Implement the new ESA transmittals in your hospital

Train your coding and clinical staff for ESA billing changes

Editor’s note: This is the first article in a two-part series.

In January, CMS published three transmittals (Transmittals 1412, 1413, and 80) that significantly changed the process of billing for erythropoietin-stimulating agents (ESA).

As noted in the March Briefings on APCs, an HCPro, Inc., sister publication, hospitals that treat end-stage renal disease know these guidelines, but other facilities might find them difficult to implement.


Jennifer McPeek, BSN, OCN, nursing program manager at the James Cancer Hospital in Columbus, OH, presented on the background of the national coverage determination (NCD) and training staff members and patients on the new process. In the September APC Payment Insider, Angela Simmons, CPA, director of clinical revenue and reimbursement at the University of Texas MD Anderson Cancer Center in Houston, will describe best practices for the technical implementation of the ESA transmittal.

Understanding the NCD

Why was an NCD made for ESAs, when drug and biologicals are usually managed at the local coverage determination (LCD) level? NCDs can occur “when there are safety issues, questions regarding efficacy of a drug, significant cost of a drug to the Medicare system, or a high impact to a number of Medicare beneficiaries,” McPeek said.

LCDs are created by Medicare Administrative Contractors, carriers, or FIs when no NCD exists, she said. The LCD cannot directly conflict with the NCD.

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McPeek described the indications covered and not covered under the new transmittals.

**Education of clinical and billing staff is critical**

The new ESA situation touches every part of a facility, McPeek said. “You need to consider your clinicians—nurses and nurse practitioners, physicians, physician extenders—billers, patient access, and patients themselves,” she said. Be sure to customize the education to meet the audience’s needs.

McPeek offered the following educational advice for each group affected by the new ESA transmittals:

- **Keep education concise for physicians and physician extenders.** McPeek said physicians and physician extenders at James Cancer Hospital are extremely busy, and she suspects the same situation exists in other hospitals. Therefore, you should strive to keep your education short, direct, and to the point. “You need to tell them only what they need to know … things like, ‘The following diagnoses meet medical necessity for ESA,’ so they can look at it and say, ‘This is what is going on, and this is what I need to do,’ ” she said.

- **Customize education to meet nursing staff members’ needs.** Nursing staff members have unique educational needs, as they are often at the front line of dealing with patients, McPeek said. “Remember, these are the staff that are probably going to deal … with the patients’ questions. Patients sometimes go to the nurse for more of the detailed information,” she said.

  The education you provide nurses should focus on answering the following questions:
  - How does this new policy affect nurses?
  - What has changed?
  - Why did it change?

  “We have to share with them that there were questions brought up about safety and efficacy. We need to tell them clearly what the new rules are,” McPeek said. Nurses must understand the process that has been established to handle the change. “They need to understand their piece in detail, but it also helps them to understand how their piece connects the dots to the other pieces,” she added.

  McPeek said nurses at her facility found some of what they heard from patients disconcerting. “We have actually had patients come in with flyers [about ESA coverage changes] that they have received from attorneys. They have read things in *The New York Times* or on the Internet. They come in scared to death and want to know what is going on, [saying], ‘Am I not going to be able to take this drug anymore? Should I be taking this?’ Nurses need to be prepared for those kinds of questions,” she said.

- **Educate billing staff members on modifiers.** The goal of biller education is simple: to get
clean bill out the door, McPeek said. “[Educate] them on the modifiers, why we are being required to put the modifiers there, the value code, what that is and where that comes from, as well as any process that you have put in place in your facility for getting ABNs … prior to therapy,” she said.

- **Ensure awareness of patient access staff members.** Make sure patient access staff members are aware of current communication from commercial payers about changing requirements, McPeek said. “Commercial payers are slowly but surely jumping on this [new rule] bandwagon as well,” she said, adding that the changes may require more interaction from patient access staff members. They are involved in “setting up payment plans, talking to the appropriate people in your facility about discounting, if that is something that is available, and [confirming] all of those pieces that we may have to pull out of our arsenal to ensure that patients continue to receive the needed, appropriate therapies,” she said.

Facilities must develop brochures and communication tools that tell patients what they need to know in layman’s terms but are also consistent with the CMS transmittals. “Communicate early and often,” McPeek said. “What has changed, what choices do they have, and how does it impact their pocketbook on the back end?”

**LCDs differ from NCDs**

Everyone needs to know that there are differences created by LCDs that affect the ESAs and NCDs, McPeek said. “There are discrepancies even between the individual fiscal intermediaries,” she added. “I must caution you all to be aware of your own local coverage decision requirements.” She said facilities need to:

- Report additional codes required by their FI
- Ensure that the hemoglobin is less than 10 and that the hematocrit is less than 30
- Include the drug’s route of administration in the documentation

“Before that bill goes out the door, make sure that you have worked out a process that gets that ESA modifier on the bill,” McPeek said.

Local FIs will still allow the use of ESAs for chronic inflammatory disease anemia in specific instances, McPeek said, adding that provider documentation must specify the anemia-associated chronic disease the ESA is being used for.

The hemoglobin and hematocrit need to meet the same requirements and include the route of administration. Report modifier -EC (ESA to treat anemia not due to radiotherapy or chemotherapy) in these instances because the anemia is not related to chemotherapy or radiotherapy. Remember, McPeek said, the rules may change again. The FDA’s Oncology Drug Advisory Committee is still discussing possible changes in coverage.

Documentation improvement: Take a team approach

Editor’s note: In the July APC Payment Insider, “Tune E/M documentation to meet the 2008 guidelines” discussed the OPPS final rule’s 11 guidelines and problem areas in E/M coding. The article was based on the March 18 HCPro audioconference, “Facility E/M Update: Meet CMS’ Latest Coding and Documentation Requirements.” The following article discusses additional ways to improve E/M effectiveness.

Sheila R. Gunn, CPC, CCS-P, PCS, CMBS-I, president of Medical Coding Consulting in Midlothian, VA, discussed two challenges during the audioconference. She presented ways to build a documentation improvement team, widening the circle of responsibility for E/M documentation improvement, and how to use modifiers in the E/M setting.

Gunn summarized the following points to remember when managing E/M documentation:
- If it was not documented, it was not done
- The medical record is a legal document
- Make up-to-date resources available

Copresenter William L. Malm, ND, RN, practice director of revenue cycle management consulting at HCPro in Marblehead, MA, recommended competency testing for nursing staff members and coders.

Malm said he sometimes includes physicians “so that they understand what the 11 guidelines contain [and] the difference between facility and professional billing.”

Malm emphasized CMS’ statement that all documentation has to be present before claim submission. He said this must be your facility’s E/M policy and procedure.

For example, “when you define critical care, you need to define what’s included, what personnel need to be there, what is the start time, what concludes your critical care,” he said.

This all must be spelled out so it’s objective and auditable.

Although E/M facilities need to follow the 11 guidelines, Malm said other organizations exist that offer guidance on documentation, such as The Joint Commission (formerly JCAHO). (See resources available from The Joint Commission by visiting www.jointcommission.org.)

When you accept other sources’ requirements for E/M, ED, or clinic documentation, be sure to put that information in your policies and procedures, Malm said.

Assemble your team

Gunn said the documentation improvement team must include varied members of the healthcare team because “the patient’s medical record is a combination of information that’s coming from different areas.” These sources include physicians, nursing, coding, patient financial services, billing, compliance, and reimbursement personnel, she added.

Facilities should think of team formulation as a building block. Select a leader, then create the group’s policies and procedures. Gunn said steps to assembling a team should include:
- Providing train-the-trainer opportunities.
- Having regular meetings to keep the momentum.
- Providing current, up-to-date references.
- Naming alternates in case of a team member’s absence.
- Ensuring that the entire facility knows that the documentation improvement team exists.
- Noting the progress of the documentation team. Set measurable goals and remember to review them.
- Determining some common team tasks. Some to consider are:
  - Assisting with follow-up on claims denied by FIs
  - Conducting random audits of E/M
  - Ensuring that work stations have the most current references available
  - Assisting chargemaster staff members with end-of-the-year changes
  - Training noncoding personnel in basic coding principles
  - Providing post-implementation audits for new services or clinics
  - Designing charge capture documents
Q&A: Experts tackle billing for implantable devices

With pacemakers and defibrillators, I know that the device reimbursement is included in the procedure and that the leads and generator must have the appropriate C codes. Is it still appropriate to bill a charge for the procedure and a charge for the devices (the device cost plus a markup)? Or does the device cost need to be part of the procedure charge? I am a novice concerning the actual bill.

Yes, you should still bill a charge for the procedure and the device on separate lines. The Medicare Claims Processing Manual, Chapter 4, Section 61.1, states the following about charging for devices:

> Effective January 1, 2005, hospitals paid under the OPPS (bill types 12X and 13X) that report procedure codes that require the use of devices must also report the applicable HCPCS codes and charges for all devices that are used to perform the procedures where such codes exist. This is necessary so that the OPPS payment for these procedures will be correct in future years in which the claims are used to create the APC payment amounts.

This stipulates that the charge for the device that is required to be reported (e.g., the pacemaker or defibrillator) be on the line for the device and not included in the charge for the procedure. For practical purposes, it will not make a difference when Medicare calculates the payment to your facility; however, it might make a difference as CMS data mines their claims data for rate setting.

What is your opinion on reporting modifier -FB when a device has been donated at no cost? We planned to charge for the procedure and add the device at no charge. If this is not correct, how do we handle this situation?

The Medicare Claims Processing Manual (Pub. 100-04), Transmittal No. 804, January 3, 2006, provides some guidance on this issue. The relevant language from that transmittal is:

> Modifier -FB; item provided without cost to provider, supplier or practitioner (examples, but not limited to: covered under warranty, replaced due to defect, free samples).

Effective for services furnished on or after January 1, 2006, hospitals must report HCPCS modifier -FB with the HCPCS code for a device which was furnished to the hospital without cost to the provider. For example, when a manufacturer furnishes a replacement device which has been recalled or which has failed and which was furnished to the provider without cost to the provider, the hospital must report the modifier with the device code to indicate that the hospital did not incur a cost for the item. This requirement applies to all HCPCS alphanumeric device codes with initial letter of C or L. Hospitals should submit a token charge (e.g., $1) on the line with the device code for the claim to be accepted and processed. If the hospital uses a device that was furnished to it for no cost, but for which the usual cost to the hospital is greater than $50, and for which there is no suitable HCPCS alphanumeric code beginning with initial letter of C or L, the hospital must use the modifier with the procedure code for the service in which the device is used.

Some additional research would be necessary to determine the extent to which this guidance is still applicable in light of the 2007 and 2008 changes relating to full and partial credit devices. Also, hospitals that receive donated devices should check with their legal counsel to determine whether there are any legal issues associated with accepting such donations (e.g., anti-kickback statute concerns).

Editor’s note: Kimberly Anderwood Hoy, Esq., JD, CPC, director of Medicare and compliance at HCPro, Inc., in Glen Allen, VA, and Hugh Aaron, MHA, JD, CPC, CPC-H, senior advisor at HCPro in Marblehead, MA, answered the above questions.

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Chemotherapy

Use modifier -59 when using multiple sites for separately identifiable services

A question in the June APC Answer Letter, an HCPro, Inc., sister publication, concerned charging infusions when there are multiple IV sites. Specifically, it asked whether each site gets an initial charge and whether each site needs a modifier.

You advised readers to treat each site separately with an initial code and add-on codes representing the type and duration of drugs administered through that IV site and to append modifier -59 to all codes that represent the second IV site.

To save time, we administer chemotherapy through a Mediport simultaneously with a peripheral site—separate chemotherapy and separate setup.

If the answer you provided in the June issue does not apply in this situation, which codes are appropriate?

Also, please advise which codes are appropriate if both infusions last more than one hour.

When administering a chemotherapeutic agent in which protocol requires the use of two separate IV sites (e.g., whether port/peripheral, peripheral/peripheral, or peripheral/peripherally inserted central catheter), use an initial code that best describes the primary reason for the encounter. Always report that code regardless of the sequence of the infusions. CMS Transmittal 968, dated May 29, 2006, states:

When administering multiple infusions, injections or combinations, the physician should report only one ‘initial’ service code unless protocol requires that two separate IV sites must be used. The initial code is the code that best describes the key or primary reason for the encounter and should always be reported irrespective of the order in which the infusions or injections occur. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code should be reported.

For example, the first IV push given subsequent to an initial one-hour infusion is reported using a subsequent IV push code.

If more than one ‘initial’ service code is billed per day, the carrier shall deny the second initial service code unless the patient has to come back for a separately identifiable service on the same day or has two IV lines per protocol. For these separately identifiable services, instruct the physician to report with modifier -59.

Therefore, you should report modifier -59 on the second initial code and second additional hour code to signify that this is a separately identifiable service. Use CPT code 96413 (up to one hour of chemotherapy administration, IV infusion technique, single or initial substance/drug) for chemotherapy infusion through the Mediport and add on code +96415 for each additional hour.

For chemotherapy administered through the peripheral site, use CPT code 96413-59 up to one hour and 96415-59 for each additional hour. Visit www.cms.hhs.gov/transmittals/downloads/R968CP.pdf for more information.

Documentation

Physician order necessary for diagnostic, therapeutic services performed in the ED

In our ED, the nurses and technicians sometimes perform services, such as an EKG or IV, even though orders for these services are not always specifically documented. Is this a concern for billing?

Yes. Medicare requires an order for therapeutic or diagnostic services performed in the ED. The Medicare Benefit Policy Manual, Chapter 6, section 20.5.1, states:

Therapeutic services and supplies which hospitals provide on an outpatient basis are those services and supplies (including the use of hospital facilities) which are incident to the services of physicians in the treatment of patients. Such services include clinic services and emergency department services.
The services must be furnished in the hospital or in a hospital department that has provider-based status in relation to the hospital under 42 Code of Federal Regulations 413.65.

The services and supplies must be furnished on a physician’s order, or on the order of nonphysician practitioners working within their scope of work and in accordance with state and local policies by hospital personnel and under a physician’s supervision.

For more information, visit www.cms.hhs.gov/manuals/Downloads/bp102c06.pdf.

Therefore, if orders are missing, you should educate your ED physicians and nurses on the subject. However, some EDs have clinical order sets or protocols that list a specific set of services ED staff members will perform based upon patients’ clinical presentations.

If a patient presents with chest pain, the protocol states that an immediate 12-lead EKG, routine cardiac monitoring, oxygen (if saturation is below a specific level), heparin lock, portable chest, and aspirin therapy begin upon ED admittance.

It is also important to ask the department whether its staff members are following protocol, particularly because you are inquiring about a situation with potentially missing orders. If your ED uses protocols, it is imperative that all ED physicians confirm that they know the specific set of services they are ordering.

Hypomagnesemia

Diagnosis determines infusion is therapeutic

A physician orders magnesium sulfate 2 g to be infused during a two-hour period for a patient with hypomagnesemia. Our pharmacy dispenses magnesium sulfate 2 g/100 ml in a premixed solution. Is this infusion hydration or therapeutic?

Patient-controlled analgesics

Charge for the medication, not IV or IV push

We use medication pumps to infuse pain medications on demand when the patient pushes a control button or to infuse a set dose continually. These patient-controlled analgesics (PCA) are administered along with a continuous IV, and the lines are piggybacked into the primary infusion line. We have been unable to find a resource that identifies medications administered by this route. Are they considered IV push medications or infusions? Should we bill them as a one-time administration or by the hour as an infusion?

Each health plan decides how it will make the determination to pay for PCAs. A survey revealed the following consensus: Charge only for the drug administered. You may not use the IV or the IV push coding method even though it is a piggyback. The IV is not continuous, and it is neither epidural nor subarachnoid. Typically, physicians start a patient on a PCA following surgery and would not bill for the administration because the patient is more than likely admitted. If a patient is admitted, the nursing charges related to the administration are part of the room and board rate and you may not bill for them separately. CMS’ Provider Reimbursement Manual, Part 1, section 2202.6, states:

Routine Services—Inpatient routine services in a hospital or skilled nursing facility generally are those services included by the provider in a daily service charge—sometimes referred to as the ‘room and board’ charge. Routine services are composed of two board components: (1) general routine services, and (2) special care units, including coronary care units and intensive care units. 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.
Recovery services

Postop pain/nausea medication, antibiotics generally not separately billable

Is it appropriate to bill for postop pain/nausea medications and antibiotics administration in a hospital setting?

I’ve been advised to continue to bill Medicare with revenue code 710 but to remove the CPT/HCPCS code. Is this appropriate, or will OCE edit its prevent billing of these services because Medicare considers them inherent to the procedure?

In 2006, CMS posted a Q&A document clarifying the appropriateness of billing separately for postop pain medications and other postop recovery services. For details, visit www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/OPPS Guidance.pdf.

In general, payment for the outpatient procedure includes postprocedure recovery services and associated pain management treatments.

If a problem not related to the surgery anesthesia or pain management occurs, you may bill for administration of IVs and injections separately. You could do so under revenue code 761 as long as documentation supports a separate charge for this service.

A question in the 2006 CMS Q&A document addressed billing separately for an injection in the recovery area: If a patient in a recovery area requires an injection (e.g., IV push, intramuscular, subcutaneous), can the administration be billed separately (along with the drug)?

CMS states that you cannot bill separately for the administration of the drug.

The bottom line is that, in general, IV infusions and injections provided postprocedure are not separately billable because Medicare considers them to be an extension of the surgical procedure and, thus, not separately billable.

Drugs provided during the recovery period are billable.

However, if the drugs relate to the surgery, pain, or anesthesia, you cannot charge separately for the administration of the drug.

Note that if a patient requires postprocedure observation for a medically necessary reason, you may bill for injections and infusions that are incurred as a result of that observation admission. (CMS covers this in an FAQ at the Web site listed in the previous answer.)

There are NCCI edits between most injection and IV infusion codes paired with surgical procedure codes. Thus, you should be cognizant of these NCCI edits and be cautious with your use of modifiers to override the edits when clinically appropriate.

Questions? Comments? Ideas?

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