# Abbey & Abbey, Consultants, Inc.

# Medical Reimbursement Newsletter

**A Newsletter for Physicians, Hospital Outpatient & Their Support Staff Addressing Medical Reimbursement Issues**

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## APC/APG Update

You should be preparing for the April 1st update to APCs. Also, the proposed changes for CY2012 should appear in the next several months. Further, Tricare is apparently moving to an APC-type payment system for outpatient services.

## GAO Report – Medicare/Medicaid Fraud, Waste and Abuse

The Government Accountability Office recently issued a report entitled, *Medicare and Medicaid Fraud, Waste, And Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments.*[1] In this report, CMS estimates that for FFY2010 $70 billion in payments were made that were improper. While healthcare providers, who are expending significant resources meeting government auditing demands, might disagree with this estimate, as long as the perception of significant improper payments exists, healthcare providers should anticipate even more auditing and demands for reviewing claims, medical records and associated appeals.

Five specific areas are addressed in this report.

- Strengthening provider enrollment standards and procedures. This involves all of the machinations that healthcare providers must pursue in obtaining proper NPIs (National Provider Identifiers) and proper filing of the various CMS-855 forms.
- Improving prepayment review of claims. Section 4241 of the Small Business Jobs Act of 2010 included specific language for using predictive modeling and other analytics technology.[2]
- Focusing postpayment claims review on most vulnerable area. This process seems to be an emerging consequence of the RAC (Recovery Audit Contractor) work. While the RACs are still gearing up their activities, specific issues are still being identified.
- Improving oversight of contractors. This is not an area in which healthcare providers can provide any real assistance. Healthcare providers typically have difficulty obtaining precise guidance from the CMS contractors.
- Developing a robust process for addressing identified vulnerabilities. The issue concerns when CMS or the RACs identify specific issues that are causing improper payments. Overall corrective action through enhanced guidance and education may not be pursued by CMS or its contractors.

Auditors and compliance personnel should download this document and review with care. Whether the last issue will result in any actions on the part of CMS should be monitored.

## New Codes for CVIR – Part 1

For CY2011 CPT has introduced major changes in the coding structure for cardiovascular interventional radiology (CVIR). This service area is growing in volume with the maturing Baby Boom generation and it is also growing in complexity with new technology. By any standard, CVIR coding and associated billing is complex. The way in which these new CPT coding structures have been developed also suggests that there will be further changes over the next several years.

The new coding structures will require significant study and analysis in order to properly code and bill. There are two aspects of particular interest to auditors:

1. Correctly following the coding guidelines, and
2. Utilizing a coding process that results in correct coding and billing.

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[1] See GAO-11-409T dated March 9, 2011.

[2] See the October, 2010 issue of this Newsletter, pages 56-57.

For example, the diagnostic heart catheterization services[3] have a new set of codes that combine three separate sets of codes that were previously used. The therapeutic services (i.e., angioplasties, atherectomies and stent placements) did not change to any great extent. For some, if not many, hospitals coding and thus billing in this area is performed utilizing charge entry through the hospital's chargemaster that statically contains the CPT codes. The service area personnel will need to fully understand the coding guidelines if this type of process is to work properly.

On the vascular side (i.e., non-cardiac coronary), the coding changes are more confusing. Currently, there is a separation between supra-inguinal and infra-inguinal[4] catheterization services. The new codes tend to bundle almost all of the services together while the old coding structure utilized a component approach. The supra-inguinal services are generally using the old coding structure while the infra-inguinal have moved to a more bundled approach, which is hierarchical organized relative to therapeutic interventions such as angioplasties, atherectomies and stent placements.

Because of the complexities on the vascular side, the ability of service area personnel to code and bill correctly through the chargemaster is certainly a legitimate question. In this area a small team approach including service area personnel, coding personnel and billing personnel may be appropriate. Such a team can review the documentation and then develop appropriate codes and charges.

Setting aside the coding process challenge, let us look at some of the code changes. In order to study the changes, consider the following breakdown of codes:

- Cardiac Coronary Catheterizations
  - Diagnostic
  - Therapeutic
  - Additional Changes
- Vascular, Non-Coronary, Catheterizations
  - Diagnostic
  - Supra-Inguinal Therapeutic
  - Infra-Inguinal Therapeutic
  - Additional Changes

Note that for our purposes the cardiac coronary area includes heart catheterization. These are services generally provided in the *Catheterization Laboratory*.

The coding structure has changed completely. The three component approach has been changed into codes that include all three components. The most frequently used codes for the catheterization laboratory are: 93451-93461:

- 93451 – Right heart catheterization
- 93452 – Left heart catheterization
- 93453 – Combined right and left heart catheterization
- 93454-93461 – Catheter placement under various circumstances which includes intraprocedural injections.

More specialized codes:

- 93462 – Left heart catheterization by transseptal puncture
- 93463-93464 – Pharmacologic administration and Physiologic exercise studies

Unchanged codes:

- 93503 – Swan-Ganz
- 93505 – Endomyocardial biopsy
- 93530-93533 – Catheterization for congenital circumstances

There are extensive, new coding guidelines in CPT including parenthetical guidance within certain sequences of codes. Here is a sampling of the guidance:

- *Right heart catheterization does not include right ventricular or right atrial angiography (93566).*
- *The cardiac catheterization codes (93452-93461), …, include contrast injection(s), imaging supervision, interpretation, and report for imaging typically performed.*
- *Cardiac catheterization (93451-93461) includes all roadmapping angiography in order to place the catheters, including any injections and imaging supervision, interpretation and report.*
- *It does not include contrast injection(s) and imaging supervision, interpretation and report for imaging that is separately identified by specific procedure code(s).*
  - See 93566 for Ventricular/Right Atrial
  - See 93567 for Aortography
  - See 93568 for Pulmonary Angiography
- *Contrast injection to image the access sites(s) for the specific purpose of placing a closure device is inherent to the catheterization procedure and not separately reportable. Closure device placement at the vascular access site is inherent to the catheterization procedure and not separately reportable.*

For the new series of injection procedures:

- *93563-93568 – Injection procedures during cardiac catheterizations. Delineated by anatomical site.*

[3] This term is being used generally to describe hearth catheterizations and diagnostic cardiac coronary services.
[4] You may also see sub-inguinal used. For the purposes of this discussion, no distinction is made.

- *All injection codes include radiological supervision, interpretation, and report.*
- *Cardiac catheterization codes (93452-93461) … include contrast injection(s) for imaging typically performed during these procedures.*
- *Do not report 93563-93565 in conjunction with 93452-93461.*
- *When injection procedures for right ventricular, right atrial, aortic, or pulmonary angiography are performed in conjunction with cardiac catheterization, these services are reported separately (93566-93568).*
- *When right ventricular or right atrial angiography is performed at the time of heart catheterization, use 93566 with the appropriate catheterization code…*
- *Use 93567 when supravalvular ascending aortography is performed at the time of heart catheterization.*
- *Use 93568 with appropriate right heart catheterization code when pulmonary angiography is performed.*
- *Separately reported injection procedures do not include introduction of catheters but do include repositioning of catheters when necessary and use of automatic power injectors, when performed.*
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Note that 93567 and 93568 can overlap with vascular (non-coronary) diagnostic catheterizations. These codes are used only when performed in connection with a heart catheterization. For example:

75625 – Abdominal aortography → 93567
75743 – Pulmonary aortography → 93568
G0275 and G0278 do not appear affected by this addition.

As you read through these guidelines, note that CPT appears quite intent on having everything bundling into the given service. For instance, roadmapping angiographies and/or angiographies used in connection with placement of closure devices and/or even the location of the closure device.

Question: How does this whole new coding structure and associated coding guidelines affect the use of:

1. G0269 – Placement of occlusive device into either a venous or arterial access site, post-surgical or interventional procedure (e.g., angioseal plug, vascular plug)
2. C1760 – Closure device, vascular (implantable/insertable).

Given the new guidance relative to the placement procedure, the G0269 should not be used because the procedure is now packaged. The C1760 is actually a supply item that represents the cost of the plug itself. For hospitals, it appears that this HCPCS can continue on the chargemaster and be billed when appropriate.

In regard to therapeutic coronary catheterizations, no significant changes were made. The inclusive hierarchical logic is reinforced with coding guidance in CPT.

- 92980-92981 – Transcatheter stenting
    - *Codes 92980, 92981 are used to report coronary artery stenting. Coronary angioplasty (92982, 92984) or atherectomy (92995, 92996), in the same artery is considered part of the stenting procedure and is not reported separately.*
- 92982 & 92984 – PTCA – Single vessel plus each additional vessel.
- 92995-22996 – Coronary atherectomy – With or without balloon angioplasty, single vessel plus each additional vessel.

Concerning the vascular catheterizations, the coding changes are even more significant, and to some extent, seem incomplete. Further changes in the next several years should be anticipated.

The vascular diagnostic coding structure really has not changed. We still have all of the cauterization codes (i.e., 1st order, 2nd order, etc.). The radiology S&I codes are still available when needed. Note that for APCs, many of these radiology codes are Status Indicator "Q2" so that more packaging occurs.

There are some potential overlaps of vascular diagnostic services with the injections codes when a heart catheterization is performed along with certain vascular diagnostic services.

- *When coronary artery, arterial conduit (e.g., internal mammary, inferior epigastric or free radical artery) or venous bypass graft angiography is performed in conjunction with cardiac catheterization, see the appropriate cardiac catheterization, injection procedure, and imaging supervisions code(s) (93451-93461, 93503-93533, 93563-93568) …*
- *When coronary artery, arterial coronary conduit or venous bypass graft angiography is performed without concomitant left heart cardiac catheterization, use 93454-93457, 93563, 93564.*
- *When internal mammary artery angiography only is performed without concomitant left heart cardiac catheterization, use 36216 or 36217 as appropriate.*

On the vascular side for supra-inguinal, the sequences of codes for angioplasties and stenting have been adjusted by removing the infra-inguinal arteries from

consideration. The atherectomy services have been totally changed and are, for the time being, Category III CPT Codes.

For transluminal angioplasty, the retained codes distinguishe open from percutaneous.

- 35471 – Balloon angioplasty renal or visceral
- 35472 – Balloon angioplasty aortic
- 35475 – Balloon angioplasty brachiocephalic trunk or branches

The corresponding radiological S&I services are still reported separately; see 75962-75968 and 75978.

For stenting procedures, we have the old codes:

- 37205+37206 – Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel + each additional vessel.

Note that the coding guidelines have been changed to exclude lower extremity (i.e., subinguinal) and certain other stenting services for which there are separate codes. Note also that open vs. percutaneous is separately recognized. See 37207+37208. Note that the Radiological S&I is separately reported through CPT 75960.

The big change in this area is with atherectomy services. CPT has decided to significantly bundle services for the atherectomies even to the point of including both open and percutaneous procedures. The new codes are:

- 0234T – Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation – renal artery
- 0235T – Visceral artery, each vessel
- 0236T – Abdominal aorta
- 0237T – Brachiocephalic trunk and branches, each vessel
- 0238T – Iliac artery, each vessel

With the increased bundling, the radiological S&I codes have been packaged and are not reported separately.

Editor's Note: In part 2 of this series of articles we will continue the discussion of vascular interventional services for infra-inguinal services.

## Drug Units

For coding and billing staffs at hospitals, properly reporting the number of units for pharmacy items has long proven a very difficult challenge. Charge capture and then reconciliation to drug administration documentation has also been a long-term issue. Three concerns that are frequently raised by hospitals include:

- NDC vs. HCPCS
- Packing and Stocking
- Computer System Interfaces

The very real solution for many of the coding and billing issues is to implement fully the National Drug Codes. NDCs separate the drug itself from the dosage administered. The CMS Level II HCPCS, mainly J-codes for pharmacy, combine the drug and the dosage. When reporting the J-codes, the proper number of units must also be reported. In some cases there may be more than one J-code for a given drug and then different dosage amounts embedded in the code description.

CMS has delayed the implementation of NDCs even though this was scheduled to occur several years ago under the HIPAA TSC (Transactional Standard/Standard Code Set) rule. Including the dosage amount in the description of the code raises significant coding and billing issues. For instance, a drug may be packaged in a 90 mg. vial. If only 30 mg. are administered, then 60 mg. are wasted. Assuming the J-code for this drug is per 30 mg. then the hospital can charge 3 units.

This then leads to the second issue, namely packaging and stocking. For the drug mentioned above, assume that there are different packaging amounts. For instance the drug may come in a 30 mg vial, a 45 mg. vial and a 90 mg. vial. Assume that a given service area stocks the 90 mg. vials or the pharmacy routinely dispenses the 90 mg. vial. Now if we administer only 30 mg. even if from a 90 mg. vial, the proper coding is with 1 unit because there is a 30 mg. vial package available.

Note that in the above simple example the hospital may inadvertently report the incorrect number of units. Actually, the pharmacy and the service area may think that the coding and billing is being performed correctly. Note that the RACs (Recovery Audit Contractors) have picked up on this situation. Your Medicaid program may also be looking at this situation.

The issue of computer systems' not correctly communicating is another ongoing challenge. Hospitals will often have a pharmacy system and then a separate billing system. The pharmacy system may need to communicate to the billing system the specific drug and quantity dispensed. Pharmacy systems use NDCs whereas billing systems use J-codes. Also, the amount dispensed from the pharmacy may or may not properly correlate to the number of units administered as discussed in our example above,

The actual interface between the two systems may also corrupt data coming across to the billing system. In

theory, the solution to the actual interfacing of the two systems should be handled by a standard interface called HL-7 for Health Level 7.

While we can identify issues, addressing those issues in order to assume proper coding and billing in this area is quite a challenge. As mentioned above, this doesn't even include proper charge capture for the drugs and then full documentation and charge capture for the administration of pharmaceuticals.

## Questions from Our Readers

**Question: We are a small hospital system with three different hospitals about 50 miles from each other. The system owns each of the hospitals and then the system also owns a number of freestanding clinics generally located in the same general areas as the hospitals. Does the 3-Day Pre-Admission Window apply for services provided at these clinics?**

The basic criterion for applying the 3-Day Pre-Admission Window for a given hospital is that the hospital must *wholly own or wholly operate* the facility. While the freestanding clinics described in the question should be considered for possible inclusion in the 3-Day Pre-Admission Window, these clinics are not owned, as a group or individually, by any one of the hospitals. Thus services provided at these clinics are not subject to possible inclusion on the inpatient billing.

The definition of this particular window seems a little unusual. In theory, it should be the services, provided anywhere, that are related to the admission that should be bundled. Operationally this type of definition would be difficult to implement. For instance, related outpatient services might be provided at a provider-based clinic at one hospital and then the patient is admitted shortly thereafter, to a hospital down the road. The two hospitals will not really know about the services being provided, at least at a coding and billing level.

However, with the full implementation of the geographic MACs (Medicare Administrative Contractors), the claims from the two hospitals (and/or clinics) could be matched for services within a window of service to check for relatedness. Then charges of overpayments could be made and recoupment of payments pursued.

*Editor's Note: While we cannot predict the future, this is not dissimilar to the post-discharge issue under MS-DRGs. A patient may be discharged to home, and, unbeknownst to the hospital, the patient goes under a Home Health Agency plan of care. The hospital does not know that there is the potential for a possible reduction in payment.*

## Current Workshop Offerings

*Editor's Note: The following lists a sampling of our publicly available workshops. A link for a complete listing can be found at:*
*www.aaciweb.com/JantoDecember2011EdCal.htm*

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On-site, teleconferences and Webinars are being scheduled for 2011. Contact Dr. Abbey at 515-232-6420 or e-mail at DrAbbey@aaciweb.com for information.

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A variety of Webinars and Teleconferences are being sponsored by different organizations including the Georgia Hospital Association, Ohio Hospital Association, Florida Hospital Association, Instruct-Online, Texas Hospital Association, Colorado Hospital Association, Hospital Association of Pennsylvania, and the Eli Research Group. Please visit our main website listed above for the calendar of presentations for CY2010 and planned workshops for CY2011.

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The Georgia Hospital Association is sponsoring a series of Webinars each month. For more information, contact Carol Hughes, Director of Distance Learning at (770) 249-4541 or CHughes@gha.org. The webinar scheduled for April 12th "***Problem DRGs and the RACS***" that will run from 9:30 a.m. to 11:00 a.m. EST.

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Dr. Abbey's latest book:
"***The Medicare Recovery Audit Contractor Program: A Survival Guide for Healthcare Providers***" is now available for purchase. This is a companion volume to "***Compliance for Coding, Billing & Reimbursement: A Systematic Approach to Developing a Comprehensive Program***", 2nd Edition.

Both of these books are published by CRC Press of the Taylor & Francis Group. A 15% discount is available for subscribers to this Newsletter. For ordering information contact Chris Smith through Duane@aaciweb.com.

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Also, Dr. Abbey has finished the second book in a series of books on payment systems. The first book is: "***Healthcare Payment Systems: An Introduction***". The second book in the series addresses fee schedule payment systems and is now available. The third and fourth books in this series are devoted to prospective payment systems and other payment systems. Both are currently in development.

This series is being published by CRC Press of the Taylor & Francis Group. Contact information is provided below. Discounts for subscribers of this Newsletter are available.

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## ****** ACTIVITIES & EVENTS ******

**Schedule your Compliance Review for you hospital and associated medical staff now. A proactive stance can assist hospitals and physicians with both compliance and revenue enhancement. These reviews also assist in preparing for the RACs.**

**Worried about the RAC Audits? Schedule a special audit study to assist your hospital in preparing for RAC audits. Please contact Chris Smith or Mary J. Wall at Abbey & Abbey, Consultants, Inc., for further information. Call 515-232-6420 or 515-292-8650. E-Mail: Chris@aaciweb.com.**

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