Revenue Roundtable
September 2017

New Federal Fiscal Year, New ICD-10 Codes Released

It is that time of year again when the ICD codes are updated. No time to waste ensuring coding staff are educated on the new ICD-10-CM codes and coding revisions.

New CPT Codes on the Horizon

The 2018 codebooks should have been ordered with chargemaster staff and HIM coders anxiously awaiting for the codes to be released. What can we look forward too?

Evaluation and Management CPT Code Creep

Year after year, claim data shows a show but steady shift of facility's bell curve to the right.

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.

 HCS HealthCare Consulting Solutions - All Rights Reserved

Time seems to fly faster and faster. 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.

New Federal Fiscal Year, New Codes Released

by Laurie M. Johnson, MS, RHIA, FAHIMA, AHIMA Approved ICD-10-CM/PCS Trainer

It is that time of year again when the ICD codes are updated. The new code release occurred much earlier than usual this year. The Centers for Medicare and Medicaid Services (CMS) released the ICD-10-PCS codes on May 16, 2017 and the ICD-10-CM on June 12th. There are 71,704 total ICD-10-CM codes which is an increase of 360. There were 226 diagnosis codes that were revised. The FY18 ICD-10-PCS has a total of 78,705 which is an increase of 2,916 procedure codes. As an additional note, CMS released an addendum to the ICD-10-CM release which includes a title update for one code – O00.212. The original title was left ovarian pregnancy without uterine pregnancy and is now titled left ovarian pregnancy WITH ovarian pregnancy.

A quick overview of some key ICD-10-CM code changes includes:

The Index and Tabular have been updated with the new, revised, and deleted codes. The Index and Tabular updates include the correction of Exclude 1 Notes, punctuation (e.g. commas to periods or addition of dashes), misspells or terminology, and inclusion terms. The Table of Drugs and Chemicals had one addition – antithrombotic (T45.52-). The External Cause Index has included the updates for transport accidents of all-terrain vehicles (which include dirt bikes) and car occupant with collision with stationary object. These transport accidents have added specificity for drivers, hangers on, etc. There were no changes in the Neoplasm Table.

Some specific code changes include:

There was an expansion to C96.2 (Malignant mast cell) to include more specificity such as aggressive systemic mastocytosis (C96.21); mast cell sarcoma (C96.22); and Other mast cell neoplasm (C96.29). Another key change is the new codes for substance abuse in remission such as F10.11 (alcohol abuse, in remission); F11.11 (opioid abuse, in remission); and F12.11 (cannabis abuse, in remission). Blindness has been expanded to now capture severity of the blindness for each eye.

A long-awaited addition is myocardial infarction, type 2 (I21.A1) Type 2 myocardial infarction has been defined by the American College of Cardiology as acute secondary ischemic cardiac injury. In addition to adding type 2 MI, types 3 – 5 and myocardial infarction, not otherwise specified have also been added this year.

Pulmonary hypertension has been expanded

ICD-10 Code Changes – Continued

to identify the underlying disease. Here are a few examples:

I27.21 (secondary hypertension);
I27.22 (pulmonary hypertension due to left heart disease);
I27.23 (pulmonary hypertension due to lung diseases and hypoxia).

Heart failure (I50.8-) has also been expanded to include various types of right heart failure. Codes for gingival recession (K06.0-) have been added to identify localized vs. generalized as well as severity (minimal, moderate, and severe). Intestinal obstruction (K56.5-, K56.6-, and K91.3) have been expanded to include partial or complete obstruction. The concept is carried into post-procedural obstruction.

New codes have been added to chronic non-pressure ulcers to identify manifestation types such as muscle involvement without necrosis, bone involvement without necrosis, and other severity. These severities are included for all anatomic sites. Lump in breast (N63) has been further specified by laterality and specific anatomic location (quadrant of the lump).

A new code has been added for abnormalities of fetal heart rate/rhythm (O36.83-) which includes trimester and fetus number. As always, if the gestation is single, then the seventh character of 0 is applied.

Unspecified injuries such as T07 (unspecified multiple injuries); T14.8 (other injuries of unspecified body region); T14.90 (injury, unspecified); and T14.91 (suicide attempt) have been expanded to include seventh characters of A, D, and S. The placeholder "X" would be utilized to maintain the seventh character position. For example, T07.XXXA would indicate unspecified multiple injuries, initial encounter.

The encounter for antenatal screening (Z36) has been expanded to incorporate the reason for the screening. For example: Z36.0 (encounter for antenatal screening for chromosomal anomalies) and Z36.81 (encounter for antenatal screening for hydrops fetalis). Another concept that has been added is the risk for dental caries (Z91.84-) which has included the risk level of low, moderate, high, or unspecified.

ICD-10-PCS codes are used for procedures performed on inpatients. CMS has previously announced that the ICD-10-PCS Reference Manual would no longer be updated. The Body Part Key, Device Aggregation Table, and Substance Key have been updated. While there are no new root operations this year, the root operations of extraction and release have been added to some body systems. The Root Operation Definitions had only a minor change in an example for dilation.

The majority of the additional 2,916 codes are found in the Medical and Surgical section. More specifically, the Respiratory and Subcutaneous Tissue and Fascia body systems were impacted by approximately 11% each of the new codes.

ICD-10 Code Changes – Continued

The Central Nervous System body system has been renamed to Central Nervous System and Cranial Nerves. Some body parts have lost laterality such as the diaphragm, ribs, and frontal bones. Some body parts specificity has been removed such as saphenous veins and omentum no longer have greater and lesser descriptions. The neck specificity has been revised from anterior and posterior to right and left. Some body parts have been renamed such as genitalia skin is now classified as inguinal skin.

The ICD-10-PCS tables have undergone some changes as well. Some tables have had the addition of rows so that the External approach has its own row. Some tables have been had new rows added based on qualifiers/devices.

A new device option of "Other Device" has been added to provide options when the specific device is not included in the table. Another way to think of this option is "Not Elsewhere Classified" or NEC. Vascular access devices are now specified as totally implantable or tunneled. A new device of short term external heart assist system has been added.

The FY18 code changes have yielded a total of 150,409 diagnosis and procedure codes. There are more codes on the horizon for FY19! Best practice is to review the changes, understand how the clinical documentation may be impacted, and know if your organization performs the new procedures.

References:
https://www.cms.gov/Medicare/Coding/ICD10/2018-ICD-10-CM-and-GEMs.html

https://www.cms.gov/Medicare/Coding/ICD10/2018-ICD-10-PCS-and-GEMs.html

New Codes on the Horizon

This time each year many professionals begin scheduling their calendars around the release dates of the OPPS Final Rule as well as the delivery date for the new code books.

A number of new CPT codes and CPT code revisions are anticipated for next year. Without looking into a crystal ball and guessing what the changes might include, by reviewing the Proposed 2018 Medicare Physician Fee Schedule (PFS) (CMS-1676-P) as well as the OPPS 2018 Proposed Rule (CMS-1678-P) discussions, we can see where CMS might be heading.

Checking the "proposed" new codes listed in both of these CMS documents do not necessarily match. The 2018 OPPS Proposed new CPT codes contain only short descriptors, while new CPT codes published in the 2018 Medicare Physician Fee Schedule reveal the AMA's complete code description. However, any discussed proposed change, new code or deleted code can only be reviewed as tentative. Until the Final Rule for both OPPS and PFS are posted, these code changes should be placed in the

New Codes on the Horizon-Continued

"potential" changes.

For 2018, many of the new codes will be created as a result of bundling mandates from the AMA's Relativity Assessment Workgroup (RAW) which focuses on the identification of potentially misvalued services. Criteria utilized includes the identification of code pairs reported together 75 percent or more of the time are considered for bundling once again in 2018. We expect to see the workgroup's recommendations impact interventional radiology and cardiac cath lab's revenue by the consolidation of CPT codes used to report endovascular repair of infrarenal aorta and endovenous ablation of incompetent veins.

A new code is anticipated to be included in the surgical section for reporting a combined bone marrow biopsy and aspiration study. Currently a "G" code is used as an add-on code with CPT 38221. This new CPT code will negate the need for G0364.

Diagnostic radiology will see a major change for chest x-rays, impacting the presently popular and highly utilized CPT codes of 71010 – 71035. Four new codes are anticipated to be introduced which will include the number of views instead of view-specific descriptors.

Abdominal x-ray codes 74000 – 74020 are also on scheduled for deletion with the creation of three new codes to report abdominal x-ray procedures described by the number of views vs view-specific descriptors.

The American College of Radiology (ACR) website contains an article entitled "CPT 2018 Anticipated Code Changes" containing other code changes impacting interventional radiology, radiation oncology, nuclear medicine, and mammography departments, as well as deleted and new Category III codes. Several Category III codes are scheduled to be converted to a new CPT Category I code.

Be sure to check out the complete listing of code changes in the AMA's CPT 2018 code book. Payment assignment for the professional reimbursements is published in the Federal Register, usually in November. For the technical component, hospitals identify payment opportunities or bundling impact with the OPPS Final Rule posting, usually found posted by CMS on or around November 1.

Other ancillary departments identified with code changes for next year include Laboratory. "Tentative" code changes do not include any new or deleted drug screen tests. Perhaps this will be the first year we do not see major revisions on how screening and definitive drug screen tests are reported. Molecular Pathology codes will be expanding to accommodate new technological advancements and test offerings. This area of the code book is anticipated to increase in the number of CPT codes year after year and for 2018 there appears to be more than 25 new codes.

Respiratory/Pulmonary departments will

New Codes on the Horizon-Continued

see only a few code changes with Rehabilitation Departments also only experiencing a couple of code revisions.

In the 2018 Final Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes (CMS-1677-F) CMS provides incremental payment (in addition to the MS-DRG payment) for technologies and drugs that qualify for new technology add-on payment (NTAP). Effective October 1, 2017 two new drugs will qualify for NTAP: 1) Bezlotoxumab (Zinplava) is eligible up to $1,900 additional payment, and 2) Ustekinumab (Stelara), providers will receive up to $2,400 additional payment above the MS-DRG.

The following drugs currently receiving NTAP will continue to be eligible for additional reimbursement for 2018: 1) Defitelio is eligible for maximum add-on payment up to $75,900; 2) Vistogard will be eligible for NTAP in the amount of $40,130; and 3) Praxbind Idarucizumab will continue to be eligible up to $1,750 additional reimbursement.

Blinatumomab (Blincyto) is a bi-specific T-cell engager (BiTE) used for the treatment of Philadelphia chromosome-negative (Ph¥) relapsed or refractory (R/R) B-cell precursor acute-lymphoblastic leukemia (ALL), which is a rare aggressive cancer of the blood and bone marrow. A technology drug or medical device no longer qualifies as ‘‘new’’ once it is more than 2 to 3 years old, irrespective of how frequently it has been used in the Medicare population. As a result, Blincyto is no longer eligible for NTAP as of October 1, 2017.

The Gore Iliac Branch Endoprosthesis (IBE) continues to be eligible for NTAP, up to a maximum of $5,250. Additionally, Intuity and Perceval Aortic Valves will be eligible for an add-on payment up to $6,110.23.

CardioMEMS HF System and magnetic controlled growth rods (MAGEC System) implanted into the patient’s spine will no longer be eligible for NTAP in 2018.

The facility’s HIM coding specialists should be aware of the add-on payment opportunities by the assignment of specific ICD-10-CM diagnosis codes for each drug and medical device eligible for NTAP.

For more detailed discussions on specific drugs and medical devices eligible for NTAP or those items whose reimbursements have sunset, see CMS-1677-F, pages 38104 – 38129.

Evaluation and Management Code Creep

Hospitals utilize evaluation and management (E&M) to bill for emergency room visits. CPT codes 99281-99285 and critical care, 99291, represent the technical component for facility resources expended to treat. As for providers, ED facility evaluation and management (E/M) codes reflect the intensity of resource use during an episode of care.

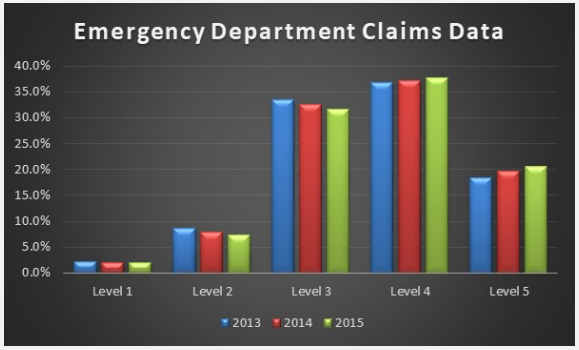
In assigning E/M levels for the physician, coders are governed by very specific rules around the documentation of history, physical and medical decision-making. Astoundingly, there are no similar guidelines on the facility

E&M Code Creep - Continued

side! The issue of guidelines for facility services has been debated for many years. But to date, the Centers for Medicare and Medicaid Services (CMS) hasn't chosen a methodology.

By evaluating coding patterns involving ED Levels 1-5 (CPT 99281-99285) within the facility and comparing them with national coding trends, hospital ED directors can gain a perspective on the department's use of these codes relative to industry norms. A basic analysis of the distribution of these 5 CPT codes can indicate patterns of under coding or over coding the ED encounters. Under coding can result in obviously lower payments while over coding can present a compliance issue. Health plan audits and investigations undoubtedly focus on claims felt to be over coded.

How does your facility's coding patterns, commonly referred to as the "bell curve", compared to other facilities? Review of the Medicare claims data for calendar years 2013, 2014 and 2015 shows a slow but steady creep to the higher E&M codes of 99284 and 99285.



The volume of claims data excludes Critical Access Hospitals as well as non-Medicare claims, and also represents only those encounters treated in the ED and discharged.

While Level 3, CPT 99283, has been considered the "norm" or typical ER encounter level of care, claims data shows Levels 3 and 4 with only minor volume differences. Data analysis now shows Level 4 to be the highest utilized E&M code for this time study. When reviewing claims data from 2007 to 2010, similar findings are observed, that is, there seems to be a steady decline in the percentage of lower level claims and increases within the more intense levels.

In the *Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 2018 (CMS-1678-P],* CMS did not mention any concerns over emergency department E&M volumes and did not reveal any plans of changing current payment policies.

CMS has been quiet thus far since publishing the following guidance for facilities to follow when developing facility-specific criteria:

While the healthcare industry continues to operate without national guidelines, CMS expects that each hospital's internal guidelines should:

- Follow the intent of the CPT code descriptor—the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code
- Be based on hospital facility resources, not physician resources

E&M Code Creep - Continued

- Be clear to facilitate accurate payments and be usable for compliance purposes and audits
- Meet HIPAA requirements
- Require only documentation that is clinically necessary for patient care
- Not facilitate upcoding or gaming
- Be written or recorded, well documented, and provide the basis for selection of a specific code
- Be applied consistently across patients in the clinic or emergency department to which they apply
- Not change with great frequency
- Be readily available for fiscal intermediary (or, if applicable, MAC) review
- Result in coding decisions that could be verified by other hospital staff, as well as outside resources

With current trends in claims data as discussed, would CMS ever consider adopting a single payment APC for any E&M level reported for emergency room encounters like they did a few years ago for clinic visits? Medicare reimburses the same APC for clinic visits Levels 1-5 by mandating the use of HCPCS G0463, *Hospital outpatient clinic visit for assessment and management of a patient.* Claims data demonstrating higher E&M levels year after year is worrisome. It is hoped CMS would never consider a single APC payment for emergency room encounters but by close review and analysis of the hospitals' emergency department bell curve will ensure the facility's data is accurate and does not reflect aberrant utilization patterns that could result in a focused audit.

As a friendly reminder, CMS' posted FAQ 2297 includes the question and response:

Q*: Can hospitals bill Medicare for the lowest level ER visit for patients who check into the ER and are "triaged" through a limited evaluation by a nurse but leave the ER before seeing a physician?*

A*: No. The limited service provided to such patients is not within a Medicare benefit category because it is not provided incident to a physician's service. Hospital outpatient therapeutic services and supplies (including visits) must be furnished incident to a physician's service and under the order of a physician or other practitioner practicing within the extent of the Act, the Code of Federal Regulations, and State law. Therapeutic services provided by a nurse in response to a standing order do not satisfy this requirement.*

Based on this FAQ, hospitals may not charge a Level 1 (CPT 99281) for those patients who are triaged and leave prior to being seen by a physician or qualified healthcare professional. A charge line may reside in the department's chargemaster for statistical capture of those patients leaving the department without being seen for any reason.

Reference HFMA article "E&M Coding Levels for Hospital EDs, 2013-15" (July 2017, pages 58-59) by William Shoemaker for additional information.

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.

For more information, contact Jeff Neustaedter at jneustaedter@hcsglobal.net.

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

---

Contributing Writers for August's Newsletter:

Laurie M. Johnson, MS, RHIA, FAHIMA, AHIMA Approved ICD-10-CM/PCS Trainer

Laurie has over thirty years of experience in health information management specializing in coding and reimbursement with previous experiences that include APC/DRG review, RAC education/services, ICD-9-CM/CPT-4/ HCPCS coding and education, revenue cycle turnaround, and now ICD-10-CM/PCS. Laurie has presented ICD-10 implementation tutorials at the national AHIMA convention and has also been a featured speaker at over forty conferences and seminars. Laurie led the award winning ICD-10 initiative for Pennsylvania Health Information Management Association and is also a past president for PHIMA.

Laurie holds a B.S. in Health Records Administration from University of Pittsburgh, a M.S. in Healthcare Information Systems, also from University of Pittsburgh.

Glenda J Schuler, RHIT, CPC, COC

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.

Glenda's Contact Information is: gschuler@hcsglobal.net; Ph: 702.638.2989

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;
- IRF, 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.

For more information, please contact:

HCS HEALTHCARE CONSULTING SOLUTIONS
Jeff Neustaedter, President
3965 W. 83rd Street, #310
Shawnee Mission, Kansas 66208
Ph: 800.659.6035
FAX 800.376.9137
Cell 816.309.8600
jneustaedter@hcsglobal.net
www.hcsglobal.net

 HCS HealthCare Consulting Solutions - All Rights Reserved