February’s edition of Chargemaster Corner discusses new and old issues impacting the facility’s Chargemaster and reimbursement opportunities.

We have modified our newsletter schedule, and following this issue we the newsletter will be published quarterly instead of monthly. We hope the articles in this issues are of value to you.

Laboratory Services on a TOB 14X

As discussed in our January Chargemaster Corner, CMS provided additional clarification and guidance for reporting laboratory services on a TOB 014X versus 013X, in Transmittal 2845, December 27, 2014. Beginning in CY 2014, payment for most laboratory tests (except for molecular pathology tests) will be packaged under the OPPS. In 2013 all laboratory tests were reimbursed based on the laboratory fee schedule.

In a recent letter to Centers for Medicare & Medicaid (CMS), the National Uniform Billing Committee (NUBC) states: “The NUBC definition for TOB 014x which was approved in 2005, is intended to represent billing for laboratory services when these services are provided only to “Non-Patients”. A non-patient means that the hospital laboratory receives a specimen and does not see the patient or draws the sample. Should the patient present themselves at the laboratory of the hospital for a lab test, that patient will be registered as an outpatient and billed using TOB 013x Hospital Outpatient. Unless the situation is corrected, the NUBC plans on filing a HIPAA complaint with CMS OESS for failure to adhere to the HIPAA standards.

CMS response states that they will request that the HCPCS Committee develop a modifier to be used on bill types 13X to resolve this issue. You should be seeing a CMS transmittal on this issue in the near future.

Observation Questions Persist…

Lots of questions have been presented to Optum Chargemaster consultants concerning the accurate reporting of observation. Granted these questions are not focusing on medical necessity, not on documentation, and even not on written physician orders……but actually focus on the proper way to count observation hours.

The Medicare Claims Processing Manual (Pub 100-4), Chapter 4, Section 290.2.2 states that “observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g. colonoscopy, chemotherapy).”

So hospitals must subtract from the total hours of observation, the hours infusion therapy occurred.” Penny continues. “Nurses monitor and observe the patient during the infusion therapy hours and are also observing the patient during the entire period of time the facility is charging for observation services. The facility would essentially be double charging when reporting both infusion hours and observation hours for the same period of time”.

But not so fast…… The Medicare Claims Processing Manual states “The hospital must determine if active monitoring is a part of all or a portion of the time for the particular drug administration services received by the patient. Whether active monitoring is a part of the drug administration service may depend on the type of drug administration service furnished, the specific drug administered, or the needs of the patient. For example, a complex drug infusion titration to achieve a specified therapeutic response that is reported with HCPCS codes for a therapeutic infusion may require constant active monitoring by hospital staff. On the other hand, the routine infusion of an antibiotic, which may be reported with the same HCPCS codes for a therapeutic infusion, may not require significant active monitoring. For concerns about specific clinical situations, hospitals should check with their Medicare contractors for further information.

Should the MAC pursue this requirement it would appear that the facility would need to define what medications require added nurse monitoring, thereby supporting the charges for both infusion hours and observation hours for the same time period.
Otherwise, it would be left up to an auditor to interpret, which might be different than the hospital’s interpretation.”

In addition, when the patient is physically in another clinical department where an examination or procedure is performed, observation time should also not be reported. The challenge with this scenario is that the time the patient left the observation area and the time the patient returns to the observation area are usually not found documented. Often CT or MRI staff does not document the time the procedure took, nor the time the patient was in that clinical area, so now how can a facility track the patient time spent away from the observation area?

Some facilities are exploring a patient flow sheet to show when the patient left and returned to the nursing unit, displaying the hours which would ultimately be subtracted from the overall total hours of observation the facility would have reported.

Ultimately, observation hours must reflect the total time the patient truly received nursing observation care. How the facility documents the combined time the patient was receiving therapeutic as well as diagnostic procedures must support the total observation hours reported.

### 2014 Imaging Procedure Bundling

Similar to the previous years’ consolidation of code pairs identified as being performed together greater than 75 percent of the time, the CPT Editorial Panel continues down the path for bundling in 2014 which includes interventional radiology procedures such as image-guided procedures, transcatheter procedures as well as embolization and occlusion services.

The impact is being seen in hospitals across the country as these code combinations are editing in billing systems. The issue and questions that the bundling has created has caused some concern with the increased use of modifier -59.

The modifier -59 is defined, by CPT:

**Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier -59 is used to identify procedures or services, other than E/M services, that are not normally reported together but are appropriate under the circumstances.**

**Documentation must support:**
- a different session
- different procedure or surgery
- different site or organ system
- separate incision or excision
- separate lesion
- separate injury (or area of injury in extensive injuries)

Please note that just because the imaging service is ordered and by protocol considered necessary. It does not mean that a modifier -59 should be automatically assigned to by-pass the system bundling edit.

Facilities must evaluate the use of the -59 modifier. The modifiers should not be used unless there are valid indications for performing imaging services that are indicated as a bundled service. Specific documentation that both services are medically necessary should be in the physician documentation.

We hope you enjoy receiving the Chargemaster Corner from Optum360. Each quarter Optum 360 will circulate this newsletter via e-mail to those interested parties who have provided contact information either via e-mail request or who have completed an informational form when attending a number of educational seminars conducted nationwide. Please share this e-mail with your co-workers and encourage them to contact Optum360 via Chargermaster.corner@gmail.com. Contact information will not be shared with any other organization and used only for means of distributing this monthly newsletter. For direct contact concerning receipt of this newsletter, please e-mail your comments to the above noted e-mail address. Thank you for your interest in this monthly Chargemaster newsletter and hope you find it helpful.

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