Correctly count observation time for outpatients

Counting time for observation isn’t always straightforward under OPPS. Coders and billers need to consider physician documentation, other procedures performed during observation, condition code 44, and the three-day payment window when deciding how many observation hours to bill.

In some cases, CMS will provide additional payment for observation related to visit services or package it into the payment for other services, such as surgery. (For more on the difference between packaged and bundled services, see the sidebar on p. 3.)

Even though a facility usually isn’t going to get paid for the observation services separately, coders and billers still need to report them correctly, including billing for the appropriate number of observation hours. This allows correct calculation of any extended assessment and management payment. Additionally, facilities still need to account for those costs, says Kimberly Anderwood Hoy, JD, CPC, director of Medicare and compliance for HCPro, Inc., in Danvers, MA.

“CMS uses these packaged services to set payment rates, so we need to represent the costs of our care on the claim so CMS can see the full costs,” Hoy says. If facilities underreport those costs, CMS may reduce future payment rates.

In addition, non-Medicare payers often reimburse facilities based on the reported costs of care. If costs aren’t reported, the payer won’t reimburse for them.

Defining observation

CMS defines observation as “ongoing, short-term treatment, assessment, and reassessment” of a patient to determine whether to admit him or her as an inpatient or to discharge the patient. The key concepts are assessment, reassessment, and making a decision, says Hoy.

“If that’s what we’re doing, that fits the definition of observation,” she says. “If we’re simply monitoring the patient, we need to look elsewhere to classify the costs.”

Observation is not covered if:

➤ It is provided as a convenience for the patient or family
➤ An inpatient admission would be appropriate
➤ It lasts more than 48 hours (in most cases)
➤ It consists of standard preparation or postop monitoring during the standard recovery time for a diagnostic, surgical, or therapeutic service
➤ It consists of time spent monitoring the patient incident to another diagnostic, surgical, or therapeutic service

“CMS uses these packaged services to set payment rates, so we need to represent the costs of our care on the claim so CMS can see the full costs.”

—Kimberly Anderwood Hoy, JD, CPC
Counting observation
< continued from p. 1

service that requires active monitoring, such as PICC line insertion, chemotherapy, and infusions

For some procedures, a patient may need to stay longer than the normal recovery time not because of a complication, but because the longer stay is standard for the procedure. For example, a patient who receives a pacemaker stays overnight so the provider can assess how well the pacemaker is working. These situations are considered extended recovery. Keep in mind that extended recovery should be billed as recovery—it is not considered observation and cannot be billed as such.

Counting observation hours

Report observation services using HCPCS code G0378 (observation services, per hour) under revenue code 0762 (observation services). Round the amount of time to the nearest hour. For example, if a patient was in observation from 1 p.m. to 3:45 p.m., report G0378x3. If a patient was in observation from 1 p.m. to 3:20 p.m., report G0378x2. Bill all hours on the same line for a single date of service using the date observation services were started.

Observation time begins when the physician orders observation services and ends when all medically necessary services related to the observation are complete. Observation can end before the patient leaves the facility if the patient is waiting for a ride home—the hours the patient spends waiting should not be reported as observation.

Receiving composite payments

In most cases, facilities don’t receive separate reimbursement for observation services. However, there are cases in which a facility may qualify for an extended E/M composite APC. For a facility to qualify, a patient must have a high-level ED or critical care visit and undergo at least eight hours of observation.

If a coder reports a surgical service with a T status indicator on the same claim, the facility will not qualify for the composite payment. That includes minor surgeries, such as laceration repairs or foreign body removal, Hoy says.

Carving out services

 Coders can report outpatient therapeutic services on the same claim as observation services. However, if a patient receives a therapeutic service that requires active monitoring, coders must carve that time out of the total observation time. The facility receives payment for the active monitoring as part of the HCPCS code for the procedure; therefore, that time cannot be included in the observation hours, Hoy says.

CMS does not specify which disciplines must provide active monitoring, says Denise Williams, RN, CPC-H, director of revenue integrity services at Health Revenue Assurance Associates, Inc., in Plantation, FL. Thus, a
A respiratory therapist could provide active monitoring for a nebulizer treatment, for example. That time would still have to be carved out of the observation hours.

A wide range of services require active monitoring, such as colonoscopies and administration of certain drugs. Carving out time for drug administration services can be particularly confusing because coders need to look at each separate service to determine whether it requires active monitoring.

Drug infusion titrations require a nurse to stand by and monitor the infusion. However, other services that fall under the same HCPCS code for drug administration do not require active monitoring. For example, during a routine antibiotic infusion, the nurse can simply start the infusion and walk away when it runs. In this case, the infusion time would not need to be carved out of the observation hours.

At one point, CMS stated that a provider would need to document the start and stop times of each procedure so the time could be carved out. In late May, as part of the July OPPS update, Transmittal R2234CP, CMS stated that it would allow facilities to calculate an average time. So instead of having an exact start and stop time, facilities could come up with an average amount of time required for these services, Hoy says.

Some facilities create tables of the standard carve-out times for certain procedures, notes Williams.

Evaluating physician documentation

In some cases, facility systems for tracking observation hours work very well, says Williams. In other cases, though, the changing regulations and requirements may have left facilities with tracking systems that ineffective.

The first thing to look at when evaluating how you calculate observation hours is the physician’s orders. What exactly do they state? Orders need to be clear and concise and must reflect the physician’s intentions. “As much as possible, you don’t want them open to interpretation,” Williams says.

> continued on p. 4

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**Understanding packaged services**

Packaging is different from bundling—bundling is a coding concept, whereas packaging is a payment concept. With bundling, coders only report the most comprehensive code and don’t report the subsequent code(s) on separate lines of the bill.

The NCCI edits specify which codes are bundled codes, and under normal circumstances, coders should not separately report codes for these services. The charges for these services should be reported as part of the charge for the bundled code, or they may appear separately on an appropriate revenue code line without a HCPCS code.

包装， meanwhile, is very different, says Kimberly Anderwood Hoy, JD, CPC, director of Medicare and compliance for HCPro, Inc., in Danvers, MA.

In general, hospitals report the packaged services, but the facility will not receive a separate payment for those services because payment has been made as part of other separately paid services reported on the same claim. For example, although recovery services are billed separately on the claim, CMS packages them into the payment for surgery.

To illustrate an example of packaging, the payment for a surgical CPT code includes:

- Surgical time and supplies
- Covered drugs
- Implantable devices
- Recovery time
- Observation time

Unlike bundled items and services, packaged items and services may—and sometimes must—be reported separately on the claim with a HCPCS code. In general, packaged services have status indicator N, but they may also have a Q1 or Q2 status indicator. Items or services that are separately payable under OPPS will have status indicators G, H, K, P, Q3, R, S, T, U, V, or X.
Count observation  < continued from p. 3

Sometimes, a physician will simply document “observe.” That could mean observation services, but it could also mean extended recovery, which would be reported very differently.

Post-procedure orders can be confusing for the same reason. The physician may write an observation order because something unexpected happened; in this situation, the patient requires observation services because of the complication. If the patient’s prolonged hospital stay is expected, though, the services may fall under extended recovery.

“If no one is watching the particulars on these, you can have a lot of confusion on your status and what types of services are occurring,” Williams says.

Look at what the documentation supports. The physician should document any adverse situations or signs and symptoms that occur. Physicians should also document when a patient requires extended recovery services.

Regardless of whether the orders are handwritten or electronic, CMS is looking more and more at physician intent, Williams says. “Some of our confusion is because [physicians] have it in their head. We need to get it to travel down their arm and actually put it on paper or in the computer.”

The order and the documentation must work together, be complete, and be in sync, she adds. This will help resolve confusion for coders and billers and protect a facility in case of an outside audit.

Timing of the physician order

In the past, facilities programmed admission/discharge/transfer (ADT) systems to calculate the time when the physician ordered observation services and when the patient was discharged. Now, CMS states that calculating observation time depends on the date and time of the order, as well as other procedures performed. So facilities must ensure that the information in their ADT system matches what is documented in the record.

CMS does not allow orders to be applied retroactively. If a physician didn’t write an order until the day after the patient’s arrival, coders can’t apply the order until the time it was actually written, Williams says.

For example, a patient presents to the ED with chest pain at 2 p.m. and begins receiving observation services at 3 p.m., but the physician doesn’t write the order for observation services until 4 p.m. The patient is discharged at 11 p.m. In this case, the coder would start counting the observation hours at 4 p.m. because that’s when the physician wrote the order.

“It’s all driven by the date and time that the order was placed in the record,” Williams says.

Authenticating physician orders

Physicians often provide verbal or telephone orders if they are not available, but a clinician needs an order. These orders are documented appropriately in the medical record and carried out. So far, so good.

However, facilities need to have someone authenticate the order with the time and date. Someone also needs to make sure the authentication is completed in a timely manner. According to the CMS Conditions of Participation, section 482.24(c)(1)(iii), in the absence of a state law that designates a time frame, all orders must be authenticated within 48 hours.

According to CMS Transmittal 327, if an order is not authenticated or not signed, an auditor will disregard that order completely, Williams says. Facilities sometimes need to use the old-fashioned method of manually reviewing the record to make sure the documentation is complete, she says.

Questions? Comments? Ideas?

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CMS revises counting for observation hours in OPPS update

As part of the July quarter update to OPPS, which became effective July 1, CMS introduced a new method for counting time for observation services. This change should be “tremendously helpful” for facilities, according to Kimberly Anderwood Hoy, JD, CPC, director of Medicare and compliance at HCPro, Inc., in Danvers, MA.

Effective July 1, CMS amended the Medicare Claims Processing Manual, Chapter 4, § 290.2.2, “Reporting Hours of Observation,” to allow providers to subtract an average time for services with active monitoring. Facilities must deduct time spent providing services with active monitoring when counting observation hours. To do this, they need the start and stop times for these services. “It can be a huge problem for people to account for this time,” says Hoy.

Providers have struggled with this issue since CMS added a clarification to the manual in 2008 requiring providers to subtract time for procedures that require active monitoring and interrupt observation care, Hoy says. Not only have facilities grappled with determining which procedures require active monitoring, they’ve also had to decide how much time to subtract.

Some services, such as a push injection, can take as little as one minute to complete, even though the CPT code says up to 15 minutes. Nurses rarely document start and stop times for such short-duration services.

The July 1 change alters the counting of observation hours so they are once again more of a clerical issue than a clinical one, says Debbie Mackaman, RHIA, CHCO, regulatory specialist at HCPro. As a result, facilities will not need a high-level person to review the record, which should be helpful.

CMS is not providing a list of average active monitoring times. Some CPT codes, such as certain physical therapy codes, include a time component, but for codes that don’t, such as PICC line placement, each facility will need to determine its own appropriate average.

“Providers who wish to use this new option should consider putting in place policies indicating which procedures will be deducted and the average time to be deducted for those procedures,” says Hoy. “This may be as simple as updating an existing policy on observation billing with an addendum with the procedures and their times.”

Revised drug reimbursements

CMS provided a long list of drugs that had incorrect reimbursement rates in its payment files, going back to April 1, 2010.

In the update, CMS detailed the time periods during which it paid incorrect reimbursement for each code. Providers need to resubmit claims for those codes to receive the correct reimbursement rate, says Mackaman. Some cases could involve substantial payment changes.

“Some providers probably don’t realize the MAC won’t automatically correct these claims,” she says. “You have to ask for all of these claims to be reviewed.”

And as the payment rate changes, so does the patient copay amount. “Patients could end up owing more money,” Mackaman says.

Many facilities may be hesitant to go back to patients and ask for additional copays, especially for services provided in 2010. However, not collecting the additional copayment could result in compliance problems down the road.

In the past, when CMS corrected reimbursement on a large number of codes, the OIG made a specific exception stating that it wouldn’t go after providers for not collecting the increased copayments, says Hoy. But don’t assume that will hold true for smaller adjustments such as these drug payment corrections. If a facility does not pursue the additional copay, CMS and the OIG could view the facility’s inaction as inducing a referral.

Outpatient diagnostic nuclear medicine

In rare cases, a physician administers a diagnostic nuclear pharmaceutical to a patient and the patient then

> continued on p. 6
Odds and ends < continued from p. 5

go to a hospital to undergo the actual nuclear medicine procedure. In these cases, the hospital must report the charge for radiolabeled products on the same bill with the nuclear medicine scan. CMS has an edit in place to prevent payment for the scan if the facility does not bill the radiopharmaceutical at the same time.

Many facilities may not be aware of this requirement, says Mackaman. To properly bill for the radiopharmaceutical and the scan, facilities should consider entering into an arrangement with the physician’s office that provides the radiopharmaceutical.

Critical care I/OCE edits

A change in January by the CPT Editorial Panel led to a revision in critical care coding. The CPT panel revised its guidance for critical care codes 99291 and 99292 to specifically state that, for hospital reporting purposes, critical care codes do not include the specified ancillary services.

CMS instructed hospitals to follow the CPT guidelines and report the ancillary services when they are provided with critical care. Facilities should append modifier -59 (distinct procedural service) to the CPT codes for the ancillary services only when they are not provided in conjunction with critical care. These ancillary services include but are not limited to EKGs, chest x-rays, and pulse oximetry.

However, CMS did not remove the edits that disallowed those ancillary codes in the NCCI edits applied through the I/OCE. As a result, hospitals encountered edits when they reported the ancillary services without a modifier even though they were reporting the services correctly in conjunction with critical care. As part of the July update to OPPS, CMS announced it is removing those edits retroactive to January 1. This will allow the proper reporting of ancillary services provided with critical care. Providers whose claims contained lines that were denied or rejected due to the critical care NCCI edits for ancillary services from January 1 through June 30 may request contractor adjustment of those claims, Mackaman says.

CMS clarifies modifier -PT use, adds new codes to I/OCE

CMS continues to clarify the use of modifier -PT (colorectal screening test converted to diagnostic test or other procedure) in the July update to the I/OCE.

According to CMS’ description of the I/OCE’s enforcement of the modifier, coders can append modifier -PT to any code in the surgical CPT range (10000–69999). As a result, CMS would waive any deductible for a surgical procedure on the same date of service.

Based on its definition, modifier -PT is only supposed to be used for very specific situations, yet the I/OCE enforcement is not as strict as the definition, says Dave Fee, MBA, product marketing manager of outpatient products at 3M Health Information Systems in Murray, UT.

“In practice it would be possible to add modifier -PT to any surgical service,” Fee says. “The OCE would not catch that. So coders need to be careful about the use of modifier -PT.”

However, coders should not get in the habit of appending modifier -PT to just any surgical code. The I/OCE may not catch incorrect use, but an auditor will, and using the modifier improperly could lead to a huge compliance problem.

The difference between the definition and the I/OCE enforcement is likely for practical reasons, Fee says. It would be difficult for the I/OCE to catch incorrect use of the modifier.

Code description changes

CMS revised the descriptions of three codes, removing the word “additional” from code 0251T (removal
bronchial valve) and 22551 (arthrodesis, anterior interbody, including disc space preparation, disectomy osteophytectomy and decompression of the spinal cord and/or nerve roots in cervical below C2). CMS also revised the description of code 0252T (removal bronchial valve additional) to add the word “additional.”

The changes make the use of these codes more specific, says Fee. Since code 0252T now has “additional” in its description, it is an add-on code. Since codes 0251T and 22551 no longer have the word “additional,” they can be reported on their own.

New payment adjustments

CMS added two new payment adjustment values for preventive services, 9 and 10. For some preventive services, the coinsurance is waived; for others, both the coinsurance and deductible are waived. Currently, no CPT codes fall into payment adjustment 10, which covers services for which only coinsurance is waived. CMS added this payment adjustment for future use.

The I/OCE includes a list of which codes have the coinsurance and deductible waived and which have only the deductible waived. For example, CMS added the administration of the hepatitis B vaccine to the list of services for which both coinsurance and deductible are waived to the list of services under payment adjustment 9.

Rural sole community hospitals will lose the 7.1% payment rate adjustment for bill type 14X, which is used to report non-patient laboratory specimens (specimens that the hospital sends to a reference laboratory for testing). The laboratory has no actual patient contact.

The pricer doesn’t know which bill type is being submitted, Fee says, so it will look for claims that exclusively have codes in the laboratory range (80000–89999). “If that’s all that’s on the claim, CMS will not apply the adjustment,” Fee says.

New APCs added

Effective July 1, CMS added eight new APCs to the I/OCE:

- 01352, Wilate injection
- 01353, belimumab injection
- 01354, hydroxyprogesterone caproate
- 09283, injection, acetaminophen
- 09284, injection, ipilimumab
- 09285, patch, lidocaine/tetracaine
- 09365, Oasis ultra tri-layer matrix
- 09406, Dx I-123 ioflupane, per dose

APC 01354 has a status indicator K (non-pass-through drugs and biologicals), while the remaining APCs have a status indicator G (pass-through drugs and biologicals).

New HCPCS codes

CMS added three new HCPCS codes for drugs and biologics:

- Q2041, injection, von willebrand factor complex (human), Wilate, 1 i.u. wvf:rc
- Q2042, injection, hydroxyprogesterone caproate, 1 mg
- Q2043, Sipuleucel-t, minimum of 50 million autologous cd54+ cells activated with pap-gm-csf, including leukapheresis and all other preparatory procedures, per infusion

Q2041 and Q2043 have status indicator G, while Q2042 has a status indicator of K.

CMS also added 14 Category III CPT codes, 12 of which are separately payable under OPPS. The new codes, which become effective July 1, include:

- 0262T, implantation of catheter-delivered prosthetic pulmonary valve, endovascular approach
- 0263T–0265T, intramuscular autologous bone marrow cell therapy
- 0266T–0268T, implantation or replacement of carotid sinus baroreflex activation device
- 0269T–0271T, revision or removal of carotid sinus baroreflex activation device
- 0272T–0273T, interrogation device evaluation (in person), carotid sinus baroreflex activation system
- 0274T–0275T, percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements

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CMS clarifies  < continued from p. 7

Bilateral codes

CMS added codes 27685 (lengthening or shortening of tendon, leg or ankle) and 27686 (revise lower leg tendons) to the conditionally bilateral list. When a provider performs one of those services bilaterally, coders need to append modifier -50 (bilateral service) to the code.

The agency also removed codes 64613 (chemodenervation of muscle[s]: cervical spinal muscle[s]) and 64614 (chemodenervation of muscle[s]: extremity[s] and/or trunk muscle[s]) from the conditionally bilateral list and added them to the inherently bilateral list.

CMS also added code 77071 (manual application of stress performed by physician for joint radiography, including contralateral joint if indicated) to the inherently bilateral list. Coders should not append modifier -50 to services on this list.

Conduct a risk assessment for E/M service coding

Editor’s note: This article is excerpted from Auditing Evaluation and Management Services: A Step-by-Step Guide to Accurate Coding, Reimbursement, and Compliance, Second Edition, by Joe Rivet, CCS-P, CPC, CEMC, CPMA, CICA, CHRC, CHC. For more information or to order a copy of the book, visit www.hcmarketplace.com/prod-9533.

A risk assessment allows a practice to take inventory of risk areas and identify current and potential risks, as well as control weaknesses. It measures a practice’s compliance level with laws, regulations, and internal policies and procedures, and should occur once every two years.

A risk assessment is important because it allows a practice to do the following:
➤ Address risks proactively
➤ Detect weaknesses that could impact operational risk
➤ Identify internal and external factors that must be addressed
➤ Determine a method to manage the risk

High-risk areas to monitor

Coding and billing pose significant risk to physician practices. If chart documentation is insufficient to support codes being billed, a practice greatly increases its risk of a government or commercial payer audit. This could result in repaying large sums of money.

Auditors should consider focusing their efforts on the following high-risk areas that the OIG has identified:

1. Billing for services not rendered or not provided as claimed. Example: A provider bills a patient’s insurance company for the performance of sleep studies. However, the provider is a cardiologist, has no access to sleep study equipment, and never sent the patient to undergo such a diagnostic study.

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2. Submitting claims for equipment, medical supplies, and services that are not reasonable and necessary. Example: A provider writes an order for a patient to have a nurse visit her home daily for two months to change a dressing on a non-healing wound. The patient does not meet the criteria to be considered homebound; therefore, she is receiving a service that is not reasonable or necessary.

3. Double billing resulting in duplicate payment. Example: A cash-strapped clinic designs its automated billing system to bill all level fours twice. The system bills all level fours for two consecutive days with different dates of service. The clinic does this to discreetly increase revenue without putting a financial burden, such as a double copayment, on patients.

4. Knowingly misusing provider identification numbers, which results in improper billing. Example: A practice’s credentialing office is delayed in processing the proper paperwork to assign an identification number to a new provider. The practice administrator works around the delay by fraudulently setting up the new provider with an established provider’s identification number. This is a risk because new providers are not allowed to submit claims without their own identification numbers.

5. Unbundling (separately billing for each component of a service instead of billing for the service using an all-inclusive code). Example: An inexperienced coder does not realize that she may not bill for local anesthesia of simple lacerations. Therefore, she bills for both the digital block and suture repair of the same site.

Unbundling happens most frequently when coders are unaware of what a procedure includes. When in doubt, coders should refer to the NCCI edit list, which lists all-inclusive codes. NCCI edits are updated quarterly and are used to process claims and determine appropriate payments to providers.

6. Failure to properly use coding modifiers. Example: A provider documents approaching an abscess on the patient’s right arm to perform an incision and drainage (CPT code 10060). The provider documents barely touching the skin with the instrument to incise the abscess before material secreted from the abscess.

The provider should have appended modifier -52 to CPT code 10060 to indicate reduced services. This modifier explains that a provider performed a procedure, but to a lesser degree than expected.

7. Clustering. Example: A provider consistently bills all patients at levels three and four, assuming that all the codes will average out in the end. As a result, the provider overcharges some patients and undercharges others. This is a compliance risk to practices and can also cost them money by undercharging patients who could have been billed at a higher level.

8. Upcoding the level of service provided. Example: A provider consistently bills all diabetic patients at level five. As the only provider in the practice who sees patients with diabetes, the provider thinks these are the most difficult patients to manage. The provider’s documentation does not support a level five for any of the patients. This is a compliance risk. Moreover, it could prompt an audit because the provider could be an outlier compared to the amount of level fives billed by his or her peers in the same specialty and location.

Divide your risk assessment among the following five steps:

1. **Plan.** Identify the goals and objectives of your risk assessment. For example, a practice conducting a risk assessment for the first time should consider obtaining a baseline assessment.

2. **Organize.** This step involves organizing the risk assessment and defining risks for each area of the practice to obtain the best data possible.

3. **Assess.** During this step, distribute the risk assessment tool to all appropriate individuals.

4. **Rank.** After completing the risk assessment, rank risks from highest to lowest. Using a weighted point scale is the most common method of ranking risks.

5. **Manage.** Finally, develop an action plan. An action plan should list all risks identified in a practice. It also should include information that explains why each risk exists and what controls are necessary to reduce or eliminate the risk.
Preop, postop transesophageal echocardiogram

Q If we perform a transesophageal echocardiogram (TEE) prior to a heart valve replacement, leave the probe in, then perform postoperative images, how would we bill this?

Our radiology department would like to bill 93312 (echocardiography, transesophageal, real time with image documentation [2D]) for the TEE, then 93321 (spectral Doppler) for the postoperative images. I believe we can only code 93312 once based on the guidance of CPT Assistant, January 2000, p. 10.

A Code 93321 does not bundle to 93312. It is considered an add-on code and may be reported with any of the following codes per the CPT Manual: 93303, 93304, 93308, 93312, 93314, 93315, 93317, 93350, and 93351.

The CPT Assistant you mention references codes 93312 and 93314 (echocardiography, transesophageal, real time with image documentation [2D] [with or without M-mode recording]; image acquisition, interpretation and report only). You may bill the spectral doppler (93321) as an add on if the physician dictates that he or she performed the add on during the image acquisition for the TEE.

The original order for the exam is not required to state with spectral doppler since this is considered a test to enhance the TEE exam and can be added at the cardiologist/radiologist discretion. The image acquisition denoted by code 93314 would indeed be included in code 93312 and cannot be separately reported using any modifier.

Billing hydration and observation

Q We have been trying to decipher the available information regarding patients placed in our observation unit who receive hydration during their course of care. If we pull out the hydration time, can we bill for observation hours pre- and post-infusion?

A I think the key to whether you should carve out the hydration time comes down to active monitoring, which not all services require.

The Medicare Claims Processing Manual (Pub. 100-4), Chapter 6, Section 290.2.2, states:

The hospital must determine if active monitoring is a part of all or a portion of the time for the particular drug administration services. Whether active monitoring is part of the drug administration service may depend on the type of drug administration service furnished, the specific drug administered or the needs of the patient. For example, a complex drug infusion titration to achieve a specified therapeutic response that is reported with HCPCS codes for a therapeutic infusion may require constant active monitoring by hospital personnel.
staff. On the other hand, the routine infusion of an antibiotic, which may be reported with the same HCPCS codes for a therapeutic infusion, may not require significant active monitoring. For concerns about specific clinical situations, hospitals should check with their Medicare contractors for further information.

In most cases, hydration would probably NOT meet the definition of a drug that requires active monitoring and therefore would not be carved out of the observation service.

**Charging for blood collection in ED**

**Q** May we charge CPT 36416 (collection of capillary blood specimen [e.g., finger, heel, ear stick]) with CPT 82962 (glucose, blood by glucose monitoring device[s] cleared by the FDA specifically for home use) in our ED?

**A** Per the *Coder’s Desk Reference for Procedures*, CPT 36416 reads: “In 36416, a prick is made into the finger, heel, or ear and capillary blood that pools at the puncture site is collected in a pipette. ... The blood is used for diagnostic study ...”

Also, the *Medicare Claims Processing Manual*, Chapter 16, section 601, states:

> A specimen collection fee is allowed in circumstances such as drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization. A specimen collection fee is not allowed for blood samples where the cost of collecting the specimen is minimal.

These services do not bundle according to the NCCI edits, but 36416 has a status indicator of N, which means it is always bundled or packaged. Medicare does not separately reimburse for the venipuncture. The question here is whether the specimen collection should be reported at all, because the collection cost could be minimal.

Medicare states that the specimen collection fee is not allowed for blood samples where the cost of collecting the specimen is minimal, such as a capillary puncture for clotting or bleeding time. We did not find that Medicare specifically excludes billing the two services together, but it is conceivable that Medicare would consider the collection required for the glucose monitoring device minimal.

**Correct use of modifier -AY for ESRD**

**Q** Our MAC is recouping payments on claims for lab tests such as a complete blood count (CBC), blood cultures, potassium, and magnesium levels for ED patients with end-stage renal disease (ESRD). The MAC initially paid the tests and medical necessity was met. Why is it retroactively recouping our payment?

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Coding Q&A  < continued from p. 11

The recoupment is related to the ESRD consolidated billing regulations that took effect January 1. Per CMS Transmittal 2134, CR 7064, certain lab tests are included in the ESRD facility payment and are no longer separately payable to any provider other than the renal dialysis facility:

Effective January 1, 2011, section 153b of the MIPPA requires that all ESRD-related lab tests must be billed by the renal dialysis facility whether provided directly or under arrangements with an independent lab. When lab services are billed by providers other than the ESRD facility and the lab furnished is designated as a lab that is included in the ESRD PPS (ESRD-related), the claim will be rejected or denied. In the event that an ESRD-related lab service was furnished to an ESRD beneficiary for reasons other than for the treatment of ESRD, the provider may submit a claim for separate payment using modifier AY.

CMS’ claims processing system reviews all renal dialysis claims (TOB 72X) against other outpatient provider claims for the beneficiary. When a renal dialysis claim is submitted, the system reviews all claims for the beneficiary that have been filed for the same dates covered by the 72X claim and retroactively denies and recoups monies for services included in the consolidated billing. The system also automatically line-item denies the services related to the consolidated billing.

Based on the information provided, a 72x claim was submitted that covered the date of service on your claim. The system located your claim and retroactively denied the lab test(s) as related to the ESRD consolidated billing and recouped the payment.

CMS established a new modifier for indicating that a lab test was performed for a reason unrelated to the treatment for ESRD: modifier -AY. CMS defines modifier -AY as “[i]tem or service furnished to an ESRD patient that is not for the treatment of ESRD.”

Use this modifier with caution and only after reviewing the documentation in the medical record. The documentation must clearly support that the test was performed for a reason unrelated to the ESRD treatment. Additional information is available in the Medicare Claims Processing Manual, Chapter 8, Section 60.1; and the Medicare Benefit Policy Manual (Pub. 100-02), Chapter 11.

During the June 1 Hospital Open Door Forum call, CMS acknowledged that it was aware of issues caused by the application of the edits in its claims processing system. CMS is investigating changes to the edits and will provide future guidance for calendar year 2012. Until further guidance is published, it referred providers to Transmittal 2134, CR 7064, for more information.