Indicator: “G”
Transmittal 3471

• C9475 Injection, necitumumab, 1 mg
  – Brand Name Portrazza
  – FDA Approval November 2015
  – Revenue Code 0636
  – Status Indicator “G”

• J7503 Tacrolimus, extended release, (envarsus xr), oral, 0.25 mg
  – Status Indicator 1st Quarter Status Indicator E
  – Status Indicator 2nd Quarter Status Indicator G
    • Revenue Code 0636
## Transmittal 3471

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>90653</td>
<td>Influenza vaccine, inactivated, subunit, adjuvanted, for intramuscular use</td>
<td>L 0636 E 0250</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J0130</td>
<td>Injection abciximab, 10 mg</td>
<td>N 0636 K 0636</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J0583</td>
<td>Injection, bivalirudin, 1 mg</td>
<td>N 0636 K 0636</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J1443</td>
<td>Injection, Ferric Pyrophosphate Citrate Solution, 0.1 mg of iron</td>
<td>N 0636 E 0250</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J2704</td>
<td>Injection, propofol, 10 mg</td>
<td>N 0636 E 0250</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Wound Clinic Products

CPT and HCPCS Code Changes
## Wound Clinic Products

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>SI</th>
<th>2015 Wound Product Designation</th>
<th>2016 Wound Care Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4103</td>
<td>Oasis burn matrix, per square centimeter</td>
<td>N</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Q4120</td>
<td>Matristem burn matrix, per square centimeter</td>
<td>N</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Q4129</td>
<td>Unite biomatrix, per square centimeter</td>
<td>N</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Q4134</td>
<td>Hmatrix, per square centimeter</td>
<td>N</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Q4152</td>
<td>Dermapure, per square centimeter</td>
<td>N</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Q4154</td>
<td>Biovance, per square centimeter</td>
<td>N</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Q4156</td>
<td>Neox 100, per square centimeter</td>
<td>N</td>
<td>High</td>
<td>Low</td>
</tr>
</tbody>
</table>

Low cost skin substitute application C5271-C5278  
High cost skin substitute application 15271-15278
# Wound Clinic Products

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>SI</th>
<th>2015 Wound Product Designation</th>
<th>2016 Wound Care Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4161</td>
<td>Bio-connekt wound matrix, per square centimeter</td>
<td>N</td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Q4162</td>
<td>Amniopro flow, bioskin flow, biorenew flow, woundex flow, amniogen-a, amniogen-c, 0.5 cc</td>
<td>N</td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Q4163</td>
<td>Amniopro, bioskin, biorenew, woundex, amniogen-45, amniogen-200, per square centimeter</td>
<td>N</td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Q4164</td>
<td>Helicoll, per square centimeter</td>
<td>N</td>
<td></td>
<td>Low</td>
</tr>
<tr>
<td>Q4165</td>
<td>Keramatrix, per square centimeter</td>
<td>N</td>
<td></td>
<td>Low</td>
</tr>
</tbody>
</table>

Application HCPCS codes C5271-C5278
Radiation Oncology April Update
Radiation Oncology-SRS

- Hospitals must report modifier “CP” (Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification [C-APC] procedure) on TOB 13X claims for any other services (excluding the ten codes in previous two slides) that are adjunctive or related to SRS treatment but billed on a different claim and within either 30 days prior or 30 days after the date of service for either CPT code 77371 or CPT code 77372).
CPT and HCPCS Chargemaster Update for 2016
Chargemaster Updates 2016

- Volume of changes potentially impacting the chargemaster

<table>
<thead>
<tr>
<th>Code Changes</th>
<th>CPT</th>
<th>HCPCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>192</td>
<td>223</td>
</tr>
<tr>
<td>Deleted</td>
<td>99</td>
<td>93</td>
</tr>
<tr>
<td>Description</td>
<td>132</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>423</td>
<td>318</td>
</tr>
</tbody>
</table>
Departments with Code Updates

• Category II
• Radiology
• Wound/Biologicals
• Clinics
• Cardiology/Card Cath Lab
• Pharmaceuticals
• Physician and Pro Fees

• Pulmonary/Respiratory
• Supplies, Devices & DME
• Neurology
• GI Lab
• Laboratory/Blood Bank
• Anesthesia Services
• Surgical Procedures
Laboratory Services
## Definitive Drug Testings

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G6030</td>
<td>Amitriptyline</td>
<td>G6045</td>
<td>Dihydrocodeine</td>
</tr>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G6031</td>
<td>Benzodiazepines</td>
<td>G6046</td>
<td>Dihydromorphinone</td>
</tr>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G6032</td>
<td>Desipramine</td>
<td>G6047</td>
<td>Dihydrotestosterone</td>
</tr>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G6034</td>
<td>Doxepin</td>
<td>G6048</td>
<td>Dimethadione</td>
</tr>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G6035</td>
<td>Gold</td>
<td>G6049</td>
<td>Epiandrosterone</td>
</tr>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G6036</td>
<td>Assay of imipramine</td>
<td>G6050</td>
<td>Ethchlorvynol</td>
</tr>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G6037</td>
<td>Nortriptyline</td>
<td>G6051</td>
<td>Flurazepam</td>
</tr>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G6038</td>
<td>Salicylate</td>
<td>G6052</td>
<td>Meprobamate</td>
</tr>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G6039</td>
<td>Acetaminophen</td>
<td>G6053</td>
<td>Methadone</td>
</tr>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G6040</td>
<td>Alcohol (ethanol); any specimen except breath</td>
<td>G6054</td>
<td>Methsuximide</td>
</tr>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G6041</td>
<td>Alkaloids, urine, quantitative</td>
<td>G6055</td>
<td>Nicotine</td>
</tr>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G6042</td>
<td>Amphetamine or methamphetamine</td>
<td>G6056</td>
<td>Opiate(s), drug and metabolites, each procedure</td>
</tr>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G6043</td>
<td>Barbiturates, not elsewhere specified</td>
<td>G6057</td>
<td>Phenothiazine</td>
</tr>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G6044</td>
<td>Cocaine or metabolite</td>
<td>G6058</td>
<td>Drug confirmation, each procedure</td>
</tr>
</tbody>
</table>

Therapeutic Drug Assay (80150-80299) remain Status Indicator B
Drug Screens

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G0431</td>
<td></td>
<td>Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter</td>
</tr>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G0434</td>
<td></td>
<td>Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter</td>
</tr>
</tbody>
</table>

CPT Codes 80300-80304 remain with Status Indicator “B”
Medicare Code Considerations

• Annual Laboratory Public Meeting that Medicare had proposed the following:

1. Delete the following G-codes:
   - G0431 and G0434 (2 codes)
   - G6030 through G6058 (28 codes)
2. Continue to not recognize the following CPT codes:
   - 80300 through 80377 (64 codes)
3. Create two G-codes to be priced at this meeting:
   - GXXX1, GXXX2
## Medicare Code Considerations

<table>
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</thead>
<tbody>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G0431</td>
<td></td>
<td>Drug screen, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter</td>
</tr>
<tr>
<td>030X</td>
<td>NEW</td>
<td></td>
<td>G0479</td>
<td></td>
<td>Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers (eg, immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service</td>
</tr>
</tbody>
</table>
# Medicare Code Considerations

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</tr>
</thead>
<tbody>
<tr>
<td>030X</td>
<td>N</td>
<td>DEL</td>
<td>G0434</td>
<td></td>
<td>Drug screen, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter</td>
</tr>
<tr>
<td>030X</td>
<td>NEW</td>
<td></td>
<td>G0477</td>
<td></td>
<td>Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg, immunoassay) <strong>capable of</strong> being read by direct optical observation only (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service</td>
</tr>
<tr>
<td>030X</td>
<td>NEW</td>
<td></td>
<td>G0478</td>
<td></td>
<td>Drug tests(s), presumptive, any number of drug classes; any number of devices or procedures, (eg, immunoassay) <strong>read by</strong> instrument-assisted direct optical observation (eg, dipsticks, cups, cards, cartridges), includes sample validation when performed, per date of service</td>
</tr>
</tbody>
</table>
Definite Drug Testings – 28 deleted codes to be reported using one of four HCPCS codes:

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</tr>
</thead>
<tbody>
<tr>
<td>030X</td>
<td>NEW</td>
<td></td>
<td>G0480</td>
<td></td>
<td>Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (eg, IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (eg, alcohol dehydrogenase)); qualitative or quantitative, all sources, includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed</td>
</tr>
</tbody>
</table>
# Medicare Code Considerations

<table>
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</thead>
<tbody>
<tr>
<td>030X</td>
<td>NEW</td>
<td>NEW</td>
<td>G0481</td>
<td>........; qualitative or quantitative, all sources, includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed</td>
<td></td>
</tr>
<tr>
<td>030X</td>
<td>NEW</td>
<td>NEW</td>
<td>G0482</td>
<td>........; qualitative or quantitative, all sources, includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed</td>
<td></td>
</tr>
<tr>
<td>030X</td>
<td>NEW</td>
<td>NEW</td>
<td>G0483</td>
<td>........; qualitative or quantitative, all sources, includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed</td>
<td></td>
</tr>
</tbody>
</table>
Transmittal 3471

• Drug Testing HCPCS Codes
• HCPCS G0477-G0483 were published on the CMS website *after* the release of the January 2016 IOCE
  – Unable to include them in the January 2016 IOCE release
  • Status Indicator Q4 (Conditionally packaged laboratory tests)
Drug Testing Reimbursements

- CMS has distributed the following announcement directed at providers:

"CMS discovered systems errors affecting claims with new drug testing laboratory codes (HCPCS codes G0477 through G0483) with dates of service on or after January 1, 2016. No provider action is required.

Your Medicare Administrative Contractor (MAC) will correct any claims previously returned to you in error with these codes and reason code **W7006**. CMS will be holding these claims until April 4, 2016."
Drug Testing Reimbursements

CPT 83992 Phencyclidine (PCP)

- All CPT codes for drug testings reported to Medicare using G0477-G0483
  - Appears this specific CPT was overlooked
  - Status Indicator Revised from Q4 1/1/16
  - Status Indicator will be revised to B 4/1/16
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>036X, 051X, 0761</td>
<td>T</td>
<td>NEW</td>
<td></td>
<td>31652</td>
<td>Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures</td>
</tr>
<tr>
<td>036X, 051X, 0761</td>
<td>T</td>
<td>NEW</td>
<td></td>
<td>31653</td>
<td>Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures</td>
</tr>
</tbody>
</table>
For many cancers and especially lung cancers, it is important to describe the location of an abnormal lymph node in a way that clinicians who may biopsy these nodes can understand. These figures offer guidance on the standardized way to describe these nodal stations in the trachea and aorta region.

American Thoracic Society mapping scheme
**Emergency/Clinic Procedure(s)**

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>036X, 0450, 0510, 0761</td>
<td>Q1</td>
<td>NEW</td>
<td></td>
<td>69209</td>
<td>Removal impacted cerumen using irrigation/lavage, unilateral</td>
</tr>
</tbody>
</table>

Do not report 69209 with 69210 when performed on the same ear

For removal cerumen that is not impacted, see E/M codes
Appendix G – Moderate Sedation

• Summary of codes which Include Moderate (Conscious) Sedation
  – 420 Codes in 2015
  – 406 Codes in 2014
  – 385 Codes in 2013
  – 349 Codes in 2012
  – 320 Codes in 2011
  – 301 Codes in 2010
  – 282 Codes in 2009

546 Codes in 2016
# Interventional Radiology

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>036X, 0320, 0402</td>
<td>T</td>
<td>NEW</td>
<td></td>
<td>10035</td>
<td>Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion</td>
</tr>
<tr>
<td>036X, 0320, 0402</td>
<td>N</td>
<td>NEW</td>
<td></td>
<td>10036</td>
<td>Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; each additional lesion (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>
In 2015, code changes radically changed how providers reported treatment of rib fractures. External fixation is now reported as an unlisted procedure. Internal fixation for rib fractures are reported using CPT 21811, 21812 or 21813. With the deletion of CPT 21805, no CPT code will exist for treatment of rib fractures without internal/external fixation.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>036X, 0761, 0490</td>
<td>T</td>
<td>DEL</td>
<td>21805</td>
<td></td>
<td>Open treatment of rib fracture without fixation, each</td>
</tr>
</tbody>
</table>
Final Thoughts

• Mastering change is key element for success
• 2016 offers new challenges
  – Good luck!!!
Glenda J. Schuler, RHIT, CPC, COC

- Vice President, Revenue Cycle Solutions, for HCS HealthCare Consulting Solutions
- AHIMA-Approved ICD-10-CM/PCS Trainer
- Over 35 years experience in billing, coding, chargemaster, CPT, revenue cycle, compliance
- National speaker for AAPC, AHIMA, state hospital associations, state HIMA chapters, VHA, HFMA and other organizations specific for:
  - Ambulatory Payment Classifications
  - Chargemasters
  - OCE Editor and CCI reporting
  - Modifiers

gschuler@hcsglobal.net
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- Inpatient (MS-DRGs), Outpatient (APCs) and Physician Practice Due Diligence & Compliance Risk Assessments including RAC, CERT, ZPIC, MAC/Carrier & OIG target areas
- CAH and Rural Health Clinic Compliance Audits and Education/Training
- DMEPOS Reviews, Operational Assessments and Education/Training
- IRF, IPF, SNF, HHA and Hospice Reviews
- Physician Documentation Assessments and Education/Training
- Revenue Cycle and Business Operations Assessments (Physician and Facility)
- Comprehensive Chargemaster Analysis, Supply and Pharmacy Assessments
- Strategic Pricing and Clinical Profile Assessments
- Client-Specific Educational Workshops and Conferences
- ICD-10-CM/PCS Education – Providers and Coders

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