Major MS-DRG Changes Taking Effect on October 1, 2015. Will you be Prepared?

The transition from ICD-9 to ICD-10 brings significant improvements and changes to billing and coding regulations and requirements, according to Dawn Lui.

TALKING POINTS
Medicare Coverage for Lumbar Spinal Stenosis Treatments
The Centers for Medicare & Medicaid Services Sends Mixed Messages for Reporting Compounds

RAC UPDATES
September RAC Update: Auditing to Continue Through December

FAQS
Frequently Asked Questions for September
The transition from ICD-9 to ICD-10 brings significant improvements and changes to billing and coding regulations and requirements, according to Dawn Lui, writing in the September edition of CCFN. Lui reports that for FY 2016, the Centers for Medicare & Medicaid Services (CMS) received several requests for changes in MS-DRG and MDC assignment as well as changes in the Medicare Code Editor (MCE). Of all the requests made for this coming October, CMS only made changes to a few including ICD-10 MS-DRGs Version 33, that will replace the logic for ICD-9 MS-DRGs Version 32.

Sandy Palmer reports on recent documents published by CMS updating Medicare coverage of a less invasive treatment for lumbar spinal stenosis (LSS), one of the most common conditions leading to back pain in aging adults.

Why did CMS create modifier JF – Compounded Drug and then apparently replace it with Healthcare Common Procedure Coding System Code (HCPCS) Q9977 – Compounded Drug, Not Otherwise Classified? Sarah Cobb explains why.

Auditing will continue through at least Dec., 31, 2015 by the current Recovery Auditors. Meanwhile, CMS plans to update its Statement of Work and then release new Requests for Proposals.
September is the wet blanket on summer fun, reminding us that it’s now crunch time with only 30 days left before ICD-10 becomes effective October 1st. This point is not lost on Dawn Lui, who authors our feature article, in which she acknowledges that another fiscal year is quickly approaching and that, “our nation embraces a new mandated pathway, replacing ICD-9, a coding and billing structure that we’ve utilized for 36 years, with ICD-10.” To help CCFN readers manage this transition, Lui delves into the major changes in MS-DRGs that are effective come October 1st for fiscal year 2016.

Also in the September edition, Sandy Palmer, recognizing the aging American population, reviews recent documents from the Centers for Medicare & Medicaid Services (CMS) regarding Medicare coverage of a less invasive treatment for lumbar spinal stenosis (LSS), one of the most common conditions leading to back pain in aging adults.

Why did CMS create a new modifier only to come up with a new HCPCS code for compounded drugs? Sarah Cobb uncovers what to many might seem to be a mystery. Sarah knows why. And so will you.

Lastly, claims auditing by the Recovery Auditors will continue through December as Toueria Morris reports in the RAC Update.

So it’s crunch time. But we can help you through it. Welcome to the September edition of CCFN.
Major MS-DRG Changes Taking Effect on October 1, 2015. Will you be Prepared?

The transition from ICD-9 to ICD-10 brings significant improvements and changes to billing and coding regulations and requirements.

By Dawn M. Lui, RHIT

As another fiscal year (FY) for inpatient services quickly approaches, our nation embraces a new mandated pathway, replacing ICD-9, a coding and billing structure that we’ve utilized for 36 years, with ICD-10. Sept. 30, 2015 is that last date for reporting claims using I-9. From Oct. 1, 2015, and thereafter, we transition to ICD-10 diagnosis and procedure coding as well as the Official ICD-10-CM and ICD-10-PCS Guidelines for Coding and Reporting.

The transition from ICD-9 to ICD-10 brings significant improvements and changes to billing and coding regulations and requirements. The Centers for Medicare & Medicaid Services (CMS) also made other regulatory changes that were addressed in the inpatient rules. For FY 2016, CMS received several requests for changes in MS-DRG and MDC assignment as well as changes in the Medicare Code Editor (MCE). Of all the requests made for this coming October, CMS only made changes to a few, which are discussed in this article.

MS-DRG CHANGES FOR FY 2016
Since we are transitioning from ICD-9 to ICD-10, CMS has implemented ICD-10 MS-DRGs Version 33, that will replace the logic for ICD-9 MS-DRGs Version 32.

CMS has designated the following ICD-10-PCS codes as operating room (O.R.) procedures and has assigned them to MS-DRG 264:

- 02HQ00Z Insertion of pressure sensor monitoring device into right pulmonary artery, open approach
- 02HQ30Z Insertion of pressure sensor monitoring device into right pulmonary artery, percutaneous approach
- 02HQ40Z Insertion of pressure sensor monitoring device into right pulmonary artery, percutaneous endoscopic approach
- 02HR00Z Insertion of pressure sensor monitoring device into left pulmonary artery, open approach

The transition from ICD-9 to ICD-10 brings significant improvements and changes to billing and coding regulations and requirements.
• **02HR30Z** Insertion of pressure sensor monitoring device into left pulmonary artery, percutaneous approach
• **02HR40Z** Insertion of pressure sensor monitoring device into left pulmonary artery, percutaneous endoscopic approach

Next, CMS assigned the following ICD-10 procedure codes to MS–DRGs 579, 580 and 581 (Other Skin, Subcutaneous Tissue and Breast Procedures with MCC, with CC and without CC/MCC, respectively):

• **0LBT0ZZ** Excision of left ankle tendon, open approach
• **0LBS0ZZ** Excision of right ankle tendon, open approach

CMS assigned ICD-10 procedure code **0UBMXZZ** (Excision of vulva, external approach) to MS–DRGs 774 and 775 (Vaginal Delivery with and without Complicating Diagnoses, respectively) under the "Only Operating Room Procedures" section.

**MDC CHANGES FOR FY 2016**

Under MDC 5 (Diseases and Disorders of the Circulatory System), CMS created two new MS-DRGs, 273 and 274 (Percutaneous Intracardiac Procedures with MCC and without MCC, respectively) and assigned procedures performed within the heart chambers using intracardiac techniques to these two MS-DRGs. These two new MS-DRGs will distinguish between intracardiac procedures (performed within the heart chambers) and intracoronary procedures (performed within the coronary vessels). CMS also decided to assign procedure code **02UG3JZ** (Supplement mitral valve with synthetic substitute, percutaneous approach) to these new MS-DRGs. Although CMS added procedure code **02UG3JZ** to these two new MS-DRGs, the agency will also continue to assign this procedure to MS-DRGs 231 and 232 (Coronary Bypass with PTC with MCC and without MCC, respectively).

In order to distinguish the more complex and invasive aortic and heart assist procedures from the less complex and less invasive procedures, CMS decided to delete MS-DRGs 237 and 238 and create, instead, five new MS-DRGs. First, CMS created two new MS-DRGs, 268 and 269 (Aortic and Heart Assist Procedures Except Pulsotion Balloon with MCC and without MCC, respectively) and assigned the more complex, more invasive aortic and heart assist procedures to them. Then the agency created MS-DRGs 270, 271 and 272 (Other Major Cardiovascular Procedures with MCC, with CC, without CC/MCC, respectively) and assigned the remaining cardiovascular procedures that were designated as the less complex and less invasive procedures to these three MS-DRGs.

For MDC 8 (Diseases and Disorders of the Musculoskeletal System and Connective Tissue), CMS made changes to procedures involving joint revisions. The agency finalized its proposal, adding code combinations which capture the joint revision procedures to MS–DRGs 466, 467 and 468 (Revision of Hip or Knee Replacement with MCC, with CC and without CC/MCC, respectively) as well as to MS-DRGs 628, 629 and 630 (Other Endocrine, Nutritional and Metabolic Operating Room Procedures with MCC, with CC and without CC/MCC, respectively) which also contained joint revision procedures. CMS has provided a table of procedure codes that are assigned to these six MS-DRGs. (See list of procedure codes on 80 FR 49390-49406).

Next, CMS made changes to the titles for spinal fusion MS–DRGs 456, 457 and 458. The agency changed the reference of “9+ Fusion” to “Extensive Fusions.” Effective Oct. 1, 2015, the titles will now display as: Spinal Fusion Except Cervical with Spinal Curvature/Malignancy/Infection or Extensive Fusions with MCC, with CC and without CC/MCC, respectively.

For MDC 14 (Pregnancy, Childbirth and the Puerperium), CMS modified the logic for MS–DRG 775 (Vaginal Delivery Without Complicating Diagnosis) since the procedure codes for induction of labor with a cervical ripening gel would not group to the incorrect MS-DRG when a normal delivery occurred. Specifically, CMS changed the following ICD-10 procedure codes to now list them as non-operating room (O.R.) codes to ensure that cases that have been reported using these procedure codes will group to the appropriate MS–DRG assignment. CMS stated that these procedures had previously been designated as an O.R. code. These codes, however, do not require the intensity or complexity of service and resources utilized to warrant an O.R. designation under ICD-10. CMS designated the following procedure codes as non-O.R.:

• **3E0P7GC** Introduction of other therapeutic substance into female reproductive, via natural or artificial opening
• **3E0P76Z** Introduction of nutritional substance into female reproductive, via natural or artificial opening
MAJOR MS-DRG CHANGES TAKING EFFECT ON OCTOBER 1, 2015. WILL YOU BE PREPARED? — continued

- **3E0P77Z** Introduction of electrolytic and water balance substance into female reproductive, via natural or artificial opening
- **3E0P75F** Introduction of other gas into female reproductive, via natural or artificial opening
- **3E0P83Z** Introduction of anti-inflammatory into female reproductive, via natural or artificial opening endoscopic
- **3E0P86Z** Introduction of nutritional substance into female reproductive, via natural or artificial opening endoscopic

**MCE CHANGES FOR FY 2016**

CMS added the list of ICD-10-CM codes listed in the table on 80 FR 49410 to the MCE “Manifestation codes not allowed as principal diagnosis” edit.

Next, CMS revised the language utilized in the title description for several MS-DRGs (see below list) and in ICD-10 procedure code SA19S5Z (Respiratory ventilation, greater than 96 consecutive hours), adding a “greater than” sign (>) before the 96 to reflect “> 96 consecutive hours” and to remove the “plus sign” (+) after the 96.

The following are the revised MS-DRGs titles:

- **003** ECMO or Tracheostomy with Mechanical Ventilation >96 Hours or Principal Diagnosis Except, Face Mouth and Neck with Major Operating Room Procedure
- **004** Tracheostomy with Mechanical Ventilation >96 Hours or Principal Diagnosis Except, Face Mouth and Neck without Major Operating Room Procedure
- **007** Respiratory System Diagnosis with Ventilator Support >96 Hours
- **870** Septicemia or Severe Sepsis with Mechanical Ventilation >96 Hours
- **871** Septicemia or Severe Sepsis without Mechanical Ventilation >96 Hours with CC
- **872** Septicemia or Severe Sepsis without Mechanical Ventilation >96 Hours with MCC
- **927** Extensive Burns or Full Thickness Burns with Mechanical Ventilation >96 Hours with Skin Graft
- **933** Extensive Burns or Full Thickness Burns with Mechanical Ventilation >96 Hours without Skin Graft

**CHANGES TO SURGICAL HIERARCHIES**

CMS made changes to the surgical hierarchy for MDC 5 (Diseases and Disorders of the Circulatory System). The agency deleted MS-DRGS 237 and 238 (Major Cardiovascular Procedures with MCC, without MCC, respectively) from the surgical hierarchy. CMS sequenced new MS-DRGs 268 and 269 (Aortic and Heart Assist Procedures Except Pulsation Balloon with MCC, without MCC, respectively) above new MS-DRGs 270, 271 and 272 (Other Major Cardiovascular Procedures with MCC, with CC and without CC/MCC, respectively). CMS also sequenced new MS-DRGs 270, 271 and 272 above MS-DRG 239 (Amputation for Circulatory System Disorders Except Upper Limb and Toe with MCC). In addition, CMS sequenced new MS-DRGs 273 and 274 (Percutaneous Intracardiac Procedures with MCC and without MCC, respectively) above MS-DRG 246 (Percutaneous Cardiovascular Procedure with Drug-eluting Stent with MCC or 4+Vessels/Stents).

**CHANGES TO THE MS-DRG DIAGNOSIS CODES IN FY 2016**

The ICD-10 combination codes for hydronephrosis due to ureteral stricture and urinary stone, codes N13.1 and N13.2. These were classified as CCs, however, these codes were not recognized as principal diagnoses that act as their own CC because Appendix J of the ICD–10 MS–DRG Definitions did not have either coded listed.

For FY 2016, CMS added N13.1 and N13.2 to the list of principal diagnoses that can act as their own CC in Appendix J of the ICD–10 MS–DRG Definitions Manual Version 33.

**CONCLUSION**

CMS received several other requests for revisions to the MS-DRGs and MDC. However, after reviewing all requester comments, including claims data and performing data analysis, and obtaining advice from clinical advisors, the above items were the only ones that CMS approved.

The above changes will all take effect on Oct. 1, 2015 (FY 2016).
DAWN M. LUI, RHIT
Dawn M. Lui, RHIT, has been a coding and CDM analyst with MedAssets since 2004. Dawn is currently responsible for researching and responding to complex facility coding inquiries as well as managing and maintaining databases. She brings more than 25 years of experience in health information management (HIM). Her expertise includes healthcare system analysis; revenue cycle management; utilization review; quality assurance management; long term facility coding; inpatient and outpatient facility coding with a specific emphasis in both the Outpatient Prospective Payment System (OPPS) and Inpatient Prospective Payment System (IPPS). She has served as a consultant; a HIPAA compliance officer; hospital manager and HIM instructor. Dawn has been a member of the board of directors for the Washington Health Information Management Association (WSHIMA) and the Seattle Health Information Management Association (SHIMA) where she has served as president, president-elect and secretary. She is a member of the PacWest HIPAA Congress, having been a HIPAA educator for physicians and their staff, as well as at medical facilities.

REFERENCE
FY 2016 Hospital Inpatient Prospective Payment Systems (IPPS) final rule, CMS-1632-F, published August 17, 2015
Back pain is one of the most common reasons adults seek medical care. Lumbar spinal stenosis (LSS) is one of the most common conditions leading to back pain in aging adults. Updated Medicare coverage of a less invasive treatment for lumbar spinal stenosis is discussed in recent documents published by the Centers for Medicare and Medicaid Services (CMS).

CMS published Transmittal R3175CP and MLN Matters MM8954, based on Change Request CR 8954 that is effective Jan. 1, 2015. These publications updated Medicare reimbursement related to Percutaneous Image-guided Lumbar Decompression (PILD) for LSS. The PILD procedure is not nationally covered for Medicare patients. However, Medicare coverage for the PILD procedure is available when performed in an approved coverage with evidence development (CED) clinical trial.

CMS Decision Memo CAG-00433N includes a lengthy discussion of PILD for LSS and determined that the procedure is “is not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act.” The Decision Memo contains the following information related to the condition and treatments:

- **PILD** is a posterior decompression of the lumbar spine performed under indirect image guidance without any direct visualization of the surgical area. This is a procedure proposed as a treatment for symptomatic LSS unresponsive to conservative therapy.
- This procedure is generally described as a non-invasive procedure using specially designed instruments to percutaneously remove a portion of the lamina and debulk the ligamentum flavum. The procedure is performed under x-ray guidance (e.g., fluoroscopic, CT) with the assistance of contrast media to identify and monitor the compressed area via epiduragram.
- Lumbar spinal stenosis is defined as the reduction of the cross sectional area, i.e. narrowing, of the lumbar spinal canal. It is usually caused by spinal degenerative conditions and is commonly found to be asymptomatic.
- There is no ‘gold standard’ for diagnosis and treatment of stenosis because of variable signs and symptoms, physicians’ history-taking and physical methods and diagnostic tests.

CMS was looking for evidence that PILD “improves health outcomes in Medicare beneficiaries with lumbar spinal stenosis.” Based on the conclusion of the analysis CMS felt the existing information was not adequate to consider PILD reasonable and necessary. Due to “weak studies, questions about missing information, questions about adverse events and conflicts of interest” CMS approved coverage of PILD procedure performed in CED studies to gain reliable evidence that could show whether PILD should be covered by Medicare for LSS.

CMS National Coverage Determination (NCD) 150.13 summarized the non-coverage for PILD:

“Effective for services performed on or after January 09, 2014, CMS has determined that PILD for LSS is not reasonable and necessary under section 1862(a)(1)(A) of the Social Security Act.”

**ICD-10 DIAGNOSIS RANGE**

Treatment options for LSS may start with conservative treatments such as physical therapy for mild cases. Patients with severe symptoms affecting their quality of life may undergo riskier surgical decompression procedures. Those surgical procedures might include laminotomy, laminectomy, discectomy and spinal fusions. Examples of some of these procedures are listed below with the CPT® codes and definitions that would be reported. The first four CPTs listed are procedures performed with an open approach that include removal of parts of the spine (vertebrae) and ligaments to remove pressure on the nerves.
**Medicare Coverage for Lumbar Spinal Stenosis Treatments — continued**

*TALKING POINTS*

**22612** – Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)

**63005** – Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g., spinal stenosis), 1 or 2 vertebral segments; lumbar, except for spondylolisthesis

**63012** – Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)

**63030** – Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar

Another procedure often performed is a percutaneous discectomy:

**62287** – Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with the use of an endoscope, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar.

In addition, there are other minimally invasive decompression procedures that can be performed. The CPT Category III codes (temporary codes for emerging technology, services and procedures) below are reported for procedures where a device is inserted that stabilizes the spinal column, but still allows movement:

**0171T** – Insertion of posterior spinous process distraction device (including necessary removal of bone or ligament for insertion and imaging guidance), lumbar; single level

**0172T** – each additional level

Percutaneous image-guided lumbar decompression (PILD) is a newer procedure used to treat lumbar spinal stenosis (LSS). Some articles refer to these procedures with the acronym IG-MLD for “image-guided minimally invasive lumbar decompression.” CMS outlined the coverage for the PILD procedure in its Transmittal 2959 in May of 2014. According to this transmittal “This coverage applies to beneficiaries who are enrolled in an approved clinical study that meets the following criteria: the clinical trial must address one or more aspects of the following questions in a prospective, randomized, controlled design using current validated and reliable measurement instruments and clinically appropriate comparator treatments, including appropriate medical or surgical interventions or a sham controlled arm, for patients randomized to the non-PILD group.”

For further information from vendors who produce equipment meant to perform the PILD type of procedure you can find these companies on the Internet:

**North American Spine** – AccuraScope – “AccuraScope Laminotomy/Laminectomy Procedure – The minimally invasive spine procedure is performed through a very small incision(s), less than an inch in size...”
https://northamericanspine.com/accurascope/lumbar-procedure/

**VERTOS MEDICAL** – “Now there is mild®, a safe, outpatient, minimally invasive, fluoroscopically guided therapeutic treatment that can help LSS patients...”
http://vertosmed.com

PILD procedures are differentiated from the other similar procedures as explained in the following coding tip published in an article from the July 2012 CPT® Assistant – Spine and Spinal Cord Code Changes for CPT:

“When visualization is only endoscopic and/or image-guided for percutaneous laminectomy procedures, the procedure is percutaneous and should be reported with new Category III codes 0274T and 0275T. Percutaneous decompression procedures of the intervertebral disc/nucleus pulposus of intervertebral disc that utilize needle-based techniques should be reported with code 62287.” (CPT 0274T is reported for cervical or thoracic procedures.)

Now that we have discussed some of the other procedures used to treat LSS, we’ll get back to the PILD procedure. Prior to Jan. 1, 2015 the following CPT Category III code was the only CPT/HCPCS code used to report PILD:

**0275T** – Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural
elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (e.g., fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; lumbar.

Effective Jan. 1, 2015 the following HCPCS code should be reported when the PILD procedure is performed in an approved clinical trial that is blinded, randomized and controlled:

**G0276** – Blinded procedure for lumbar stenosis, percutaneous image-guided lumbar decompression (PILD) or placebo-control, performed in an approved coverage with evidence development (CED) clinical trial

For PILD procedures performed Jan. 1, 2015 and after if they are performed in an approved clinical trial that is NOT blinded, randomized and controlled the CPT Category III code (0275T) would be reported.

According to Transmittal R3175CP the implementation date is March 2, 2015 for Local System edits and July 6, 2015 for Shared Systems edits.

Other Medicare requirements for outpatient facility (hospital) claims when PILD is performed for LSS include the following:

- **Type of Bill (TOB)**
  - 13X Hospital outpatient
  - 85X Critical access hospital (CAH)

- **ICD-9 Diagnosis codes (through 9/30/2015)**
  - V70.7 Examination of participant in clinical trial

- With one of the LSS diagnosis codes
  - 724.01 – Spinal stenosis, thoracic region
  - 724.02 – Spinal stenosis, lumbar region, without neurogenic claudication
  - 724.03 – Spinal stenosis, lumbar region, with neurogenic claudication

- **ICD-10 Diagnosis codes (beginning 10/1/2015)**
  - Z00.6 Encounter for examination for normal comparison and control in clinical research program

- With one of the LSS diagnosis codes
  - M48.05 Spinal stenosis, thoracolumbar region
  - M48.06 Spinal stenosis, lumbar region
  - M48.07 Spinal stenosis, lumbosacral region

- **Condition Code**
  - 30 Qualifying Clinical Trials

- **Modifier**
  - Q0 Investigational clinical service provided in a clinical research study that is in an approved clinical research study

- **Clinical Trial Number**
  - 8-digit clinical trial identifier number listed on the CMS Coverage with Evidence Development website

**SUMMARY**

Medicare provides coverage for PILD procedures performed for LSS only when the procedure is performed under an approved clinical study. For procedures performed between Jan. 9, 2014 and Dec. 31, 2014 CPT category III code 0275T is reported. Effective Jan. 1, 2015, however, either CPT 0275T or HCPCS code G0276 may be reported. G0276 is reported when the procedure is performed under a clinical trial that is blinded, randomized and controlled. CPT 0275T is reported for all other approved clinical trials that are not blinded.

**SANDY PALMER, RHIT,**

Sandy Palmer, RHIT, is a charge and revenue integrity analyst for MedAssets. Her expertise includes inpatient and outpatient facility coding, as well as content and database management for the MedAssets KnowledgeBase applications. She has more than 17 years of experience in health information management (HIM) and is a member of the American Health Information Management Association (AHIMA).

**REFERENCES**

Transmittal 3175 – Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)-Blinded Clinical Trial – Follow-Up CR to Implement a Second Claims Processing Procedure Code

Medicare Claims Processing Manual, Chapter, 32, Section 330 & Chapter, 32, Section 68

Decision Memo for Percutaneous Image-guided Lumbar Decompression for Lumbar Spinal Stenosis (CAG-00433N)
The Centers for Medicare & Medicaid Services Sends Mixed Messages for Reporting Compounds

By Sarah Cobb, BS, CPhT, RMC

This past April, the Centers for Medicare & Medicaid Services (CMS) created modifier JF – Compounded Drug. Subsequently, this new modifier was deleted the following quarter and CMS then created the new Healthcare Common Procedure Coding System Code (HCPCS) Q9977 – Compounded Drug, Not Otherwise Classified.

CMS has noted that the creation of HCPCS code Q9977 was not meant to be a replacement for any existing codes. CMS intended claims for compounded drugs to be submitted with HCPCS code Q9977 beginning July 1, 2015 and modifier JF would no longer be effective.

We assume CMS foresaw the misuse of this modifier, perhaps with the modifier erroneously appended to HCPCS codes across the board. Consequently, HCPCS code Q9977 was created for simpler reporting. However, this new code has still left coders investigating compounded drugs, wondering what CMS considers a compounded drug and when this new code would be reported.

The history of the modifier and the HCPCS code creation began last year with the release of a report from the Office of the Inspector General (OIG), a division of the U.S. Department of Health and Human Services. In its report, Compounded Drugs Under Medicare Part B: Payment and Oversight, the OIG expressed concern for contaminated compounded drugs posing a threat to public health. The rise in concern stemmed from a fungal meningitis outbreak that linked 751 cases and 64 deaths to contaminated injectable compounded drugs. These contaminated compounds were thus deemed in violation of the Federal Food, Drug, and Cosmetic Act (the Act). Medicare Part B does not pay for compounded drugs in violation of this act. However, the OIG found that neither CMS nor Medicare Administrative Contractors (MACs) tracked the number of claims for compounded drugs under Part B or the corresponding amounts paid, and that Part B claims did not contain information that can be used to systematically identify claims for compounded drugs. As a result, the OIG recommended CMS establish a process to recognize Part B claims for compounded drugs. The OIG report concluded that:

“CMS concurred with our recommendation to establish a method to identify Part B claims for compounded drugs and noted that it may be possible to create a modifier or specific code that physicians would be required to use when billing for compounded drugs. CMS stated that this approach may allow compounded drugs to be distinguished from other drugs that are billed under NOC codes, but that any issues related to public safety of compounded drugs should be addressed before the drugs are administered.”

CONCLUSION

As we’ve seen, CMS complied with the OIG’s recommendation by creating a specific code for compounded drugs. However, you may be wondering what exactly is considered to be a compounded drug. Officially, the U.S. Food and Drug Administration (FDA) defines compounding as:

“a practice in which a licensed pharmacist, a licensed physician, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist, combines, mixes, or alters ingredients of a drug to create a medication tailored to the needs of an individual patient.”
The OIG report gave a few examples of when providers prescribe compounded drugs:

• “a noncompounded version of the medicine is discontinued or generally unavailable,
• the patient is allergic to certain dyes or preservatives in the noncompounded version,
• the patient has unique needs and requires tailored dosage strength (e.g., an infant), or
• the pharmacist can combine several medications to increase compliance in taking the medications.”

Unfortunately, there is limited guidance from CMS at this time regarding the reporting of HCPCS code Q9977. For that reason, we have been on the lookout for new guidance from the MACs, who have begun to detail specific instances in which the submission of HCPCS code Q9977 will be required. Currently, some MACs are requiring HCPCS code Q9977 to be submitted for compounded pain pump infusions and intravitreal bevacizumab acquired from a compounding source or compounded in the physician’s facility/office. However, ultimately the decision to use the not otherwise classified code, Q9977, may depend on what your MAC considers to be a compounded drug.

SARAH COBB, BS, CPHT, RMC
Sarah is a Registered Medical Coder and Nationally Certified Pharmacy Technician. As a healthcare professional, Sarah has over 15 years of healthcare experience. Currently, Sarah is a Coding and CDM Analyst for Pharmacy Services with MedAssets. In this position, Sarah is responsible for maintaining the pharmacy content for the MedAssets products. Sarah also provides Medicare guidance for billing and coding pharmacy services.

Sarah is a graduate of Georgia State University.

REFERENCES
The Office of the Inspector General, Compounded Drugs Under Medicare Part B: Payment and Oversight
Compounding and the FDA: Questions and Answers
http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/ucm339764.htm
Transmittal R3264CP
MLN Matters® MM9167
The “Requests for Quotes” (RFQs) for the next round of Recovery Auditor (RA) contracts, was withdrawn by the Centers for Medicare and Medicaid (CMS) effective June 4, 2015. Auditing will continue through at least Dec, 31, 2015 by the current RAs. CMS plans to update its Statement of Work (SOW) and then release new Requests for Proposals (RFPs).

The RA in each region is as follows:
- Region A: Performant Recovery
- Region B: CGI Federal, Inc.
- Region C: Connolly, Inc.
- Region D: HealthDataInsights, Inc.

CMS approved the RAs to begin reviewing Outpatient Therapy Threshold claims beginning mid-January of 2015. Therapy claims over the threshold amount of $3,700 that were paid March 1, 2014 through Dec. 31, 2014 can be included in those reviews. CMS has also set restrictions on the number of Additional Documentation Requests (ADRs) that could be sent related to these claims, in an effort to reduce provider burden. CMS has the following list posted on its website:

- 1st ADR: can only request documentation for 1 claim
- 2nd ADR: can request up to 10 percent of total eligible claims
- 3rd ADR: up to 25 percent of remaining eligible claims
- 4th ADR: up to 50 percent of remaining eligible claims
- 5th ADR: up to 100 percent of remaining eligible claims

Now as 2015 is quickly bringing ICD-10 into our focus, we can only be sure there will be more RA updates to follow.

Toueria Morris, COC
Toueria Morris, COC, is a charge and revenue integrity analyst for MedAssets. Toueria is responsible for developing rules for the MedAssets CCA product. She was previously a coding and CDM analyst at MedAssets. As a healthcare professional, Toueria has more than 16 years of experience. In her previous roles she gained expertise in CDM management and maintenance, revenue cycle management, auditing, charge capture as well as training clinical departments in documentation improvement and providing coding guidance.

REFERENCE
Centers for Medicare & Medicaid Services (CMS) Research-Statistics-Data-and-System - Monitoring Programs
Q: WE ARE HAVING ISSUES WITH PACEMAKER CLAIMS AND HAVE FOUND THAT THE NATIONAL COVERAGE DETERMINATION (NCD) POLICY, 20.8.3, CARDIAC PACEMAKERS: SINGLE CHAMBER AND DUAL CHAMBER PERMANENT CARDIAC PACEMAKERS STATES THE FOLLOWING: “Effective for claims with dates of service on or after August 13, 2013, contractors shall return to provider claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, if conditions of requirement 9078.3 are not met.” Where can we find the requirements for 9078.3?

A: The information you need can be found in section 9078-04.3 of the February 20, 2015 CMS Transmittal R3204CP; it is located right above Business Requirement 9078-04.3.1.

BR9078-04.3 states:
“Contractors shall pay outpatient claims for implanted permanent cardiac pacemakers, single chamber or dual chamber, HCPCS codes C1785, C1786, C2619, or C2620, provided that the claim contains at least one of the following CPT codes, at least one of the following ICD-9/ICD-10 codes, and when the claim is submitted with the -KX modifier:

• CPT 33206, 33207, or 33208, 33227, or 33228,
• ICD-9/ICD-10 426.0/I44.2, 426.12/I44.1, 426.13/I44.1, 427.81/I49.5, or 746.86/Q24.6”

If these requirements are not met, the Centers for Medicare & Medicaid Services (CMS) has instructed the Medicare Administrative Contractors (MACs) to return the claim to the provider. (CMS Transmittal R3204CP)

Q: IS MODIFIER 25 REQUIRED ON G0378, AND IF SO, WHERE IS THE CMS GUIDANCE THAT INDICATES THIS REQUIREMENT?

A: Modifier 25 [Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Healthcare Professional on the Same Day of the Procedure or Other Service] is not appropriate to report with HCPCS G0378 [Hospital observation service, per hour]. However, it may be appropriate to append to an E/M level of service CPT® code if supported by facility documentation and meets modifier 25 coding/reporting guidance.

The NCCI Policy Manual for Medicare Services (2015) provides the following guidance of when to append modifier 25, which states:

“Modifier 25: The CPT Manual defines modifier 25 as a ‘significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service.’ Modifier 25 may be appended to an evaluation and management (E&M) CPT code to indicate that the E&M service is significant and separately identifiable from other services reported on the same date of service. The E&M service may be related to the same or different diagnosis as the other procedure(s).”

REFERENCE
NCCI Policy Manual for Medicare Services (01/01/2015), chapter I:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

CMS Transmittal R3204CP
MS-DRG Changes Taking Effect on October 1, 2015

(answers on following page)
MS-DRG Changes Taking Effect on October 1, 2015

(Over, Down, Direction)
AORTIC (1,1,SE)
APPROACH (11,2,W)
DIAGNOSIS (1,12,E)
DISEASES (20,12,N)
DISORDERS (12,11,SW)
ENDOSCOPIC (13,10,N)
FUSION (6,14,SW)
INCISION (13,17,NW)
LEFT (1,16,N)
MITRAL (1,7,E)
OPEN (7,18,NE)
OPERATING (11,8,SE)
PATHWAY (13,13,NE)
PERCUTANEOUS (12,9,W)
PULMONARY (14,1,S)
RIGHT (17,20,NW)
SEPSIS (6,8,W)
SPINAL (9,1,S)
STRUCTURE (12,12,NE)
TRANSITION (11,10,NW)
CCFN Staff Credits

Jennifer Bardeen
Senior Director, Content and Compliance

Shelley Nave, RHIA, COC
Senior, Coding and CDM Analysis

Tara O’Neill
Art Director

Chuck Buck
Creative Consultant

Contributing Writers
Dawn M. Lui, RHIT
Sandy Palmer, RHIT
Sarah Cobb, BS, CPhT, RMC
Toueria Morris, COC

Keep your subscription coming.
CCFN is a free monthly e-magazine discussing the latest information in the world of coding and compliance. To register for your free subscription, visit www.medassets.com/preference-center.

CCFN provides a discussion of coding practices for educational purposes only. MedAssets has made every effort to provide accurate content. Official coding guidelines are maintained by the Central Office on ICD-9-CM of the American Hospital Association.

No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form by any means, electronic, mechanical photocopying or recording without the publisher’s written permission.

100 North Point Center East
Building 100, Suite 200
Alpharetta, GA 30022
888.883.6332
www.medassets.com

© 2015, MedAssets, Inc. All rights reserved.
CPT® is a registered trademark of the American Medical Association.