

Revenue Roundtable June 2017

Bedside Procedures – The Reporting Dilemma

Many hospitals struggle with the concept of whether charges should or should not be separately reported.

Implementing the new codes for July

Several ancillary departments are impacted by the July 2017 OPPS updates. The implementation date is just around the corner.

Mark Your Educational Calendar

The year seems to be flying by and before you know it.... it will be time to update the chargemaster for 2018. HCS' educational dates are located on Page 10.



Revenue Roundtable
June 2017

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Time seems to fly faster and faster and it's hard to believe we are discussing mid-year coding changes already. Before you turn around we will be reviewing the 2018 code updates. It's time now to consider the educational needs of staff for the new coding rules, payment regulations and the numerous anticipated new, revised and deleted CPT and HCPCS codes by dedicating time in busy schedules to attend one of HCS' 2018 Chargemaster seminars. Please see the educational time schedule on page 10.

Bedside Procedures – The Dilemma

Inpatient coding professionals are used to MS-DRG systems where all of the diagnoses and procedures map to a single MS-DRG. If the hospital receives only one payment for the entire hospital stay, many department directors and Chief Financial Officers often do not place emphasis on reporting charges for bedside procedures. In addition, a common concern for hospital providers is that if they charge a bedside procedure for an inpatient, they are “double dipping”—that is, they are charging twice because everything is included in the room rate. When departments are

questioned about what services have been included in the current room rate, no one seems to know. It has been the perception that “all” nursing services provided are part of the room and board.

By definition, a bedside procedure is any procedure that is performed at the patient's bedside. It really is that simple. Some of the most common examples of bedside procedures are:

- Thoracentesis or Paracentesis
- Lumbar puncture
- Peripherally inserted central catheter (PICC) line insertion
- Insertion of a urinary catheter
- Cardioversion
- Incision and drainage procedures
- Negative pressure wound therapy
- Central line declot procedures
- Pleurodesis
- Arthrocentesis and joint injections
- Echocardiograms
- Biopsies (e.g., bone marrow biopsy)
- Endotracheal intubation
- Blood transfusions

Why should hospitals focus on charging bedside procedures? One of the major reasons is that all patients spending the night in a hospital bed are not inpatients. Outpatient observation patient volumes have been on the rise even with the implementation of the two-midnight rule, and capturing charges for all injections, infusions as well as any procedures performed is imperative when submitting these claims for payment. Missed charges definitely count when it comes to receiving maximum reimbursement for observation services. Should we charge for these services only for observation patients and ignore these services when the patient is an inpatient? Doesn't seem plausible....particularly when providers should be charging all patients consistently.

When a bedside procedure is performed, a sterile field is prepared, instrumentation available, required supplies ready, and nursing staff in attendance to assist the physician. There is virtually no difference in a procedure that is performed at bedside versus the same procedure that is performed in a treatment room or operating room.

Bedside Procedures – Continued

Charging for procedures performed at the inpatient bedside can improve cost data captured for each individual patient which can dramatically provide more specific cost information to make informed operational decisions. It can also increase transparency as data ultimately reflects cost of services provided related to the MS-DRG. Clinical nursing departments may become more focused on charge capture if they get credit for these services, ultimately helping to support added staff or new equipment requests.

These procedures would be generated for both inpatients as well as any patient in observation/outpatient status. As a general rule, any procedure performed by a physician, PA, NP, resident or intern, or any other health care professional qualified to perform the surgical procedure, can be billed to capture the technical component for these procedures.

When an ancillary department is present and assists the physician, this ancillary department should generate the charge for

the procedure. For example, if an ultrasound-guided thoracentesis is performed and radiology department brings the equipment and operates the ultrasound machine while the physician performs the procedure, radiology will capture the procedure charge. If endoscopy or respiratory therapy is present and assists with a bedside bronchoscopy, the ancillary department present will undoubtedly charge for the procedure. It is those instances when no other ancillary department is present and nursing assists the physician that the charge should be captured by the specific nursing area. The cost of nursing resources utilized when providing bedside procedures is no less important than the cost of resources to perform the same procedures in a hospital department, even though the performance of the procedure does not differ.

Approximately eighty percent (80%) of procedures performed at the patient's bedside would require a consent to be signed by the patient and/or representative which could be one helpful indication to nursing staff that a charge should be

reported when a signed consent is obtained. Nurses may actually perform other billable procedures, such as insertion of a urinary catheter, declot a central/peripheral vein or perform a bladder scan.

Documentation is key to ensure the medical record contains the physician's order and procedure note or supportive documentation by the professional who performed the procedure.

Once a facility decides to pursue charges for the above discussed bedside procedures, it is suggested a room and board policy be developed should the facility not currently have such a policy. Are all of the services currently provided to inpatients truly included in the cost, and in turn, included in the charge for the room rate? Medicare does provide the following guidance:

Inpatient routine services in a hospital or skilled nursing facility generally are those services included in by the provider in a daily service charge--sometimes referred to as the "room and board" charge. Routine services

Bedside Procedures – Continued

are composed of two board components; (1) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care Units (ICU's). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

Reference: *Provider Reimbursement Manual, 2202.6*

After making the decision to report bedside procedures, the process should include representatives from the chargemaster team, finance, third-party contracting, revenue integrity, all clinical departments impacted as well as those responsible for charge capture or charge entry. Answers to some of these questions is important, and can include some of the following: 1) When will the charges be captured? 2) Who will be responsible for the charge capture? 3) If using a manual charge ticket, how will the

completion of the ticket take place and by whom? 4) Can the electronic medical record be utilized to charge upon completion of documentation?

Facilities need to keep the charge capture process simple to not be burdensome and time-consuming but consistent and accurate. The skills and expertise of IT may be extremely helpful and an IT team member should be included in the planning stages and processes.

The successful implementation of a charge capture process for bedside procedures will be helpful for observation/outpatients patients. Many times, inpatients and outpatients are in the same nursing unit, are taken care of by the same nursing staff, receiving many of the same services. Observation patients often receive services and procedures such as drug administration, lumbar punctures, and foley catheter insertions in addition to observation. While outpatient coders routinely report the CPT codes for these procedures, the charges are often missed, making it a challenge for the

surgical CPT code to link with the charge line and report on the UB-04.

The *Medicare Provider Reimbursement Manual* states in Section 2202.4 that charges refer to the regular rates established by the provider. It continues on by stating, "Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient." Effective February 2014, Medicare issued Transmittal 3106 which contained some additional guidance:

Inpatient routine services in a hospital generally are those services included by the provider in a daily service charge--sometimes referred to as the "Room and Board" charge. They include the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made to Medicare Part A. Many nursing services provided by the floor nurse (such as

Bedside Procedures – Continued

IV infusions and injections, blood administration, and nebulizer treatments, etc.) may or may not have a separate charge established depending upon the classification of an item or service as routine or ancillary among providers of the same class in the same State. Some provider's customary charging practice has established separate charges for these services following the PRM-1 instructions, however, in order for a provider's customary charging practice to be recognized it must be consistently followed for all patients and this must not result in an inequitable apportionment of cost to the program. If the PRM-1 instructions have not been followed, a provider cannot bill these services as separate charges. Additionally, it is important that the charges for service rendered and documentation meet the definition of the HCPCS in order to separately bill.

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R3106CP.pdf>

As noted, *Transmittal 3106* includes additional clarification concerning what nursing services may or may not be separately generated such as IV infusions and injections, blood administration, and nebulizer treatments, depending on whether they are classified as routine or ancillary among providers of the same class in the same state.

Unfortunately, hospitals don't often know what other hospitals in their state do. Hospitals can try reaching out to their state hospital association to see if the association can provide that information. It has been reported by a hospital in Texas that recently a third-party payer had denied charges for injections and infusions reported on an inpatient claim, TOB 0111. The reason for the denial...the payer quoted *Transmittal 3106*.

Should the facility elect to charge for all bedside procedures, it becomes imperative to review any claim/charge denial with contract management. When contracts are

renegotiated the bedside procedure payment policy should be a point of discussion.

New Code Updates for July 2017

Several new CPT and HCPCS codes have been made available through the issuance of *Transmittal 3783*, July 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS). Some of the significant coding updates are discussed below:

Pharmacy will have four new vaccine products to report using the following new CPT codes:

CPT 90587 *Dengue vaccine, quadrivalent, live, 3 dose schedule, for subcutaneous use (SI E1)*

CPT 90620 *Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB-4C), 2 dose schedule, for intramuscular use (SI M)*

New Code Updates...(Cont'd)

CPT 90621 *Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB-FHbp), 2 or 3 dose schedule, for intramuscular use (SI M)*

CPT 90651 *Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 2 or 3 dose schedule, for intramuscular use (SI M)*

Issued by the AMA in January, 2017, CMS has now assigned status indicators and incorporated these four new vaccines into the Hospital Outpatient Prospective Payment System. While the status indicators of E1 (Not covered by any Medicare outpatient benefit category) and M (Items and Services Not Billable to the MAC) have been assigned to these vaccine products, providers may report these specific vaccine products July 1, 2017. These new CPT codes will be included in the 2018 CPT codebook.

An existing vaccine CPT code 90682, *Influenza virus vaccine, quadrivalent (riv4), derived from recombinant dna, hemagglutinin (ha) protein only, preservative and antibiotic free,*

for intramuscular use, has changed status indicators from E1 to L. Transmittal 3783 states CPT 90682 is approved for use in the 2017-2018 flu season. Because this code is not payable until the start of the 2017 flu season, the status indicator will be retroactively corrected from 1/1/17 through 6/30/17 to E1. Effective 7/1/17 the status indicator be updated to L.

Two new drugs will be eligible for reporting July 1, 2017 which has been granted pass-through status with the assignment of status indicator G. These new codes are:

HCPCS C9489 *Injection, nusinersen, 0.1 mg.* Nusinersen (INN), marketed as Spinraza, is a biologic drug used in treating spinal muscular atrophy (SMA), a rare neuromuscular disorder.

HCPCS C9490 *Injection, bezlotoxumab, 10 mg.* Bezlotoxumab is a human monoclonal antibody designed for the prevention of recurrence of Clostridium difficile infections. Both C9489 and C9490 will be reportable using revenue code 0636.

Other pharmaceutical HCPCS codes introduced July 1 are listed below:

HCPCS Q9984 *Levonorgestrel-releasing intrauterine contraceptive system (Kyleena), 19.5 mg (SI E1).* Kyleena is a hormone-releasing IUD that prevents pregnancy for up to 5 years

HCPCS Q9985 *Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg (SI N).* CMS introduced a miscellaneous or “not otherwise specified, HCPCS for this steroidal progestin product. There are several different brand names for this product and pharmacy staff will be helpful to identify all drug products which may be eligible for reporting using Q9985.

HCPCS Q9986 *Injection, hydroxyprogesterone caproate (Makena), 10 mg (SI K).* CMS changed the status indicator of J1725, *Injection, hydroxyprogesterone caproate, 1 mg,* from K to E1, so facilities will be unable to report J1725 to Medicare after July 1, 2017. A new HCPCS code, Q9986 will be reportable and payable with noted dosage change from “per 1 mg” to “per 10 mg”.

New Code Updates...(Cont'd)

The last code change for drugs is the deletion of C9487 replaced with HCPCS Q9989, *Ustekinumab, for Intravenous Injection, 1 mg*. This code was introduced in April 2017 and is an immunosuppressive recently approved by the FDA for treatment of Crohn's disease. The brand name for this drug is Stelara.

The Blood Bank will undergo a change for July 1, 2017. Up to this point, all blood products have been reported using HCPCS "P" codes. HCPCS P9072, *Platelets, pheresis, pathogen reduced or rapid bacterial tested, each unit*, will change from status indicator R, Blood and Blood Products, to E1, Not covered by any Medicare outpatient benefit category. To replace this blood product's HCPCS code, CMS created HCPCS Q9988, *Platelets, pathogen reduced, each unit*, containing status indicator R.

The FDA approved a plasma pathogen reduction system for use in reducing the risk of transfusion transmitted infections often present in plasma from whole blood and/or apheresis. This system exposes the specimen to ultraviolet light and a chemical called

amotosalen. The specimen is purified to remove the chemical and any remaining byproducts. It can then be utilized for transfusion purposes. Code Q9988 may also be used for plasma subjected to rapid bacterial testing. A new HCPCS Q9987, *Pathogen(s) test for platelets*, was created to report the specialized testing performed on the pheresis platelet product.

Over 17 million patients receive in excess of 60 million units of individual blood components annually in North America, Europe and Asia, and each of these components is at risk for bacterial contamination. The biggest risk in the nation's blood supply is no longer HIV or hepatitis C, its bacterial contamination of platelets, resulting in at least 20 deaths and hundreds of adverse reactions in recent years, health experts say. This can essentially mean that as many as 12,000 bacterially contaminated blood components may be transfused every year representing the single greatest source of fatalities attributable to infectious agents in transfusion medicine today. In recognition of this risk, the American Association of Blood Banks implemented a standard requiring all of

its members implement methods to limit and detect bacterial contamination in platelets.

Verax Biomedical has introduced a test called Platelet PGD Test for the detection of bacterial contamination in platelets. It is the only test cleared by the FDA as a Safety Measure for leukoreduced apheresis platelets within 24 hours prior to transfusion. The hospital may presently be performing the PGD test (reporting using an unlisted CPT code) and as of July 1, will be reporting the pathogen testing on the platelet product using Q9987. Usually this test will be performed and reported one to two days prior to the transfusion of the platelet product; therefore, both Q9987 and Q9988 will rarely, if ever, be reported on the same date of service.

For 2017, in response to the Protecting Access to Medicare Act of 2014 (PAMA), the AMA has developed a new category of CPT codes, known as Proprietary Laboratory Analysis (PLA), which will be released on a quarterly basis. These alphanumeric CPT codes will be in a distinct chapter of the code book, located

New Code Updates...(Cont'd)

after the Pathology and Laboratory CPT code book sections, and before the Medicine code section. At the present time there are three new codes that have been released, with expected new codes to be released each quarter.

Proprietary Laboratory Analyses codes describe proprietary clinical laboratory analyses and can be either provided by a single ("sole-source") laboratory or licensed or marketed to multiple providing laboratories (e.g., cleared or approved by the Food and Drug Administration (FDA)).

The PLA CPT codes will easily be recognized as they end in the letter U. There are three CPT codes that were introduced February 1, 2017 and are listed below:

CPT 0001U – Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported

Proprietary Name and Clinical Laboratory or

Manufacturer: Precise Type HEA Test, Immucor, Inc.

CPT 0002U – Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps

Proprietary Name and Clinical Laboratory or Manufacturer: PolypDX, Atlantic Diagnostic Laboratories, LLC, Metabolomic Technologies Inc

CPT 0003U – Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score

Proprietary Name and Clinical Laboratory or Manufacturer: Overa (OVA1 Next Generation), Aspira Labs, Inc., Vermillion, Inc.

Proprietary Laboratory Analyses (PLA) codes describe proprietary clinical laboratory analyses and can be either provided by a single ("sole-source") laboratory or licensed or marketed to multiple providing laboratories (e.g., cleared or approved by the Food and Drug Administration (FDA)). PLA CPT codes are available to any clinical lab or manufacturer that wants to specifically identify their lab test. Applications are being accepted as January 2017, approved on a quarterly basis and implemented the following quarter. These new codes can be obtained by checking the following website, **amaproductupdates.org**, with the new codes included in the code book the following year. It has been reported the AMA anticipates approximately 500 applications to be submitted initially, with the approval of the above three mentioned CPT codes.

Two additional PLA CPT codes were introduced May 1, 2017 which are displayed below:

CPT 0004U Infectious disease (bacterial), DNA, 27 resistance genes, PCR amplification

New Code Updates...(Cont'd)

and probe hybridization in microarray format (molecular detection and identification of AmpC, carbapenemase and ESBL coding genes), bacterial culture colonies, report of genes detected or not detected, per isolate

Proprietary Name and Clinical Laboratory or Manufacturer: Gram-Negative Bacterial Resistance Gene PCR Panel, Mayo Clinic, Check-Points Health BV, Wageningen, Netherlands

CPT 0005U Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score

Proprietary Name and Clinical Laboratory or Manufacturer: ExosomeDx Prostate (IntelliScore), Exosome Diagnostics, Inc.



Seminars – Mark Your Calendar!!

2018 CPT and HCPCS Update Seminars: It is anticipated the 2018 CPT and HCPCS code additions, revisions and deletions will greatly impact not only the facility's chargemaster but also reimbursements and charge capture processes. HCS will be conducting two information-packed seminars that will focus on updating the chargemaster. Attendees can return home armed with the necessary information to implement the new changes and educate departmental staff.

This all day seminar will focus on all ancillary departments impacted by the new coding revisions as well as include problematic charging and billing areas hospitals are currently experiencing and provide some added insight on other facility successes in overcoming the ever-complex world of chargemaster.

Monday, November 13, 2017 (Dallas, TX) at DFW Westin.

Tuesday, November 14, 2017 (San Antonio, TX at Marriott Northwest)

For more information, contact Jeff Neustaedter, President of HCS HealthCare Consulting Solutions.

Brochure and registration material will be emailed in mid/late August.

Newsletter/About HCS

Revenue Roundtable Newsletter

Welcome to the Revenue Roundtable Newsletter. HCS HealthCare Consulting Solutions would like to introduce you to this bi-monthly newsletter, developed for the healthcare professional working within a variety of settings. The future newsletters will feature industry experts who will discuss best practices for a variety of topics plaguing healthcare providers ultimately impacting the facility's bottom line.

Subscription is "free". Comments and questions are always welcomed. Recipients of this newsletter are encouraged to share with colleagues and co-workers. To submit subscription requests, ask questions or communicate directly with the "Revenue Roundtable" newsletter editors, please e-mail: newsletter@hcsglobal.net

Newsletter/About HCS...Continued

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Glenda brings an extensive background in chargemaster, billing, operations, ICD-10-CM/PCS, DRG coding and hospital CPT-4 coding, and has over 30 years of healthcare industry experience and expertise in all areas of health information, medical records, utilization review, patient access and business services. Additionally, she's an expert in third party reimbursement, electronic submission of claims, billing and collections, and revenue cycle solutions.

Glenda is a nationally featured speaker for the American Academy of Professional Coders (AAPC), American Health Information Management Association (AHIMA), VHA, various state hospital associations and OptumInsight.

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About HCS

HealthCare Consulting Solutions (HCS) provides a broad spectrum of services and solutions in revenue cycle management, chargemaster, strategic pricing, coding, documentation, reimbursement, billing, compliance and education for hospitals and physician practices. Now in its twenty-first year, HCS prides itself on adding new services to better meet the ever-expanding needs of the health care industry.

HCS specializes in assisting health care providers become more efficient through increasing their payment incentives and growth in a compliant business environment. HealthCare Consulting Solutions focuses on hospital and physician consulting services that include:

- Inpatient (MS-DRGs), Outpatient (APCs) and Physician Practice Due Diligence & Compliance Risk Assessments including RAC, CERT, ZPIC, MAC/Carrier and OIG target areas;
- CAH and Rural Health Clinic Compliance Audits and Education/Training; DMEPOS Reviews, Operational Assessments and Education/Training;
- IRE, IPF, SNF, HHA and Hospice Reviews;
- Chargemaster Assessments with Training and Education;
- Pharmacy and Supply Assessments;
- Physician Documentation and Quality Training;
- Hospital and Physician Compliance Audits;

- Revenue Cycle, Business Operations, and Charge Capture/Lost Charge Assessments;
- Web-based Registration Solutions;
- Educational workshops/conferences;
- Strategic Pricing, Cost and Charge Analysis and Hospital/Physician Profiles; and,
- Hospital and physician national/regional/local call center

HCS Seminars: Our seminar and education/training division provides chargemaster, coding, billing and compliance educational programs for state hospital associations, hospital systems, and National Group Purchasing Organizations.

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