Taking the Pain Out of OB Triage and Fetal Biophysical Profile Testing

“OB triage services may be reported with the outpatient evaluation and management (E/M) HCPCS code G0463” reports Toureria Morris.

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FAQS
Frequently Asked Questions for May
FEATURED ARTICLE
Taking the Pain Out of OB Triage and Fetal Biophysical Profile Testing
By Toueria Morris, CPC-H

A frequent question among healthcare professionals who see obstetrical (OB) patients is how does a facility report triage services in the Labor and Delivery department? “OB triage services (i.e., evaluation, monitoring, IV hydration, administration of medication, labs) may be reported with the outpatient evaluation and management (E/M) HCPCS code G0463 – Hospital outpatient clinic visit for assessment and management of a patient for non-scheduled patients,” reports Toueria Morris, writing in this edition of CCFN. “According to the 2014 Outpatient Prospective Payment System (OPPS) final rule, new HCPCS code G0463 is ‘for hospital use only representing any clinic visit under OPPS.’ Therefore, OPPS hospitals are required to report code G0463 in place of the five levels of hospital outpatient E/M codes for new and established patients (99201 – 99215),” concludes Morris.

RAC UPDATES
Billing Hydration Therapy
By Jamarrae Summerour-Clark, MBA/HCM, RHIT, CPC

As of March 7, 2014 the Centers for Medicare & Medicaid Services stated that recovery auditors could continue to conduct automated reviews through June 1, 2014 — reviews that do not require documentation from the medical record.

TALKING POINTS
Show Me the Money: Reporting Skin Substitute Products and Application
By Karen D. Chappell, MBA, EJD, CCS, CIRCC, LPN

With increased packaging — as noted in the 2014 Outpatient Prospective Payment System (OPPS) final rule — accurate reporting of skin substitutes is key to being reimbursed correctly for these costly products, advises Karen D. Chappell.

TALKING POINTS
Calculating Units for Drugs and Biologicals: What Should You Do When the Numbers Do Not Match?
By Kelly Kronenberg, CPhT, RMC

 Appropriately billing units of service for the supply of drugs and biologicals becomes confusing when the units of drugs administered do not match the units described by the reportable HCPCS code.

ICD-10 TALK
Biophysical Profile Coding in the ICD-10 World
By Darnacea Harris, MHA, RHIT, CCS

A biophysical profile (BPP) is a prenatal test used to check on a baby’s wellbeing. The BPP is a combination of fetal heart rate monitoring via non-stress test, and fetal ultrasound.
Two big news stories from the Centers for Medicare & Medicaid Services (CMS) continue to reverberate. Just recently, CMS was forced to reveal that it would be issuing an interim final rule “soon” with the compliance date of October 2015 for the implementation of ICD-10. And just as the dust was settling from that announcement, CMS turned around to report that it was cancelling its “limited scope” of ICD-10 end-to-end testing scheduled for late July of this year. It is against this backdrop of change that we publish the May edition of CCFN.
Taking the Pain Out of OB Triage and Fetal Biophysical Profile Testing

A frequent question among healthcare professionals who see obstetrical (OB) patients is “how does a facility report triage services in the Labor and Delivery department?” This question may apply to any number of scenarios.

By Toueria Morris, CPC-H

OB triage services (i.e., evaluation, monitoring, IV hydration, administration of medication, labs) may be reported with the outpatient evaluation and management (E/M) HCPCS code G0463 - Hospital outpatient clinic visit for assessment and management of a patient for non-scheduled patients.

According to the 2014 Outpatient Prospective Payment System (OPPS) final rule, new HCPCS code G0463 is “for hospital use only representing any clinic visit under OPPS.” Therefore, OPPS hospitals are required to report code G0463 in place of the five levels of hospital outpatient E/M codes for new and established patients (99201 –99215). This technical charge may be reported on the UB04 to capture facility resources consumed for clinic visits, such as room and staff time, supplies and other overhead items for Medicare facility services under the OPPS.

If the patient requires additional diagnostic testing due to the assessments or evaluation, and the physician orders medically necessary testing, this occurrence may be charged in addition to the E/M visit code. When reporting both an E/M code and a procedure code on the same date of service, the E/M code would require the use of modifier 25 to signify this as a separately identifiable procedure. The services must be medically necessary and documented in the patient’s medical record.

If, during those times when a labor and delivery (L&D) department healthcare professional sees an OB patient for a scheduled service (e.g., steroid injections) and the patient is then placed on a fetal monitor as part of that assessment, it would not be appropriate to report an E/M code for the monitoring in addition to the steroid injection.

E/M level codes should only be reported during a scheduled visit when the patient’s condition has changed and the patient requires additional medical attention. When a patient presents to the L&D department...
department with an order (scheduled visit) for a service, the assessment and monitoring provided by the attendant to the patient is inclusive with the ordered service or procedure. Therefore, the E/M is not separately reportable.

**E/M level codes should only be reported during a scheduled visit when the patient’s condition has changed and the patient requires additional medical attention.**

Take the case when a patient presents at a clinic for a scheduled injection, and during the visit the patient’s blood pressure, when taken, is extremely high. The physician is notified and a physical examination is performed. In this scenario, the clinic would report the outpatient E/M code for the physician examination, appending modifier 25, in addition to reporting the appropriate CPT/HCPCS code for the administration of any drug or substance.

Often times, pregnant women seeking care in a hospital’s outpatient setting are not scheduled visits. These situations occur when patients present to the hospital emergency department or L&D department with false labor or other issues. When this happens, it would be appropriate to report the outpatient E/M service. If the patient requires additional diagnostic testing due to the assessment and evaluation and the physician orders medically necessary testing this may be charged in addition to the E/M level code. When reporting both an E/M level code and a procedure code(s) on the same date of service the E/M code would require the use of modifier 25 to signify this as a separately identifiable procedure.

If the patient is ordered to admit to observation status and the physician orders additional diagnostic testing it is appropriate to charge for the tests in addition to the observation charge.

A common test provided to OB patients during an outpatient visit is the fetal non-stress test (NST). This test is performed to evaluate the pregnancy and the development of the fetus. A non-stress test is performed with fetal monitoring and is based on the fetus’ heart rate accelerating with fetal movement. A reactive NST (CPT code 59025) requires 20 plus minutes of fetal monitoring and interpretation. This is often confused with a “reactive fetal heart rate,” which is an ultrasound evaluation and is inclusive of a fetal biophysical profile (BPP) examination.

A BPP is physiological examination to determine the health of a term or near term fetus. A NST is one of five elements that make up a fetal BPP. However, when NST is performed with BPP it is not separately reported (CPT code 59025).

A fetal BPP includes the following:
1. Ultrasound evaluation fetal movements – three or more discrete body or limb movements within 30 minutes
2. Ultrasound fetal tone – one or more episodes of a fetal extremity extension with return to flexion, or opening of closing of a hand
3. Ultrasound fetal breathing – one or more episodes of fetal breathing movements for 30 seconds or more within 30 minutes
4. Ultrasound evaluation of amniotic fluid volume, amniotic fluid exceeding 2 cm is considered adequate
5. NST – evaluation of fetal heart rate response by an external monitor (If the fetus is non-active, an acoustic device may be used to stimulate activity.)

When medically appropriate, the physician may order a NST in addition to the BPP. When NST is performed with fetal BPP, it would not appropriate to report 59025, as NST in inclusive of CPT code 76818 [Fetal biophysical profile; with non-stress testing. When NST is not performed with BPP, providers should report CPT code 76819 [Fetal biophysical profile; without non-stress testing].

There are circumstances when the hospital outpatient department may separately report NST and BPP. For example, if the NST is performed by another healthcare professional during a different or separate session than the BPP. For example, the L&D department performed the NST and the BPP was performed by the radiology department. In this scenario, the L&D would report CPT code 59025, with modifier 59, and the radiologist would CPT code 76819.

When billing NST and/or BPP, specific documentation is the key to accurately coding the procedure performed. A physician or other qualified healthcare professional must order both NST and BPP. Documentation must support medical necessity, and also support each of the five individual elements for CPT 76818 and four elements for CPT 76819.
The results of the examination must be readily available to the physician or other healthcare professional in order to make a medical decision. Findings from examinations and tests should always be documented in the patient’s medical record.

It is also extremely important that the documentation support, when appropriate, the reporting of modifiers 25 and 59.

There are several facets that must be taken into consideration when reporting OB triage services. The facility record should contain documentation that tells the story of the visit, including orders for any scheduled and non-scheduled services provided with clear details of testing performed and involvement of the physician and staff attending the patient.

Since most of L&D patients are not Medicare beneficiaries, MedAssets recommends that providers consult with their state Medicaid and private payers for billing guidance regarding L&D services, as Medicare billing requirements may differ.

TOUERIA MORRIS, CPC-H

Toueria Morris, CPC-H, is a Coding and CDM Analyst for MedAssets. Toueria is responsible for maintaining the ancillary content for MedAssets products and provides coding guidance. As a healthcare professional, Toueria has over 12 years 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.

REFERENCES

CPT Assistant December 2004 Volume 14, Issue 11
CPT Assistant May 1998 Volume 8, Issue 5
Billing Hydration Therapy

By Jammarrae Summerour-Clark, MBA/HCM, RHIT, CPC

The healthcare industry today is facing many challenges. For example, the implementation of ICD-10 has been delayed by an act of Congress until, at least, 2015. Meeting documentation guidelines and ensuring that claims are being submitted correctly for reimbursement continues to be an issue. Moreover, the Centers for Medicare & Medicaid Services (CMS) will not conduct post-payment patient status reviews for claims with admission dates between Oct. 1, 2013 through Oct. 1, 2014 while, in the meantime, the agency reports that it will make improvements in the audit process for the future.

As of March 7, 2014 CMS stated that recovery auditors (RAs) could continue to conduct automated reviews through June 1, 2014. These are reviews that do not require documentation from the medical record. While all additional documentation requests (ADRs) submitted as of Feb. 28, 2014 are to be completed within 45 days, the RAs will have up to 60 days to review and make determinations on automated claims reviewed. So, as of March 28, 2014, there are no new issues posted for RAC regions A, B, C, or D.

With that being said, providers should pay attention to an issue that was recently reviewed by an RA.

Region C Contractor Connolly Healthcare conducted an automated review of outpatient claims, regarding Hydration Therapy (C003932013), revealing that some providers are billing hydration therapy with diagnosis codes that are not considered medically necessary, based on the local coverage determinations (LCDs).

According to LCD L322738 Hydration Therapy should be coded as followings:

**EXPECTED REVENUE CODES**

Listed below are revenue codes that are normally used to report hydration therapy. But it important to note that not every revenue code will be applicable to all the CPT®/HCPCS codes listed. Providers should refer to the CMS Internet-Only Manual Publication 100-04, Claims Processing Manual, for additional direction.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0250</td>
<td>Pharmacy - General Classification</td>
</tr>
<tr>
<td>0258</td>
<td>Pharmacy - IV Solutions</td>
</tr>
<tr>
<td>0260</td>
<td>IV Therapy - General Classification</td>
</tr>
<tr>
<td>0263</td>
<td>IV Therapy - IV Therapy/Drug/Supply Delivery</td>
</tr>
<tr>
<td>045X</td>
<td>Emergency Room - General Classification</td>
</tr>
<tr>
<td>076X</td>
<td>Specialty Services - General Classification</td>
</tr>
</tbody>
</table>

**CPT/HCPCS CODES**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96360</td>
<td>Hydration iv infusion initial</td>
</tr>
<tr>
<td>96361</td>
<td>Hydrate iv infusion add-on</td>
</tr>
<tr>
<td>J7030</td>
<td>Normal saline solution infusion</td>
</tr>
<tr>
<td>J7040</td>
<td>Normal saline solution infus</td>
</tr>
<tr>
<td>J7042</td>
<td>5% dextrose/normal saline</td>
</tr>
<tr>
<td>J7050</td>
<td>Normal saline solution infus</td>
</tr>
<tr>
<td>J7060</td>
<td>5% dextrose/water</td>
</tr>
<tr>
<td>J7070</td>
<td>D5w infusion</td>
</tr>
<tr>
<td>J7120</td>
<td>Ringers lactate infusion</td>
</tr>
</tbody>
</table>

**EXPECTED ICD-9 CODES**

The codes listed are only those diagnoses for which the identified CPT/HCPCS procedures are covered. If a covered diagnosis is not on the claim, it will automatically result in a denial of the claim for not meeting medical necessity.

Providers should pay attention to an issue that was recently reviewed by an RA.
### RAC UPDATES

**Billing Hydration Therapy — continued**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.80</td>
<td>DIABETES WITH OTHER SPECIFIED MANIFESTATIONS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED</td>
</tr>
<tr>
<td>275.42</td>
<td>HYPERCALCEMIA</td>
</tr>
<tr>
<td>276.0</td>
<td>HYPEROSMOLALITY AND/OR HYPERNATREMIA</td>
</tr>
<tr>
<td>276.50</td>
<td>VOLUME DEPLETION, UNSPECIFIED</td>
</tr>
<tr>
<td>276.51</td>
<td>DEHYDRATION</td>
</tr>
<tr>
<td>276.52</td>
<td>HYPOVOLEMIA</td>
</tr>
<tr>
<td>458.9</td>
<td>HYPOTENSION UNSPECIFIED</td>
</tr>
<tr>
<td>535.00</td>
<td>ACUTE GASTRITIS (WITHOUT HEMORRHAGE) - ACUTE GASTRITIS WITH HEMORRHAGE</td>
</tr>
<tr>
<td>535.01</td>
<td>ACUTE GASTRITIS (WITHOUT HEMORRHAGE) - ATROPHIC GASTRITIS WITH HEMORRHAGE</td>
</tr>
<tr>
<td>535.10</td>
<td>ATROPHIC GASTRITIS (WITHOUT HEMORRHAGE) - ATROPHIC GASTRITIS WITH HEMORRHAGE</td>
</tr>
<tr>
<td>535.11</td>
<td>ATROPHIC GASTRITIS (WITHOUT HEMORRHAGE) - GASTRIC MUCOSAL HYPERTROPHY WITH HEMORRHAGE</td>
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<td>535.20</td>
<td>GASTRIC MUCOSAL HYPERTROPHY (WITHOUT HEMORRHAGE) - GASTRIC MUCOSAL HYPERTROPHY WITH HEMORRHAGE</td>
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<td>GASTRIC MUCOSAL HYPERTROPHY (WITHOUT HEMORRHAGE) - ALCOHOLIC GASTRITIS WITH HEMORRHAGE</td>
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<td>535.30</td>
<td>ALCOHOLIC GASTRITIS (WITHOUT HEMORRHAGE) - ALCOHOLIC GASTRITIS WITH HEMORRHAGE</td>
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<tr>
<td>535.31</td>
<td>ALCOHOLIC GASTRITIS (WITHOUT HEMORRHAGE) - OTHER SPECIFIED GASTRITIS WITH HEMORRHAGE</td>
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<td>535.40</td>
<td>OTHER SPECIFIED GASTRITIS (WITHOUT HEMORRHAGE) - OTHER SPECIFIED GASTRITIS WITH HEMORRHAGE</td>
</tr>
<tr>
<td>535.41</td>
<td>OTHER SPECIFIED GASTRITIS (WITHOUT HEMORRHAGE) - UNSPECIFIED GASTRITIS WITH HEMORRHAGE</td>
</tr>
<tr>
<td>535.50</td>
<td>UNSPECIFIED GASTRITIS AND GASTRO-DUODENITIS (WITHOUT HEMORRHAGE) - UNSPECIFIED GASTRITIS AND GASTRO-DUODENITIS WITH HEMORRHAGE</td>
</tr>
</tbody>
</table>

Medicare also established limited coverage for CPT/HCPCS codes 96360, 96361, J7030, J7040, J7042, J7050, J7060, J7070 and J7120, when hydration therapy is provided in addition to an angiography or CT scan with contrast with a primary diagnosis of V15.89. In this case one of the secondary diagnoses from the list below would be required.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>535.60</td>
<td>DUODENITIS (WITHOUT HEMORRHAGE) - DUODENITIS WITH HEMORRHAGE</td>
</tr>
<tr>
<td>535.61</td>
<td>DUODENITIS WITH HEMORRHAGE</td>
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<tr>
<td>535.70</td>
<td>EOSINOPHILIC GASTRITIS, WITHOUT MENTION OF HEMORRHAGE - EOSINOPHILIC GASTRITIS, WITH HEMORRHAGE</td>
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<td>535.71</td>
<td>EOSINOPHILIC GASTRITIS, WITH HEMORRHAGE</td>
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<tr>
<td>536.2</td>
<td>PERSISTENT VOMITING</td>
</tr>
<tr>
<td>558.9</td>
<td>OTHER AND UNSPECIFIED NONINFECTIOUS GASTROENTERITIS AND COLITIS</td>
</tr>
<tr>
<td>578.0</td>
<td>HEMATEMESIS</td>
</tr>
<tr>
<td>643.10</td>
<td>HYPEREMESIS GRAVIDARUM WITH METABOLIC DISTURBANCE UNSPECIFIED AS TO EPISODE OF CARE</td>
</tr>
<tr>
<td>643.13</td>
<td>HYPEREMESIS GRAVIDARUM WITH METABOLIC DISTURBANCE ANTEPARTUM</td>
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<tr>
<td>643.20</td>
<td>LATE VOMITING OF PREGNANCY UNSPECIFIED AS TO EPISODE OF CARE</td>
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<tr>
<td>643.23</td>
<td>LATE VOMITING OF PREGNANCY ANTEPARTUM</td>
</tr>
<tr>
<td>643.80</td>
<td>OTHER VOMITING COMPLICATING PREGNANCY UNSPECIFIED AS TO EPISODE OF CARE</td>
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<tr>
<td>643.83</td>
<td>OTHER VOMITING COMPLICATING PREGNANCY ANTEPARTUM</td>
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<tr>
<td>780.2</td>
<td>SYNCOPE AND COLLAPSE</td>
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<tr>
<td>780.4</td>
<td>DIZZINESS AND GIDDINESS</td>
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<tr>
<td>780.97</td>
<td>ALTERED MENTAL STATUS</td>
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<tr>
<td>787.01</td>
<td>NAUSEA WITH VOMITING</td>
</tr>
<tr>
<td>787.03</td>
<td>VOMITING ALONE</td>
</tr>
<tr>
<td>787.91</td>
<td>DIARRHEA</td>
</tr>
<tr>
<td>V58.11</td>
<td>ENCRYPT FOR ANTINEOPLASTIC CHEMOTHERAPY</td>
</tr>
</tbody>
</table>

In summary, the billing of hydration therapy has been a regular source of confusion for many providers. Here are some important points to remember:

- IV infusion therapy (96360 with/without 96361) will be paid only once per session. Medicare would not expect to see infusion therapy (96360) billed more than once per day.
- When administering multiple infusions, injections or combinations, report one “initial” service code unless protocol requires that two separate IV sites must be used.
- If more than one “initial” service code is billed on the same date of service then modifier 59 is required.
- Infusions for additional hours are only to be reported if the interval is greater than 30 minutes beyond the one-hour increment.
Managing Discharge Disposition Codes

By Rebecca Kidder, RN, CPC-P

In the February 2014 edition of CCFN, we published an article encouraging hospitals to review their process for not only assigning discharge disposition codes but also the process for validating that the planned services were received as intended for the specified DRGs. Please note an update to that article.

MedAssets calls your attention to MLN Matters® Number: SE1411. Released on March 3, 2014 to supplement SE0801, SE 1411 provides detailed instructions and Q&A for reporting each discharge disposition code.

Article SE1411 announced the release of several new disposition codes:

“The National Uniform Billing Committee (NUBC) approved 15 new patient discharge codes (81-95) adapted after existing codes with ‘a Planned Acute Care Hospital Inpatient Readmission’ appended in the title. A new patient discharge status code 69 was created in order for providers to be able to indicate discharges/transfers to a Designated Disaster Alternative Care Site. NUBC implemented these new codes effective for services on or after October 1, 2013. For Inpatient Prospective Payment System (IPPS) hospitals, the post-acute transfer payment policy will apply to claims that contain the planned readmission patient discharge status codes (81-95) as its current non-readmission counterpart code applies. For IPPS hospitals, the post-acute transfer payment policy will not apply to claims that contain patient discharge status code 69.”

The article contains a table describing each of these new codes. On March 6, 2014, however, shortly after the article was released, the Centers for Medicare & Medicaid Services (CMS) rescinded the article and indicated it would be revised and reposted again when the revisions are completed.

Providers should remain alert for this new release and ensure that the new discharge disposition codes are incorporated into their current processes for accurately identifying and reporting the disposition location to minimize any adverse impact to the DRG reimbursement.

REFERENCES
CMS MLN Matters SE1411, Clarification of Patient Discharge Status Codes and Hospital Transfer Policies, 2014-03-03
Show Me the Money: Reporting Skin Substitute Products and Application

By Karen D. Chappell, MBA, EJD, CCS, CIRCC, LPN

In the 2014 Outpatient Prospective Payment System (OPPS) final rule, the Centers for Medicare & Medicaid Services (CMS) packaged the payment for skin substitute products that do not qualify for pass-through status indicator G (SI) into the payment for the associated skin substitute application procedure.1

With increased packaging, the correct reporting of skin substitutes is key to being reimbursed correctly for these costly products. Effective Jan. 1, 2014, CMS implemented an edit that requires hospitals to report the application of the following:

a. Pass-through and high cost skin substitute products with CPT® codes 15271 – 15278 and;

b. Low cost skin substitute products with HCPCS code C5271 – C5278.

This new development creates a serious challenge when assigning these CPT codes. The HIM coder and wound care department must determine the brand name of the skin substitute product in order to assign the correct CPT procedure code for the application of that product. Hospitals will need to ensure that the encoder and department charge capture vehicles are updated at least quarterly mapping the skin substitute to the correct HCPCS code and the correct application CPT code.

CMS assigned skin substitute products with a July 2013 payment rate of more than $32 per square centimeter (sqcm) to the high cost group. Skin products with a payment rate less than $32 per sqcm or with no payment information were assigned to the low cost group. CMS will update the assignment of these products to the high/low cost groups as new payment information becomes available.2

In the April 2014 quarterly OPPS update, CMS assigned two skin substitutes to the high cost group based on new pricing information. HCPCS code Q4148, Neox 1K, per square centimeter and Q4147, Architect extracellular matrix, per sqcm were assigned to the High Cost Group. HCPCS code Q4143, Repriza, per sqcm, was assigned to the low cost group.

The following example demonstrates how application of Dermacell would be reported using the prescribed codes:

Sixteen (16) square centimeters of Dermacell are applied to the right forearm as a skin substitute graft.

**Report:**

16 units of Q4122, Dermacell, per square centimeter (Status Indicator G); and

1 unit of 15271, Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area. The reimbursement for this is $1,206.41 for the Dermacell.

The reimbursement is $1,249.18 for the application procedure. This reimbursement could be delayed for OCE edits or denied if reported incorrectly.

With increased packaging of services, it is imperative that coders read the CMS quarterly updates to stay current with the changes to OPPS reimbursement for all products and services, including skin substitutes. MedAssets recommends that hospitals review the mapping of these services for accuracy with the quarterly OCE edits to ensure the correct assignment of the high cost/low cost range of codes. MedAssets also recommends that hospitals conduct periodic chart audits to ensure that the correct Q-code for the skin substitute products and the correct CPT codes for skin substitute application have been reported.

KAREN D. CHAPPELL, EJD, MBA, CIRCC, CCS, CIRCC
Ms. Chappell is a CDM Consultant, Revenue Cycle Advisory Solutions with MedAssets. Ms. Chappell specializes in chargemaster compliance. She is a leading subject-matter expert in the CDM, coding chart audits, and interventional radiology coding. Ms. Chappell is responsible for performing CDM reviews to assess compliant charging structures. She also performs chart...
TALKING POINTS

Show Me the Money: Reporting Skin Substitute Products and Application — continued

audits on outpatient accounts to assess compliant billing and charge capture opportunities. Her expertise includes helping clients improve compliance, confirm accuracy and completeness of charge capture and coding, and identifying potential missed revenue opportunities. She has more than 20 years of revenue cycle experience.

As an example of the kind of value Ms. Chappell provides, she recently completed a CDM review of a two-hospital system. As a team member for the project, she worked with the health system to implement best practice processes to improve charge structure, enhance workflow processes, and educate clinical staff to increase awareness of the chargemaster and hospital reimbursement. Also, Ms. Chappell has completed chart audit reviews for several hospitals and educated charge capture staff on charge capture opportunities and compliance issues to focus on.

Prior to joining MedAssets, Ms. Chappell was a revenue integrity charging manager at Boca Raton Regional Hospital. She was responsible for managing the revenue integrity of the hospital and implementing detailed action plans to improve charge capture as the result of external charge compliance audits. Her duties also included chargemaster maintenance, implementing MedAssets CDM Master, performing root cause analysis of pre-bill edits and providing education and training to prevent and resolve pre-bill edits.

Ms. Chappell holds an Executive Juris Doctorate from Concord College and a Master’s Degree in Business from American Intercontinental University. She is a Certified Coding Specialist (CCS) through American Health Information Management Association (AHIMA) and is a Certified Interventional Radiology Cardiovascular Coder (CIRCC) through the American Academy of Professional Coders (AAPC). She is also a Licensed Practical Nurse (LPN).

REFERENCES

1 CMS MLN Matters® MM8572, January 2014 Update of the Hospital Outpatient Prospective Payment System, January 2014.

2 CMS MLN Matters MM8653, April 2014 Update of the Hospital Outpatient Prospective Payment System, April 2014.
Calculating Units for Drugs and Biologicals: What Should You Do When the Numbers Do Not Match?

By Kelly Kronenberg, CPhT, RMC

Appropriately billing units of service for the supply of drugs and biologicals is not always a straightforward process when reporting their use to Medicare.

Here’s the easy part: A HCPCS code describes 10 milligrams, and 10 milligrams are administered to the Medicare beneficiary. In this case, one unit of the drug should be reported on the Medicare claim. This seems pretty simple, and it is.

The process becomes confusing when the units of drugs administered do not match the units described by the reportable HCPCS code. For example, 7 mgs of a drug is administered and the drug HCPCS code description is “per 4 mgs.”

When hospitals report drugs and biologicals on a Medicare claim they must make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of the drug or biological used in the care of the patient. Not appropriately billing the correct units of a drug or biologicals could result in the hospital receiving an under payment or receiving an over payment. Neither one is good for the hospital.

Here are some “do’s” and “don’ts” along with other guidance that will assist you in appropriately billing drugs and biologicals when the numbers don’t match.

**APPROPRIATE CALCULATION: DO’S**
- Report all appropriate HCPCS codes and charges based on the Centers for Medicare & Medicaid Services (CMS) requirements
- Bill in multiples of the dosage specified in the HCPCS code long descriptor
- If the full dosage provided is less than the dosage for the HCPCS code descriptor specifying the minimum dosage for the drug, providers report one unit of the HCPCS code for the minimum dosage amount

**APPROPRIATE CALCULATION: DON’TS**
- Hospitals should NOT bill the units based on the way the drug is packaged, stored, or stocked.

**BILLING UNIT FORMULA**
To help simplify your calculations, follow this formula: when calculating billing units, the dose is divided by the HCPCS descriptor.

**DOSE/HCPCS LONG DESCRIPTION = BILLING UNIT**
If the HCPCS descriptor describes “per 50mg,” and the physician administered 200mg, the billing unit would be “4.”

If the units given to the patient are less than the HCPCS code long description it is appropriate to round-up and use “1.”

If the HCPCS descriptor is “per 5mg,” and the physician administered 4.3mg, the appropriate billing unit would be “1.”
- \(4.3 \text{mg}/5 \text{mg} = 0.86\) so this would round up to 1

**CONVERSION OF UNITS**
The units should be reported in multiples of the units included in the HCPCS code descriptor. So, when calculating, remember to make sure the calculations are in like units.

The HCPCS code may be described in terms of milligrams (mg) while the common package size may be listed in micrograms (mcg).

The unit of measure in the HCPCS codes may not be expressed in the same format as the dose of the drug dispensed. For example, the HCPCS code may be described in terms of milligrams (mg) while the common package size may be listed in micrograms (mcg).
Calculating Units for Drugs and Biologicals: What Should You Do When the Numbers Do Not Match? — continued

**TALKING POINTS**

**ANNUAL AND QUARTERLY HCPCS CODE UPDATES**
Failing to update your charge description master (CDM) according to the annual and quarterly updates could result in under payment.

**COMMONLY USED PHARMACY METRIC CONVERSIONS**
Due to the complexity of drug conversion factors, it is important that your CDM end-users should always be involved and educated when structuring your charges.

**Conversion Table:**

<table>
<thead>
<tr>
<th>Conversion</th>
<th>Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 gm = 1000 mg</td>
<td>0.005 mg = 5 mcg</td>
</tr>
<tr>
<td>1 mg = 1000 mcg</td>
<td>0.05 mg = 50 mcg</td>
</tr>
<tr>
<td>0.5 mg = 500 mcg</td>
<td>0.5 gm = 500 mg</td>
</tr>
<tr>
<td>10% = 100mg/ml</td>
<td>0.05 gm = 50 mg</td>
</tr>
<tr>
<td>1 fl oz = 30 ml</td>
<td>1 fl oz = 28.3 gm</td>
</tr>
</tbody>
</table>

**CALCULATION EXAMPLES: CEFTAZIDIME**
HCPCS code: J0713 [Injection, ceftazidime, per 500 mg]

A physician administers a small dose of 2.25 mg of ceftazidime to a patient, the descriptor for J0713 is 500 mg and the dose is for 2.25 mg.

**Billing Unit Formula:**

\[
\text{Dose/HCPCS Long Description} = \text{Billing Unit} \\
2.25\text{mg/500\text{mg}} = 0.005 \text{ round up to (1) unit} \\
= 1 \text{ Unit of J0713 is reported}
\]

**CALCULATION EXAMPLE: SKIN SUBSTITUTE**
A physician applies 37.8 square centimeter (sqcm) of Dermagraft Q4106 [Skin substitute, Dermagraft, per sqcm] to a patient’s wound: What would the billing unit be?

37.8 sq cm/1 sq cm = 37.8 Units of Q4106  
37.8 would round up to “38” Units of Q4106 reported

**ACCURATE CDM DESCRIPTIONS**
To ensure your facility is accurately reimbursed for drugs that are administered, it is important to have accurate CDM descriptions, particularly with pharmacy charges. The drug names, strengths, volumes and routes can vary extensively in the realm of pharmacy. Having accurate descriptions not only aids CDM end-users in choosing the appropriate HCPCS code, but also ensures that proper billing units are being charged. If the strength or size is incorrect in the description, the potential for calculating the billing units incorrectly is likely. And if the billing units are calculated incorrectly, it is possible your facility is missing reimbursement. So, accuracy is very important.

**EXCELLENT CDM DESCRIPTIONS**
Excellent CDM descriptions have the following descriptive information:

- Drug Name
- Concentration or Strength
- Volume, Quantity, or Size
- Drug Route

Hospital staff responsible for reporting the supply of drugs and biologicals must have a clear understanding of how to report units provided, especially when the HCPCS’s code does not describe the dosage administered to a patient.

In conclusion, hospitals should be acutely be aware of their CDM descriptions for drugs and biologicals to ensure the descriptions are accurate and that they reflect the correct billing units, as described by the HCPCS codes.

**KELLY KRONENBERG, CPHT, RMC**
Kelly Kronenberg, CPhT, RMC, is a pharmacy senior coding and CDM analyst. Kelly has been with MedAssets for 20 years. While at MedAssets she has performed charge master implementation mapping projects specializing in the pharmacy department and related areas for a number of acute care hospitals nationwide. She also has worked on pharmacy CDM department restructuring and reviews projects. Currently, Kelly maintains the pharmacy content material for the MedAssets Knowledgebase which includes Medicare compliant billing codes, NDC codes and identification of over the counter items.

**REFERENCES**
ICD-10-PCS eases the coding of BPP by including more specificity in a single code. The BPP is located in the “Imaging” section of ICD-10-PCS. Procedures included in this section include plain radiography, fluoroscopy, CT, MRI and ultrasound. The characters in the Imaging section are different from those in the Medical/Surgical section. The seven characters are the following:

The ICD-10-PCS code path is: Imaging>Fetus and Obstetrical>Ultrasonography

The coder should then choose the trimester, which is divided by 0-14 weeks (first trimester), 14-28 weeks (second trimester) and more than 28 weeks (third trimester). The coder may also specify whether the pregnancy is single or multiple gestations. The table associated with the BPP is BY4. A BPP of a second trimester twin gestation is coded to BY4DZZZ.

**TEST YOURSELF**

Code the following using both ICD-9-CM and ICD-10-PCS conventions.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>ICD-9-CM</th>
<th>ICD-10-PCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine fetal ultrasound, second trimester twin gestation</td>
<td>75.94/99999</td>
<td>BY4DZZZ</td>
</tr>
<tr>
<td>Ultrasound fetal non-stress test monitoring for single gestation, 12 weeks</td>
<td>75.78/99999</td>
<td>BY44ZZZ</td>
</tr>
</tbody>
</table>

Answers: 1) 88.78/874DZZZ 2) 75.34/8749ZZZ
Frequently Asked Questions for May

Q: What is the correct way to report and code a vacuum assisted positron emission mammography (PEM) guided biopsy for the breast? In the past we were using 19103 with 78811 (STAT ONLY), now that the new breast biopsy codes are bundled into specific modalities there isn’t an appropriate code to support the exam.

A: As you are obviously well aware of, for calendar year (CY) 2014 a number of breast procedure codes have been deleted and replaced with specific modality codes. Since PEM was not included in the new codes and there is not an available HCPCS code that specifically describes a vacuum assisted PEM guided biopsy, we can only recommend reporting CPT® code 19499 Unlisted procedure, breast.

Furthermore, some private payers have indicated the use of PET Mammography (PEM) for the detection of breast cancer or subsequent monitoring of breast cancer is considered “investigational.” Generally, investigational services and procedures are not covered under OPPS. We strongly recommend that you follow up with your Fi/MAC regarding this service.

Q: Is the reimbursement for all services (CPTs, HCPCS) subject to the 2 percent sequestration reduction regardless of the status indicator? Or, are only the CPTs/HCPCS that are reimbursed based on APC subject to the 2 percent reduction? Where is the guidance that explains this situation?

A: According to FAQs on the sequestration reduction published by the Medicare contractor Palmetto J11, all services for all CPT/HCPCS codes are subject to the 2 percent reduction. The reduction is not limited to services reimbursed by APC.

The following FAQs relate to this question. We have listed the link to this FAQ document under “Resource.” You may want to review the complete document for further details.

Q: How long is the 2 percent reduction to Medicare fee-for-service claim payments in effect?

A: The sequestration order covers all payments for services with dates of service or dates of discharge (or a start date for rental equipment or multi-day supplies) April 1, 2013 through March 31, 2015.

Q: Are drugs excluded from the 2 percent reduction?

A: No. All fee-for-service Medicare claim payments are subject to the 2 percent reduction. There are no exemptions provided in the law for drugs or any other health care item or service provided under the fee-for-service program.

Q: Does the 2 percent payment reduction under sequestration apply to the payment rates reflected in Medicare fee-for-service fee schedules or does it only apply to the final payment amounts?

A: Payment adjustments required under sequestration are applied to all claims after determining the Medicare payment including application of the current fee schedule, coinsurance, any applicable deductible and any applicable Medicare Secondary Payment adjustments. All fee schedules, including pricers, are unchanged by sequestration; only the final payment amount is reduced.
Taking the Pain Out of OB Triage

(answers on following page)
(Over, Down, Direction)
BPP (20,10,W)
CLINIC (15,7,N)
DELIVERY (2,19,E)
EMERGENCY (10,9,NW)
FETAL (8,10,SE)
HEARTBEAT (15,18,N)
LABOR (11,14,S)
MEDICATION (15,1,SW)
MONITOR (7,10,SW)
NST (20,17,NW)
OBSTETRIC (17,1,S)
ORDER (5,3,SW)
PREGNANT (1,11,SE)
PROFILE (8,11,W)
SCENARIO (14,3,S)
STERIOD (10,7,NW)
STRESS (15,19,NE)
TRIAGE (5,14,E)
ULTRASOUND (13,1,W)
CCFN Staff Credits

Jennifer Bardeen
Senior Director, Content and Compliance

Shelley Nave, RHIA, CPC-H
Senior, Coding and Compliance Analysis

Chuck Buck
Creative Consultant

Tara O’Neill
Art Director

Contributing Writers
Toueria Morris, CPC-H
Jammarae Summerour-Clark, MBA/HCM, RHIT, CPC
Karen D. Chappell, MBA, EJD, CCS, CIRCC, LPN
Kelly Kronenberg, CPhT, RMC
Darnacea Harris, MHA, RHIT, CCS

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

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