January 2015 Quarterly Edition

Holidays are past, Chargemaster have been updated and everything seems to be running smoothly, right? Wrong!! There continues to be questions concerning coding, billing and Modifier 59 changes particularly with the new Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes that were effective January 1, 2015. This edition of Chargemaster Corner explores a few of the problematic areas we have been hearing from our clients.

2015 CPT/HCPCS Code Changes

The American Medical Association (AMA) issues a CPT code book annually and contains a complete list of CPT codes. The HCPCS codes are published at the end of each year and released with the OPPS Final Rule. Within the AMA’s website, providers can find additional instructions for vaccine products as well as several new Category III codes, reportable January 1, 2015.

The Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2015 Outpatient Prospective Payment System (OPPS) final rule on Friday afternoon, October 31, 2014. The rule will become effective Jan. 1, 2015, presenting a unique challenge for most hospitals to implement the HCPCS codes in a timely manner as well as read and modify revenue cycle functions to accommodate the many changes introduced by CMS in this final rule.

New J1 Status Code indicator and Packaged Services

As delineated in the Federal Register, October 31, 2014, a new Outpatient Prospective Payment System (OPPS) the J1 – Hospital Part B Services paid through a comprehensive Ambulatory Payment Classification (APC), will have a large impact on reimbursement.

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 Status Indicators of F, G, H, L, and U; ambulance services, diagnostic and screening mammograms, all preventive services; and certain inpatient Part B services.

Medicare will consider the entire hospital stay, defined as all services reported on the hospital claim reporting the primary service, to be one comprehensive service for the provision of a primary service into which all other services appearing on the claim would be packaged.

This results in a single Medicare payment and a single beneficiary copayment under the OPPS for the comprehensive service based on all included charges on the claim.

Hospitals should review procedures with this status indicator J1 and evaluate impact. Major outpatient surgeries, such as Cardiac Catheterizations will be impacted.

Modifier -59 Changes in 2015

CMS is establishing four new HCPCS modifiers to define subsets of the -59 modifier, a modifier used to define a “Distinct Procedural Service.”

–XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter

–XS Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure

–XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner

–XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

CMS will continue to recognize the -59 modifier in many instances but may selectively require a more
specific - X(EPSU) modifier for billing certain codes at high risk for incorrect billing.

CMS will continue to recognize the -59 modifier, but notes that Current Procedural Terminology (CPT) instructions state that the -59 modifier should not be used when a more descriptive modifier is available.

Reference: Medicare Learning Network (MLN) Matters: MM8863

There has been no additional information from CMS or payers to date. Questions of implementation by private payers remain.

Claim submissions will need to be monitored for denials and application of the new modifiers.

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**New Breast Ultrasound Code Questions**

The definition of “complete” with the new CPT code 77641 has caused some confusion.

Code 76641 is intended to describe a complete ultrasound examination of all four quadrants of the breast, the retroareolar region, and the axilla when performed.

Code 76642 is intended to describe a focused ultrasound examination of the breast, with a limited assessment of one or more of the elements included in code 76641, but not all, and of the axilla when performed.

An instructional parenthetical note has been added to direct the user to report code 76882 only for the axillary ultrasound procedure.

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**Laboratory Clinical Services**

Since the beginning of OPPS, clinical diagnostic laboratory tests (laboratory tests) provided in the hospital outpatient setting have been separately paid to hospitals at clinical laboratory fee schedule (CLFS) rates.

Under their revised packaging approach, CMS has determined that laboratory tests (other than molecular pathology tests) that are integral, ancillary, supportive, dependent, or adjunctive to the primary services provided in the hospital outpatient setting are services that should be packaged.

CMS feels that laboratory tests and their results support clinical decision making for primary services provided in the hospital outpatient setting, including surgery and diagnostic evaluations.

The laboratory services will be considered integral, ancillary, supportive, dependent, or adjunctive to a primary service or services provided in the hospital outpatient setting when they are provided on the same date of service as the primary service and when they are ordered by the same practitioner who ordered the primary service.

According to the NUBC definition, the 14X TOB should be used only for the billing of non-patient lab tests, when the specimen but not the patient is present at the hospital. However, CMS attempted to expand the use of the 14X to cover exceptions to its new hospital payment policy, instituted January 1, which bundles payments to hospitals and their laboratories for outpatient clinical lab tests under the Hospital Outpatient Prospective Payment System (OPPS). As part of this policy, outlined in the 2014 OPPS Final Rule and Transmittal R2845CP, CMS instructed hospitals to bill most clinical lab tests on a 13X TOB, except in three circumstances when lab tests can be billed separately on a 14X and paid under the Clinical Laboratory Fee Schedule (CLFS):

- For non-patient specimen tests, i.e., when the patient’s specimen is submitted to a hospital for analysis without the patient being present at the hospital.
- When the hospital collects specimen and provides lab tests to the patient and the patient does not receive any other hospital outpatient services during the same encounter.
- When the hospital provides lab tests that are clinically unrelated to other hospital outpatient services provided during the same encounter, meaning the lab tests are ordered by a practitioner different from the one who ordered the other outpatient services and for a different diagnosis.

The latter two exceptions were the cause of the National Uniform Billing Committee’s (NUBC’s) concerns, as CMS did not pursue the established change request process or notify the Committee of the changes prior to implementation.
These changes became effective July 1, 2014, and are retroactive for dates of service on or after January 1, 2014.

Note the following about the new TOB requirements:
• The L1 modifier is an immediate solution for 2014 and may be replaced by a different policy next year.
• Hospitals are not required to resubmit any claims once the changes take effect in July.
• Molecular pathology tests are still excluded from the bundling rule and do not require the new modifier on claims.

Sole Community Hospitals (SCHs) are subject to the OPPS bundling rule; however, SCHs with qualified labs continue to be eligible for the 62 percent CLFS payment amount (described in the Medicare Claims Processing Manual) when they provide outpatient lab tests that are separately payable under exceptions 2 or 3. SCHs with qualified labs must bill separately payable outpatient lab services on a 13X TOB with the new L1 modifier to obtain the 62 percent CLFS payment. The 14X does not provide differential CLFS payments for any hospitals paid under the OPPS. Once the new modifier becomes effective in July, SCHs may want to cancel or adjust claims submitted prior to July 1 in order to receive corrected reimbursement.

Though CMS made the mistake of redefining the 14X TOB, hospitals are the ones paying for it. Hospitals are now faced with the task (and cost) of changing their billing practices not only to comply with the recently established bundling rule and its exceptions, but also to ensure the facility remains compliant when applying this new modifier.

Laboratory tests not payable on the Clinical Diagnostic Laboratory Fee Schedule (CLFS) will be based on OPPS (for hospitals subject to OPPS) and current methodology for hospitals not subject to OPPS.

Reference: Claims Processing Manual, Chapter 16, Section 30.3.

Those laboratory procedures reimbursed by OPPS will not require the new L1 modifier; rather, only those laboratory CPT codes reimbursed by the CLFS will require this new modifier. At the present time, most pathology services are reimbursed by OPPS and not the CLFS.

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