2012 OPPS proposed rule

CMS proposes new APCs for combination CT codes

Providers complained and CMS listened, at least a little. As part of the 2012 OPPS proposed rule, CMS announced plans to create two new APCs for combined CPT® codes for computed tomography (CT) of the abdomen and pelvis.

“CMS really listened to comments it received during the last year from many organizations on its rate-setting methodology for the ‘new’ combined CT code for CT of the abdomen and CT of the pelvis,” says Jugna Shah, MPH, president of Nimitt Consulting, Inc., based in Washington, DC.

With the AMA continuing to develop even more combination CPT codes, this issue isn’t going away anytime soon. Providers anticipate combination codes for other services, such as CT of the head and neck, among others, Shah says, so CMS’ recognition of how to set appropriate payment rates using historical claims data is critical.

“This is a huge win for providers because CMS incorrectly treated CPT codes 74176, 74177, and 74178 as new services, when in actuality the new codes merely represent a combination of existing services historically reported under separate CPT codes,” says John Settlemyer, MBA/MHA, assistant vice president of revenue cycle at Carolinas Healthcare System in Charlotte, NC.

This win for all providers would not have been realized without the significant efforts and comments of the Provider Roundtable, American Hospital Association, American College of Radiology, and others, Settlemyer adds.

CPT code changes

In 2011, the CPT editorial panel created three new codes for CT of abdominal and pelvis:

➤ Code 74176, CT, abdomen and pelvis; without contrast material
➤ Code 74177, CT, abdomen and pelvis; with contrast material(s)
➤ Code 74178, CT, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions

CMS assigned those new CPT codes to existing APCs with payment rates that many thought were far too
New APCs  
< continued from p. 1

low to cover the costs of providing two combined services.

“To put that level of a combination CPT code in the existing composite APC and providing payment at that level doesn’t make sense,” says Debbie Mackaman, RHIA, CHCO, regulatory specialist for HCPro, Inc., in Danvers, MA. CMS assumed it would cost the same amount when, in fact, it didn’t. Luckily, CMS realized this after looking at claims and charge data, she says.

Process for assigning APCs

New CPT codes come out in the fall after the proposed rule is released. The final rule comes out by November 1 each year, but new CPT codes may be released later.

As a result, CMS can’t include the new codes in the OPPS proposed rule released in July. Because CMS doesn’t know in advance what the new codes will be, it assigns them to the APCs it believes are the most appropriate, then asks for comments in the final rule, Shah says. The process doesn’t make sense if the new CPT codes represent a combination of two services that are already being performed.

“You’ve got 10 years’ worth of data on CT of the abdomen and CT of the pelvis, you have the predecessor codes, and the charge data from hospitals for over 10 years,” Shah says. “CMS didn’t seem to utilize the claims data for CY 2011 rates, which is why providers have had to live with compromised, lower payment rates this year, but thankfully CMS listened to comments and hopefully starting in 2012, payment rates for combination CPT codes will be appropriate so that providers do not have to face payment reductions.”

Many organizations have been working hard to convince CMS that these new codes are just that: new codes but not new services. They argued that CMS should use its historical claims data to set appropriate payment rates for the single and combined CT services, Shah says.

For 2012, the proposal means that hospital payments will be restored almost fully to pre-2011 payment levels. For 2013, CMS will be able to use current 2011 claims data to determine the median cost. “Let’s hope providers developed their charges for the combined codes in a manner that is consistent with the historical costs of providing the combined procedures,” Settlemyer says.

“Since we expect to see more and more combination codes being released by the AMA, this change on CMS’ part is critical to ensure adequate future payments,” Shah adds.

Original APC assignment

CMS originally assigned the new CT codes to the APC for single CT of abdomen and single CT of pelvis (APCs 0283, 0332, 0333).

During its presentation to the Advisory Panel on Ambulatory Payment Classification Groups February
When CPT code 74177 or 74178 is reported with CT codes that describe CT services for regions of the body other than abdomen and pelvis in which contrast is used, CMS proposes that the code would be assigned to APC 8006 (CT and CTA with contrast).

“In a regulatory environment of ever shrinking reimbursements, this comes as good news for hospitals that perform a fair volume of these procedures,” says Mackaman.

The following is a rounded comparison of the current and proposed APC national unadjusted payment rates:

➤ 74176 CT abdomen and pelvis without contrast
   - 2011 APC: 332; $194
   - 2012 proposed APC: 331; $417 (+$223)

➤ 74177 CT abdomen and pelvis with contrast
   - 2011 APC: 283; $300
   - 2012 proposed APC: 334; $592 (+$292)

➤ 74178 CT abdomen and pelvis without contrast followed by with contrast
   - 2011 APC: 333; $334
   - 2012 proposed APC: 334; $592 (+$258)

Cost savings for multiple procedures

Combination codes are becoming more common as the AMA continues to combine codes for procedures that physicians perform together the majority of the time, such as the CT of the abdomen and pelvis. Because they are done together, the AMA and CMS believe facilities incur lower costs.

That may be true, Mackaman says. Facilities don’t have the registration or medical records costs for multiple visits. However, the technicians and RNs still perform the same amount of work for a combination service as they do if they perform the services individually.

In addition, most of the CMS composite payments do not reflect the true costs associated with the procedures, Mackaman says. Consider the composite APC payment for observation. Facilities incur high costs when they provide observation for 24–48 hours with a high-level ED or critical care visit. Under the APC 8002 composite, facilities receive $714.33 for the observation.

> continued on p. 4

28–March 2, CMS discussed its normal process for assigning CPT codes for new services to APCs. CMS assigns the code to what it believes is the most appropriate APC, then collects two years’ worth of claims data on the code. It then reviews the claims data to determine whether the APC assignment is appropriate.

The problem in this case is the new CPT codes didn’t represent a new clinical service, for which CMS had no historical data, Shah says. The new codes simply represented existed services being wrapped together with a new physical code, but that shouldn’t have precluded CMS from developing more appropriate payment rates for 2011.

“While these are new CPT codes, they do not represent new services, nor are they replacement codes,” adds Dave Fee, MBA, product marketing manager, outpatient products at 3M Health Information Systems in Murray, UT. “The service(s) they describe is a combination of two services for CT scans of adjacent body parts, such as CT scans of the abdomen and pelvis. The individual services and the corresponding CPT codes remain and should still be used, when appropriate.”

Those who attended the APC Panel meeting had plenty of questions about the APC assignment for the CT codes. They also offered plenty of suggestions of what CMS could do with the claims charge and cost data to develop more accurate payment rates for 2012, says Shah.

Proposed APCs and payment rates for CY 2012

CMS proposes to create two new APCs to assign the CPT codes for combined abdominal and pelvis CT services:

➤ APC 0331 (combined abdominal and pelvis CT without contrast) for CPT code 74176

➤ APC 0334 (combined abdominal and pelvis CT with contrast) for CPT codes 74177 and 74178

When CPT code 74176 is reported with CT codes that describe CT services for other regions of the body other than the abdomen and pelvis in which contrast is not used, CMS proposes assigning it to imaging composite APC 8005 (CT and CTA without contrast).
New APCs  < continued from p. 3

Most of the other composites are also set up to pay facilities less for performing services together because CMS assumes it costs facilities less to perform them at the same time, Mackaman says. So while the proposed new APCs should pay more, composite APCs in general do not.

Moving forward

Although CMS is proposing new APCs for these specific CT combination codes, facilities shouldn’t assume a similar outcome every time the AMA introduces new combination codes.

“I would hope CMS would take this as a lesson and more seriously consider creating new composites for new CPT codes or adjusting the payments for the old composites if the new CPT codes are included in them,” Mackaman says. “I would hope this would be part of CMS’ review going forward.”

Settlemyer believes the proposal could set a precedent for similar future decisions. “When you really think about it, CMS already applied this logic in 2011 when it assigned the 16 new endovascular CPT codes to APCs,” he says. “In the proposed rule CMS discusses how they cross mapped 2009 codes in combinations they thought represented new codes to simulate payment for the new codes. This is precisely what they should have done with CT abdomen/pelvis from the outset.”

CMS could also set another precedent, but one that would not be as beneficial to providers, Settlemyer says. One significant change proposed in the rule is the concept of “capping payment” for APCs 8009 (Cardiac resynchronization therapy defibrillator) and 0108 (Insertion/replacement/repair of automatic implantable cardioverter defibrillator leads, generator, and pacing electrodes) at the lesser of the OPPS calculated payment rate or MS-DRG 227 inpatient payment rate.

“Providers really need to think about this and provide comment to CMS because this too could be precedent-setting,” Settlemyer says. “Ultimately, CMS could disregard outpatient cost as the underlying basis for OPPS payment. I do not think this is appropriate and could open the floodgates for future similar actions.”

2012 OPPS proposed rule

CMS to revise conversion factor, physician supervision

CMS proposed no changes to E/M visit coding guidelines, nor did it discuss drug administration in the 2012 OPPS proposed rule released July 1.

This doesn’t mean that hospitals won’t see payment rate changes for these important and high-volume services.

“That is the one thing we can count on every year; individual APC payment rate fluctuations, so take a few minutes now to review the proposed payment rates compared to current rates for your most frequently billed services either by volume or percent of charges,” says Jugna Shah, MPH, president of Nimitt Consulting, Inc., in Washington, DC.

In addition to the proposed new APCs for CT of the abdomen and pelvis, here are some of the other changes CMS proposed for 2012.

Conversion factor update/increase

Under the 2012 OPPS proposed rule, CMS is projecting a market basket update of 1.5%. However, this amount will likely decrease to 1.1% after CMS factors in all adjustments.

One such adjustment pertains to a special payment provision proposed for 11 cancer hospitals. CMS proposed changes on how these cancer hospitals will receive reimbursement because its internal studies have
shown that these hospitals have a much lower payment-to-cost ratio (PCR) compared to all other hospitals. The intent of CMS’ proposal is to create some payment parity between the hospitals.

If the PCR for these cancer hospitals is below the weighted average PCR for all other OPPS hospitals, CMS proposes to increase the payment to these cancer hospitals on a hospital-specific basis. The increase would be equal to the percentage difference between the cancer hospital’s PCR and the weighted average PCR of other OPPS hospitals. The Patient Protection and Affordable Care Act requires this to happen in a budget neutral way. CMS indicates that this provision will cause a 0.6% reduction in payment rates for non-cancer OPPS hospitals.

CMS’ proposal to complete its transition to using full community mental health centers (CMHC) data to set the CMHC partial hospitalization program (PHP) APC per diem payment rates is another payment adjustment that will impact final payment rates. If finalized, this proposal will result in a 0.2% payment increase for all other hospitals. These are two examples of adjustments to the final conversion factor that affect it going up and down.

**Supervision for outpatient therapeutic services**

For CY 2011, CMS finalized a number of changes to physician supervision requirements for hospitals. Most notably, CMS created a new category of nonsurgical extended duration therapeutic services that require direct supervision at the initiation of the service but can then be followed by general supervision for the remainder of the service. CMS stated its plan to convene a panel to review the supervision level of additional services that might be added to this category of nonsurgical extended duration services as well as other services. CMS did not enforce the supervision requirements for critical access hospitals (CAH) in 2011 but indicated that it would do so in the near future.

In the 2012 OPPS proposed rule, CMS discussed its plan to use the existing APC Advisory Panel with some modifications, including the addition of panel members from the CAH and rural hospital community, to review the supervision levels of services brought to its attention.

CMS outlines the process it proposes along with its plan on handling requests for services to review and other criteria it expects to use. As a result, CMS also proposes extending its nonenforcement policy of supervision requirements to CAHs. This means CAHs will be exempt from these requirements for one more year, says Shah.

**Drugs and pharmacy costs**

CMS has proposed increasing the drug packaging threshold from $70 to $80 for CY 2012, which means that more drugs are likely to be packaged. It also proposed decreasing the payment for all separately payable drugs and biologicals without pass-through status from the current average sales price (ASP) + 5%, to ASP + 4%.

“This reduction in payment combined with proposing to move the drug packaging threshold from its current mean daily cost of $70 to $80 could potentially minimize the improved reimbursements from the imaging procedures,” says Debbie Mackaman, RHIA, CHCO, regulatory specialist at HCPro, Inc., in Danvers, MA.

The payment reduction is bad enough and may be due in part to the proposal to increase the drug packaging threshold, says Shah. It could become worse in the final rule because CMS clearly indicates that the final ASP plus percentage could drop by a percentage point when everything is factored in, she explains. “Therefore hospitals need to take a look at this in the proposed rule, provide comments to CMS, and begin preparing their facilities for this potential payment reduction,” she says.

**Payment for partial hospitalization services**

CMS proposed continuing its methodology for creating separate APCs for partial hospitalization when provided in the hospital setting rather than a CMHC. CMS also proposed updating the existing four CMHC PHP APC payment rates.

Under this proposal, CMS would pay:

- $97.78 for APC 0172 (level 1 partial hospitalization for CMHC)
CMS plans to revise  
$113.62$ for APC 0173 (level II partial hospitalization CMHC)  
$162.34$ for APC 0175 (level 1 partial hospitalization for hospital-based PHPs)  
$189.87$ for APC 0176 (level II partial hospitalization for hospital-based PHPs)

Hospital Outpatient Quality Reporting Program
CMS proposes adding nine quality measures to the current list of 23 measures that hospital outpatient departments must report.
This will bring the total number of measures that must be reported for 2013 payment determination to 32.

The new measures include:
➤ Six chart abstracted measures  
➤ One healthcare-associated infection measure to be reported to the National Health Safety Network  
➤ One measure pertaining to the use of a safe surgery checklist  
➤ One measure collecting hospital outpatient department volume for selected surgical procedures

CMS also proposed adding one measure—influenza vaccination coverage among healthcare personnel—to the list for reporting for the CY 2015 payment determination.

Comment on the 2012 OPPS proposed rule
Have something to say about the 2012 OPPS proposed rule? You may submit comments to CMS until August 31.

The process need not be time or labor intensive, and telling CMS what your organization thinks about some of its proposals is important. Comments may be brief and to the point. They can be positive and express support for proposed changes. Alternatively, your comments may express opposition to some of CMS’ proposals. These comments should be loud and clear—otherwise you may face inappropriate or burdensome new requirements.

Remember commenting pays off, says Jugna Shah, MPH, president of Nimitt Consulting, Inc., in Washington, DC. “We’ve seen this over the years and most recently with the proposed payment change for the new combined CT codes, so don’t delay; tell CMS what you think about its various proposals for CY 2012,” says Shah.

You may submit comments electronically, via first class or express mail, or via hand delivery.

Tips for preparing your electronic submission
➤ Type out your comments beforehand in a word processing program, then copy and paste as appropriate. This will make commenting easier and faster, and can help ensure that you haven’t omitted anything.
➤ Ask someone to read your comments. This individual can catch typographical errors and missing words, and might even suggest adding additional information.
➤ Forward your comments to your compliance department for its review before submitting them to CMS.
➤ Organize staff to discuss your organization’s topics of interest. Ensure that all group members have an opportunity to review the comments before you post them.

After you have everything typed out, uploading it is the easiest part if you elect to submit electronically. Follow the steps below to send your comments to CMS electronically.

Electronic comments
Visit www.regulations.gov website and search for “2012 OPPS” or enter the document ID (i.e., “CMS-2011-0130-0002”) in the search field. Select the appropriate
Comments may be hand-delivered to CMS’ offices in Washington, DC, or Baltimore, MD. Because access to the interior of the Hubert H. Humphrey Building in Washington is not readily available to persons without federal government identification, CMS advises leaving comments in the CMS drop slots located in the main lobby of the building.

Commenters who plan to deliver their remarks to the Baltimore office should call in advance to schedule their arrival with a CMS staff member.

Paper submissions

Alternatively, you can submit your comments in hard copy. CMS provides addresses in the proposed rule for regular mail and express or overnight mail submissions.

## 2012 Medicare Physician Fee Schedule Proposed Rule

Keep an eye on three-day payment window clarification

HIM staff in hospitals might not pay attention to the Medicare Physician Fee Schedule (MPFS) proposed rule, but they need to know one change CMS plans for 2012.

As part of the MPFS proposed rule, CMS clarified that the three-day payment window applies to non-provider–based, wholly owned, or operated physician offices (i.e., hospital-owned freestanding physician practices).

“If the hospital is the sole owner or operator of the physician’s office or clinic and has exclusive responsibility for conducting or overseeing the entity’s routine operations, regardless of whether the hospital also has policymaking authority over the entity, then the payment window rule will apply,” says Debbie Mackaman, RHIA, CHCO, regulatory specialist for HCPro, Inc., in Danvers, MA.

Overview of the three-day rule

The three-day rule defines certain preadmission services as inpatient operating costs, meaning they are bundled and billed as part of the inpatient claim and payment is made as part of the applicable diagnosis-related group payment.

Under the three-day rule, CMS assumes all preadmission diagnostic and related non-diagnostic services occurring three calendar days prior to admission are related. Coders can separately bill clinically unrelated non-diagnostic preadmission services. Prior to June 25, 2010, CMS only considered the services related if the outpatient diagnosis code exactly matched the inpatient principal diagnosis code. However, CMS now defines “related” as “clinically associated with the reason for a patient’s inpatient admission.”

CMS proposed changes for 2012

When a physician furnishes a service in a hospital, including an outpatient department of a hospital, CMS pays the physician under the MPFS. That payment is generally at a facility-based payment rate that is lower than the “nonfacility” payment rate in order to avoid duplication of compensation for supplies, equipment, and staff that CMS directly pays to the hospital.

When the three-day payment window applies to non-diagnostic services related to an inpatient admission furnished in a wholly owned or wholly operated physician practice, CMS would pay the physicians’ services subject to the three-day payment window at the facility rate.

“Basically, the physician will be paid the lesser amount, as if the service was provided in the hospital setting,” says Mackaman. The services that are subject to the three-day payment window would be billed to Medicare...
**Three-day payment window** <continued from p. 7

similar to services that are furnished in a hospital, including an outpatient department of a hospital. CMS would apply the payment window to all diagnostic services furnished and to any nondiagnostic services clinically related to the reason for the patient’s inpatient admission.

**CMS future plans and what they mean**

CMS plans to create a new HCPCS modifier that will tell the claims processing system to only pay the facility rate. Coders would have to append that modifier to all physician preadmission diagnostic and admission-related nondiagnostic services, billed on the CMS 1500 claim, that are subject to the three-day payment window.

CMS would only pay the professional component (PC) for CPT/HCPCS codes that have both a technical component (TC) and a PC when those services are billed with the new modifier because they were provided in the three-day payment window in a hospital’s wholly owned or operated physician practice.

In addition, CMS proposes to pay the facility rate for codes without a PC/TC split to avoid duplicate payment for the technical resources required to provide the services. The hospital will have to report those costs on the hospital’s inpatient claim for the related inpatient admission.

“The hospitals would have to include the overhead on the inpatient claim. The physician’s claim would have to be billed with the new modifier and reimbursed at the lower facility amount,” says **Kimberly Anderwood Hoy, Esq., CPC**, director of Medicare and compliance for HCPro, Inc. “It is unclear how this overhead should be calculated and priced on inpatient claim, however.”

Hoy suggests that the hospital may split the charge for the physician office visit in the percentage that code is split for the facility and non-facility payment amounts. If the non-facility amount is $100 and the facility amount is $75, 75% of the visit charge would be billed as the professional charge with the appropriate HCPCS code and proposed modifier on the CMS 1500 claim form. The remaining 25% would be billed on the inpatient claim.

The hospital would be responsible for informing the physician’s office about related inpatient admissions prior to the inpatient stay. Hospitals would need to track which patients were seen in its wholly owned or operated physician offices and are then admitted within three days.

“This may be the most operationally difficult type of service to track for the hospital because these services may be in completely different computer systems that hospital coders and billers may not have access to,” says Hoy.

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**CMS may rescind lab requisition signature requirement**

After 10 years, the requirements for signatures on lab requisitions are still in flux.

CMS is now proposing to rescind the requirement for signatures on all lab requisitions that it previously finalized in the 2011 Medicare Physician Fee Schedule (MPFS) last November, according to the “Medicare Program; Clinical Laboratory Fee Schedule: Signature on Requisition” notice of proposed rulemaking published in the Federal Register.

“This is great news,” says **Debbie Mackaman, RHIA, CHCO**, regulatory specialist for HCPro, Inc., in Danvers, MA. “This is one instance where the comments of providers, labs, and other stakeholders were considered in greater detail and they made a positive impact on the final outcome.”

Per the 2011 MPFS final rule, a physician’s or non-physician provider’s signature is currently required on lab requisitions for tests paid under the clinical lab fee schedule, regardless of whether there is a signed order. This is the opposite of prior CMS rulings that indicated signatures were not required on requisitions, although written and signed orders were required.
Differentiating between neurostimulator codes

Q
I have questions about neurostimulator codes 95971 (Electronic analysis of implanted neurostimulator pulse generator system; simple spinal cord or peripheral neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming) and 95972 (Electronic analysis of implanted neurostimulator pulse generator system; complex spinal cord or peripheral neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming first hour), which represents the physician’s time, effort, and cognitive skill set in programming or reprogramming the actual pulse generator to ensure proper functioning of the device.

I have difficulty deciding how to choose between the two. My initial question has to do with an implantation of a stimulator. Would I code 95972, since that is the “initial insertion”? And if so, when the patient returns for the stimulator to be reprogrammed, does dictation need to list the parameters affected (four or more) and the time spent performing the reprogramming?

A
The insertion of a neurostimulator system requires three separate procedures:
- Implantation of the electrode(s) that stimulate the nerve
- Implantation of the neurostimulator generator
- Programming of the neurostimulator

For instance, if a spinal neurostimulator system was implanted, the three potential CPT codes are as follows:
- 63685, Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
- 63650, Percutaneous implantation of neurostimulator electrode array, epidural
- 63655, Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural

And
- 95971, Electronic analysis of implanted neurostimulator pulse generator system; simple spinal cord or peripheral neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming
- 95972, Electronic analysis of implanted neurostimulator pulse generator system; complex spinal cord or peripheral neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming first hour

CPT code 95973 represents an “add-on” code to be used in conjunction with 95972 for each additional 30 minutes beyond one hour.

To assign the correct evaluation of neurostimulator code, the physician would need to include in his or her dictation whether the spinal cord or peripheral device affects three (simple) or fewer or more than three (complex) of the following as well as the time spent programming or reprogramming if the device is considered complex:
- Eight or more electrode contacts
- Alternating electrode polarities
- Cycling
- Dose time
- More than one clinical feature
- Number of channels
- Number of programs
- Pulse amplitude
- Pulse duration
- Pulse frequency
- Stimulation train duration
- Train spacing

You can find an excellent discussion of neurostimulator implantation in the August 2005 and September 1999 CPT Assistant. Read these discussions to gain a clinical perspective on overall neurostimulator implantation.

> continued on p. 10
Billing for psychiatric patient in the ED

**Q.** How should we bill and code for a psychiatric patient (diagnosed with schizophrenia and bipolar disorder) who was brought by the ambulance and sent to the psychiatric emergency department (ED) for behavior aggression and agitation? The patient was seen by the ED psychiatrist and treated with Haldol and Ativan by intramuscular injection. Since no psych bed was available, the patient remained in the psychiatric ED and was not admitted. The patient was discharged after three days.

**A.** The visit level reported in the hospital’s psychiatric ED should be based on the hospital’s internal ED or psych ED visit leveling guidelines. These guidelines should comply with the 11 CMS general visit guidelines that state that the visit level should be based on facility resource utilization and follow the intent of the CPT descriptors, among others. The visit level reported should not include the physician’s work. It is also a good policy to minimize the inclusion of work related to separately billable procedures when calculating the visit level. In the scenario above, the ED visit level should be calculated excluding the administration of IM Haldol and Ativan as much as possible. The administration of these medications is separately billable and you do not want to create a perception of double billing.

CMS has made a minimal exception to including separately billable procedures when calculating the visit level only if the separately billable procedure is used as a proxy for resource use that is not associated with the separately payable services (Federal Register, vol. 72, No 227, November 27, 2007, p. 66806).

For the psychiatric patient described above, nursing assessments, evaluation, and monitoring would likely compose a significant portion of the facility resources used during the visit. Remember, these facility resources can include ED technicians, medical assistants, sitters—not only the nursing staff.

The highest level of service reported for the ED visit described above would most likely be a level 5—99285. It does not seem that the patient’s condition or interventions meet the CPT descriptor for critical care, 99291. Was an order written for admission? If so, the calculation of the ED visit level should stop at the point of the inpatient order. In the CMS Claims processing manual (see below), if the patient was ordered to be an inpatient, a room and board charge may be reported on the claim, even if the patient was discharged from the psych ED before he or she was transferred to an inpatient bed.

For more information, review the Medicare Claims Processing Manual (PUB. 100-04), Chapter 3 section 40.2.1-Noncovered Admission Followed by Covered Level of Care (Rev. 1, 10-01-03), HO-415.16, A3-3610.12.

Under subsection K – Inpatient Acute Care Hospital Admission Followed By a Death or Discharge Prior To Room Assignment, CMS states:

> A patient of an acute care hospital is considered an inpatient upon issuance of written doctor’s orders to that effect. If a patient either dies or is discharged prior to being assigned and/or occupying a room, a hospital may enter an appropriate room and board charge on the claim. If a patient leaves of his own volition prior to being assigned and/or occupying a room, a hospital may enter an appropriate room and board charge on the claim as well as a patient status code 07, which indicates the patient left against medical advice. A hospital is not required to enter a room and board charge, but failure to do so may have a minimal impact on future DRG weight calculations.

Boarding patients in the ED is not uncommon, but most hospitals are taking steps to minimize this occurrence. The ED outpatient coding levels and rules have no mechanism for compensating the facility for extended ED stays. ED “boarders” also require use of valuable ED nursing staff time that will not then be available to care for more emergent, critically ill, or injured patients.
Seventh character for fracture coding in ICD-10-CM

When should we use the seventh character A for a traumatic closed fracture in ICD-10-CM? Is it only for the first visit since it is for the initial encounter? Does the same hold true for open fracture codes?

ICD-10-CM fracture codes include additional information that can be provided by the seventh character extension. In ICD-10-CM Manual chapter 19 (Injury, Poisoning and Certain Other Consequences of External Causes) and chapter 20 (External Cause of Morbidity), the seventh character identifies the encounter as:

➤ A – initial encounter for fracture
➤ D – subsequent encounter for fracture with routine healing
➤ G – subsequent encounter for fracture with delayed healing
➤ K – subsequent encounter for fracture with nonunion
➤ P – subsequent encounter for fracture with malunion
➤ S – sequela

According to the ICD-10-CM Official Guidelines, the seventh character A applies as long as the patient is receiving active treatment for the fracture. Active treatment includes:

➤ Surgical treatment
➤ Emergency department encounter
➤ Evaluation and treatment by a new physician

Use the seventh character D for encounters after the patient has completed active treatment. Report the other seventh characters, listed under each subcategory in the Tabular List, for subsequent encounters for treatment of problems associated with the healing, such as malunions, nonunions, and sequelae.

Use the appropriate complication codes to report care for complications of surgical treatment for fracture repairs during the healing or recovery phase.

For an open fracture, the seventh character identifies the type of open fractures using the Gustilo-Anderson classifications. When coding open fractures in ICD-10-CM, select the appropriate seventh digit from these options:

➤ B – Initial encounter for open fracture type I or II
➤ C – Initial encounter for open fracture type IIIA, IIIB, or IIIC
➤ E – Subsequent encounter for open fracture type I or II with routine healing
➤ F – Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with routine healing
➤ H – Subsequent encounter for open fracture type I or II with delayed healing
➤ J – Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with delayed healing
➤ M – Subsequent encounter for open fracture type I or II with nonunion

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Contributors

We would like to thank the following contributors for answering the questions that appear on pp. 9-12:

Andrea Clark, RHIA, CCS, CPC-H
President
Health Revenue Assurance Associates
Plantation, FL

Glenn Krauss, RHIA, CCS, CCS-P, CPUR
Independent HIM consultant
Madison, WI

Shannon McCall, CCS, CCS-P, CPC, CPC-I, CEMC, CCDS
Director of Coding and HIM
HCPro, Inc
Danvers, MA

Candace E. Shaeffer, RHIA, RN, MBA
Chief Compliance Officer
LYNX Medical Systems, Inc.
Bellevue, WA
Coding Q&A  < continued from p. 11

➤ N – Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion
➤ Q – Subsequent encounter for open fracture type I or II with malunion
➤ R – Subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion

Remember, if the physician does not document whether a fracture is open or closed, the default is closed, just as instructed in ICD-9-CM. However, if the physician does not document a fracture as displaced, the coder defaults to displaced.

Billing outpatients for dialysis in inpatient unit

Q We have an inpatient dialysis unit, but are not an outpatient dialysis center. On rare occasions, someone comes in for an outpatient procedure or is seen in the ED and needs dialysis. We try to reschedule them at the dialysis center, but that sometimes is not possible and they need to have the treatment. Is there a way to report this service or do we have to eat the cost?

A In the CY 2003 OPPS Final Rule, CMS provided a mechanism for reporting these types of non-routine dialysis treatments. In specific scenarios, you can report HCPCS code G0257 (Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility).

According to the Medicare Claims Processing Manual (Pub 100-04), Chapter 4, section 200.2, these circumstances are defined as:

➤ Dialysis performed following or in connection with a dialysis-related procedure, such as a vascular access procedure or blood transfusion
➤ Dialysis performed following treatment for an unrelated medical emergency; e.g., if a patient goes to the ED for chest pains and misses a regularly scheduled dialysis treatment that cannot be rescheduled, CMS allows the hospital to provide and bill Medicare for the dialysis treatment
➤ Emergency dialysis for ESRD patients who would otherwise have to be admitted as inpatients in order for the hospital to receive payment

Report G0257 in addition to other separately reported services.

Documentation should support that the patient could not be rescheduled for the treatment at his usual dialysis facility or that the dialysis is being performed due to an emergent situation that precludes the service being provided at a dialysis facility.