Correctly bill ancillary bedside procedures in addition to the room rate

As technology evolves, providers can perform more procedures at the patient’s bedside than they ever could in the past. Previously, they could only perform these procedures in another department of the hospital, and they had to charge separately for them.

As charges become more specific to provide additional concrete and transparent cost data, providers must consider what procedures they routinely provide to patients and what procedures are specifically related to the patient’s condition.

In some cases, hospitals may charge for certain services when the provider performs the service in an ancillary department, but not at a patient’s bedside. The facility’s staff may believe they are not permitted to charge for a service provided at the bedside of an inpatient or may think the cost is already accounted for in the regular room rate.

“If we’re going to charge them in the ancillary department, why can’t we charge them when they are done at the bedside?” says Denise Williams, RN, CPC-H, vice president of revenue integrity services for Health Revenue Assurance Associates, Inc., in Plantation, FL. “They are the same procedures and they are done for the very same indications.”

Charging for inpatient services

CMS provides very little guidance regarding how hospitals should bill inpatient services, including ancillary bedside procedures. This lack of guidance confuses facilities because it’s unclear what they can bill for in addition to the room rate.

Although it would be helpful if CMS provided additional guidelines, the agency does allow latitude so facilities with different needs can make things work for their structure, says Kimberly Anderwood Hoy, JD, CPC, director of Medicare and compliance for HCPro, Inc., in Danvers, MA.

Individual payers also add to the confusion by stipulating that facilities cannot bill for certain ancillary bedside procedures or invoking Medicare coverage rules that don’t exist, Hoy adds.

So instead of having actual guidelines, many consultants and payers are creating best practices based on Medicare’s recommendations, Hoy says. Sometimes these individuals or entities inaccurately cite those recommendations as actual CMS guidance. As a result, third-party payers incorrectly deny items billed separately from the room rate. (For more on what CMS actually says, see the related article on p. 4.)
Apply charges uniformly

CMS specifically says facilities must apply charges uniformly to inpatients and outpatients. This becomes important when providers render ancillary services to inpatients, Hoy says.

Facilities often question whether they can bill something as an ancillary service for an inpatient. In many cases, facilities would absolutely bill those services separately for outpatients, Hoy says.

“What we see is a disparate application of charges between inpatients and outpatients, and it isn’t really clear that this is what Medicare intends,” she says. CMS seems to intend that facilities separately bill the same services for inpatients and outpatients, she adds.

Each facility has its own charging methodology, so the staff has to look at that methodology as an individual facility or system, Williams says. Then weigh the pros and cons of the decision you’re going to make, she adds.

Some providers include everything in the room rate. As a result, these providers have a really high room rate because they believe it’s too difficult operationally to list out all of the separate charges. Other providers find it easier to delineate the separate items, resulting in a lower room rate, Hoy says.

“That philosophy of how am I going to set my charges is really up to you, and you need to establish that,” Hoy says. “However, facilities should also follow the common practices of other hospitals in the same area.”

Determine what’s in the room rate

So how should a facility’s staff initiate the discussion about what to bill separately? Start by determining and defining what’s included in the room rate, Williams says. Generally, the room rate includes:

- Housekeeping and maintenance services
- Electricity
- Water
- Trash and biohazard disposal
- Administrative services

Consider avoiding the term “overhead” because this is a generic word that is open to interpretation, Williams says. “If you use that term, you want to specify exactly what your definition of overhead is,” she says.

Facilities must also define what they consider standard nursing services. Think about whether any nurse can provide a particular service within his or her scope of practice. “You may decide that something is standard nursing care and happens for most of your patients,” Williams says. “Therefore, you’re going to include that in your room rate.”

Other nursing services, such as specialized wound care, fall outside of that definition. Specialized wound care is not something every nurse can perform, and it is not a service provided to all patients.

Also, determine whether you charge a service separately to any patient in your facility regardless of whether the patient is an inpatient or outpatient. Remember that you must apply charges uniformly to every patient.
“You have to sit down and have a discussion and get away from the idea that everything for an inpatient is included in the room rate,” Williams says.

Create a policy for the room rate

Once a facility decides to charge for ancillary bedside procedures, staff must then create a policy definition to describe what is included in the facility’s room rate, Williams says. “It’s probably a good idea to do it anyway, whether you decide to proceed down the path now or you think you might do it later. It really is important to know for now and for the future exactly what is included in your room rate,” she says.

For example, hospital XYZ defines its room rate to include the following services:

➤ Nursing care provided by any RN without additional certification or training required, such as vital signs and routine postoperative care
➤ All dietary requirements eaten or provided via the gastrointestinal tract (meals, snacks, enteral nourishment)
➤ Housekeeping services
➤ Electricity, water, and other systems required to operate the facility
➤ Disposal of trash, biohazard materials, etc.
➤ Supplies that are available to the general patient population and not specifically ordered by a physician
➤ Alcohol, Betadine®, and other skin cleansing products
➤ Cotton balls and cotton tip applicators

All other items/services not defined by the above categories are considered to be nonroutine and patient-specific services. When provided for an individual patient, hospitals should report these services as a separate line item on the patient’s bill.

Once a facility creates its policy, it will be able to demonstrate to CMS and to other auditors that it is charging all patients in the same way, Williams says.

“If you don’t have some of these things defined, you can tell CMS what you think is happening,” she says. “If I’m CMS or a CMS entity that is auditing, and I ask six different people this question and I get six different answers, I’m going to start to wonder if all patients really are being charged the same.”

In addition to serving as defense during an audit, the written policy will document the decision-making process and provide guidance for the future, says Williams.

Define bedside procedures

After defining what is included in the room rate for the inpatient room, review what services remain, and determine whether a line-item charge is appropriate and/or feasible, Williams says. Define bedside procedures the facility does not currently report on inpatient claims. The trick is to actually create the definition, Williams says, because the phrase “bedside procedures” is similar to the term “overhead” in that its meaning is somewhat subjective.

“We’ve coined that phrase for things done for the patient at the bedside and they are an inpatient,” Williams says. When patients are in observation, facilities often already capture many of these charges.

Consider using outpatient procedures as a guide to determine whether a service meets the facility’s definition of what is and isn’t included in the room rate. Consider procedures such as:

➤ Lumbar punctures
➤ Insertion of Foley catheter
➤ Declotting of implanted vascular access device

Also, consider ICD-9-CM procedure codes that providers don’t perform in the OR. “Surgeries are charged so the cost is captured for the individual patient,” Williams says. “We are interested in those procedures that are not currently line item reported.”

Charging methodologies

Facilities can use a variety of methods to charge for ancillary procedures.

Consider establishing a line-item charge for bedside procedures using a revenue code that HIM coders report
(e.g., 0369). HIM can then report the appropriate CPT code based on the documentation in the record. The data is then stored internally for costing and trending purposes, Williams says.

Even though facilities don’t report CPT codes on inpatient bills, some hospitals have decided to put the CPT code on the bill for their internal information and to ensure they capture every service, Williams says.

Not every bedside procedure results in an identical charge, she says. Facilities must consider what to charge for each procedure, or they can choose to bill the same amount they would in the outpatient setting.

For inpatient claims, report the service with revenue code 0230. Most payers consider revenue code 0230 to be a “routine service” revenue code and an extension of the room rate.

For outpatient claims, report the service with an ancillary revenue code (e.g., 0361, 0761, or 0260).

**Effect on payment rates**

CMS has determined that billing for ancillary services affects APC and MS-DRG payment rates. CMS uses cost reporting to set these payment rates, and when facilities don’t appropriately report ancillary

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**What CMS actually says about billing ancillary procedures**

When considering what guidance CMS provides regarding billing ancillary procedures, hospitals must understand how CMS defines charges. In §2202.4 of the Provider Reimbursement Manual, CMS states:

> Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients’ charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions.

CMS makes it clear in §2203 that although it cannot dictate a facility’s charges or charge structure, it can determine whether the charges are allowable for use in apportioning costs, says Kimberly Anderwood Hoy, JD, CPC, director of Medicare and compliance for HCPro, Inc., in Danvers, MA. Apportioning refers to how a facility allocates costs between Medicare and non-Medicare patients.

Apportioning can be traced back to when CMS reimbursed hospitals based on costs, Hoy says. Even though this is no longer the case, CMS still relies on this guidance to build rates, among other things. “So they are still concerned about what costs are appropriate to Medicare and what costs are appropriate to other payers,” Hoy says.

To qualify for apportioning, facilities should establish a charge structure and apply it uniformly to all patients. The charge structure should be reasonably and consistently related to the costs of the services, Hoy says. “If you have a cost for a service, it should be represented in some reasonable and consistent way somewhere on your claim.”

A facility must follow the same method of charge setting regardless of the setting in which the services take place (e.g., inpatient, outpatient, distinct part units, or skilled nursing facility). A facility must also follow that charging practice for Medicare and non-Medicare patients. The consistent application is what makes the costs apportionable, which is the ultimate goal, Hoy says.

In some instances, facilities may choose to incorporate the cost as part of a routine rate and consider other costs as ancillary. Either way, those charges should relate to costs. If a payer denies the charges, it is not allowing certain costs, Hoy says. As a result, facilities will have an imbalance between costs and charges. That’s because the payer has taken away the charge even though the facility still incurs the costs.

**Additional CMS guidance**

CMS provided additional information as part of the 2009 IPPS final rule. In the IPPS rule, CMS provides
charges. CMS does not account for those charges in the reimbursement.

When facilities group a large number of services into a category that is not well defined, CMS cannot easily determine the differential costs between patients. “If your room rates include a lot of different things that only a few patients receive, then it’s very hard to tell which patients are more expensive and need more services compared to ordinary patients,” says Hoy.

CMS’ inability to distinguish each of the different nursing services across multiple types of patients presents a large challenge when it comes to setting PPS payment rates because the agency can’t tell which patients require more expensive services.

By separating specialized nursing services and reporting more detailed incremental charges, facilities provide CMS with additional data that it can use to set appropriate payment rates.

Providers also need more specific cost information to ensure the reimbursement they negotiate with third-party payers is commensurate with their costs, Williams says. “So we have to consider what procedures are routinely provided to patients and which ones are patient-condition specific,” she explains.

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Information about common practices among providers in a state. CMS seems to say that facilities should base their decisions regarding whether to classify a service as routine or ancillary on what other facilities are doing, Hoy says.

As stated in the 2009 IPPS final rule, CMS requires facilities to follow the “common or established practice of providers of the same class in the same state” (73 Federal Register 48466). When no common or established classification of an item or service as routine or ancillary exists, CMS will recognize a provider’s customary charging practice as long as the facility consistently follows the practice for all patients, and as long as the practice does not result in an inequitable apportionment of cost to the program.

“As long as you are consistent about it, CMS is going to let you determine what your charging practices are going to be,” Hoy says.

Common charging practices will vary; however, CMS defines routine and ancillary services in §2202.6 of the Provider Reimbursement Manual as follows:

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 (SCUs), including coronary care units (CCUs) and intensive care Units (ICUs). 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.

Many ancillary services are not regular nursing services and are not specified in CMS’ list of routine services, Hoy says.

Contrasting with routine services, CMS defines ancillary services in §2202.8 as follows:

Ancillary services in a hospital or SNF include laboratory, radiology, drugs, delivery room (including maternity labor room), operating room (including postanesthesia and postoperative recovery rooms), and therapy services (physical, speech, occupational). Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge.

According to these two definitions, regular nursing services are routine and should be included in the room rate. Specialty nursing services are ancillary services that are not included in the room rate and that facilities customarily charge separately.
The bottom line is facilities must charge all patients the same way, Hoy says. Facilities must also establish a charge structure that is separate from the one in the chargemaster. They need a way to consistently mark up charges as well as a plan for how they will structure their charges, Hoy says.

**Look at one example**

In the 2009 IPPS final rule, CMS discusses charging for blood transfusions. This service is not specifically mentioned in the list of routine services or the list of ancillary services. Transfusions are arguably a specialty service, Hoy says. So providers must consider the common charging practices of hospitals in the same state as well as charging practices in their own subunits or other settings.

Facilities must separately bill transfusions in the outpatient setting because they are separately paid. In general, facilities bill transfusion ancillary cost centers (i.e., OR or ED) separately. In fact, facilities cannot bill for the blood itself without reporting the transfusion code as well.

In some ancillary areas, such as the ED, facilities also normally bill blood transfusions separately. It may be inappropriate to not bill transfusions separately for inpatients, Hoy says.

Determining which procedures to include in the room rate and which to charge separately is not an easy process, says Williams.

“This is definitely an Olympic-sized exercise,” she says. “Decisions will not be made overnight. This is going to take some work.”

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**ICD-10 anatomy refresher: Respiratory system**

*by Shelley C. Safian, PhD, CCS-P, CPC-H, CPC-I*

*Editor’s note: With the increased specificity required for ICD-10-CM coding, coders need a solid foundation in anatomy and physiology. To help coders prepare for the upcoming transition, we will provide an occasional article about specific anatomical locations and body parts as part of a larger series for ICD-10-CM preparation. This month’s column addresses the anatomy of the respiratory system.*

The respiratory system, responsible for inspiration (carrying oxygen into the body) and expiration (the expulsion of carbon dioxide), is composed of two tracts: the upper respiratory tract and the lower respiratory tract.

**Upper respiratory tract**

The upper respiratory tract begins at the nose, followed by the nasal cavity and paranasal sinuses, then culminates with the pharynx.

Respiration begins with the intake of air through the two nostrils (the openings of the nose). While air can be brought in through the mouth, the mouth and oral cavity are considered part of the digestive system. The air continues to flow through the nasal cavity, which is composed of the nasal septum (bone and cartilage) and the nasal conchae (bone).

The paranasal sinuses, air-filled cavities within the skull above and behind the nose, are lined with a mucous membrane and include the maxillary, frontal, ethmoidal, and sphenoidal sinuses.

The pharynx, commonly known as the throat, begins behind the nose (the nasopharynx) and continues down behind the oral cavity (the oropharynx) to the larynx. This enables the air to travel from the nasal cavity to the larynx, where the lower respiratory tract begins.

**Lower respiratory tract**

The epiglottis is a flap that opens to permit air to travel into the larynx or closes to prevent food particles and liquids from traveling into the larynx and ultimately the lungs. Food particles in the lungs can create severe breathing problems. The epiglottis tops the larynx, which includes the thyroid cartilage and the cricoid cartilage.
The air continues through the larynx into the trachea. At a point approximately at the center of the chest (thoracic cavity), the trachea forks into two parts, identified as the left and right primary bronchi.

The bronchi enter the left and right lungs, respectively, and continue to branch out into smaller bronchioles. The bronchioles branch out into smaller tubelike structures called alveolar ducts that end with alveolar sacs. The sacs are surrounded by a fishnet-like network of capillaries from the pulmonary vein and artery to enable the exchange of gases (oxygen and carbon dioxide)—the purpose of the respiratory system.

This structure is similar to the branches of a tree. The trachea is like the trunk of a tree, branching out its limbs (the bronchi). Each limb then has its branches (the bronchioles) whose twigs (the alveolar ducts) blossom with buds (the alveolar sacs).

The lungs, located in the lower respiratory tract, are within the thoracic cavity and represent the largest portion of the respiratory system. The ribs form a protective cage around the lungs, meeting at the sternum in the anterior medial (front center) of the thorax. The diaphragm sits distally to the lungs.

Structure of the lungs

The lungs are composed of two hemispheres: the right lung and the left lung. The right lung is subdivided into three segments: the superior lobe, the middle lobe, and the inferior lobe. The superior lobe is located posterior to the first rib and the top of the sternum, the middle lobe approximately at the fifth rib. The seventh rib protects the distal end of the inferior lobe.

The left lung only has two lobes: the superior and the inferior. The oblique fissure (an angular crack) separates the lobes.

The exterior surface of the lungs is covered by the visceral pleura, a lubricated membrane. This slippery fluid, contained in the intrapleural space, hinders friction between the internal surface of the ribs and the lungs when they expand after inhalation.

ICD-9-CM: What you need to know

Coders need to understand the intimate details of the upper and lower respiratory systems to report diseases and conditions of the respiratory system (Chapter 8, codes 460–519). For a patient diagnosed with acute sinusitis, the physician must document...
which specific sinus is infected or inflamed so the coder can report the correct required fourth digit. If working with an ear, nose, and throat specialist, coders should focus on the upper tract; coders working with a pulmonologist will focus on the lower tract.

**ICD-10-CM: What you need to know**

Diseases of the respiratory system are listed in Chapter 10, codes J00–J99. At this point in time, the guidelines are the same as ICD-9-CM with additional guidance for the proper reporting of ventilator-associated pneumonia.

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**January I/OCE update**

**CMS adds new modifier -PD, two edits, additional APCs**

Modifier -PD (diagnostic or related nondiagnostic item or service provided in a wholly owned or wholly operated entity to a patient who is admitted as an inpatient within three days or one day) is now included in the I/OCE, according to January updates detailed in Transmittal 2370.

“This is one of the real sleepers in this release,” says Dave Fee, MBA, product marketing manager of outpatient products at 3M Health Information Systems in Murray, UT. “When you think of a new modifier, you don’t think of it as a big deal.”

That’s not the case with modifier -PD, he says. Here’s why: A hospital wholly owns or wholly operates a clinic or an ambulatory surgery center (ASC). A patient receives services at the clinic or ASC.

So far, so good.

However, if the patient is admitted to the hospital within three days, the services provided by the other entity must be included as part of the inpatient stay.

A problem arises when the clinic or ASC is wholly owned by the hospital but not provider-based. Provider-based clinics bill through the hospital, and both information management systems are tied together. A non-provider-based clinic or ASC is freestanding and has its own information management system and billing practices. The freestanding clinic or ASC also submits bills on its own. “They’re really almost independent, but they happen to be wholly owned,” Fee says.

Because the freestanding facility doesn’t share information systems with the hospital, the hospital may not know when the three-day rule applies unless the patient mentions that he or she had previously received services at the freestanding facility.

“How do you know if they had a minor service provided somewhere else unless they mention it?” Fee says. “It really speaks to the need to have an enterprisewide [electronic health record].”

Providers should expect additional guidance about modifier -PD to clarify some of this confusion, Fee says. “I think all of the rules are still settling out, so we need to keep a close eye on this,” he says.

**New edits**

CMS added two new edits to the I/OCE: edit 84 (claim lacks required primary code [RTP]) and 85 (claim lacks required device code or required procedure code [RTP]).

Edit 84 creates an interesting interplay between CPT codes 33225 (insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacing cardioverter-defibrillator or pacemaker pulse generator [including upgrade to dual chamber system]) and 33249 (insertion or repositioning of electrode lead[s], for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator), Fee says.

The codes have Q3 status (codes subject to payment as part of a composite); however, they are not truly composites. Code 33225 is an add-on code, so facilities must bill it with the appropriate primary code. If a
facility bills codes 33225 and 33249 together, CMS will only pay for 33249 and package 33225 into the payment. However, if a facility bills code 33225 with a different primary code, CMS will pay for both. “They are like composites, but they are not actually composites” Fee says. “They are conditionally paid, but the composite flag is not set.”

Edit 85 applies mainly to HCPCS codes C9732 (insertion of ocular telescope prosthesis including removal of crystalline lens) and C1840 (telescopic intraocular lens). Facilities should report these two codes together. If a facility bills one without the other, it will trigger the edit and prevent payment.

The only exceptions occur when certain modifiers are appended. These include modifiers -52 (reduced services), -73 (procedures discontinued prior to anesthesia), and -74 (procedures discontinued after anesthesia administration or after the procedure has begun), Fee says.

APC changes

CMS added only 28 new APCs to the list, which is not an extensive number, Fee says. It does, however, bring the total number of APCs to 850. Many of the new APCs are related to pharmaceuticals, which seems to be a trend, he says.

CMS reassigned 15 APCs from status indicator G (pass-through drugs and biologicals) to status indicator K (non-pass-through drugs and biologicals). In addition, APC 00668 moved from status indicator S (significant procedure, not discounted when multiple) to status indicator T (significant procedure, multiple reduction applies).

Codes that require two devices

Codes 0238T (transluminal peripheral atherectomy, including radiological supervision and interpretation; iliac artery, each vessel) and 33249 now require two device pairs to satisfy edit 71 (claim lacks required device code). This is important to note because codes rarely require two devices to bypass the edit, Fee says.

Code 0238T requires both a PERM device and the leads, while code 33249 requires both the implantable cardioverter-defibrillator and the leads. “We just need to make sure both devices are coded,” Fee says.

Reimbursement changes

Although CMS intended to lower the fixed dollar threshold for outlier payments from $2,025 to $1,900, it did not because of an error it made in calculating the update to the 2012 OPPS. The threshold is currently $2,025. “That’s one of the changes that came out well after the fact,” Fee says. (For more information, see 77 Federal Register 218.)

However, CMS did change the reimbursement rate for drug codes having status indicator K to average sales price plus 4%.

Code changes

CMS added four codes to the list of male procedures:

➤ G8822, male patients with aneurysm minor diameter > 6 cm
➤ G8828, aneurysm minor diameter <= 5.5 cm for men
➤ G8829, aneurysm minor diameter 5.6–6.0 cm for men
➤ G8830, aneurysm minor diameter > 6 cm for men

CMS added 15 codes to the list of female procedures:

➤ 81266, Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (e.g., pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline; each additional specimen)
➤ G8802–G8805, pregnancy test, urine or serum
➤ G8806–G8809, transabdominal or transvaginal ultrasound
➤ G8810, Rh-immunoglobulin (Rhogam) not ordered for reasons documented by clinician
➤ G8811, documentation Rh-immunoglobulin (Rhogam) was not ordered, reason not specified
➤ G8823, female patients with aneurysm minor diameter > 6 cm
➢ G8824, female patients with aneurysm minor diameter 5.6–6.0 cm
➢ G8827, aneurysm minor diameter <= 5.5 cm for women
➢ G8831, aneurysm minor diameter > 6 cm for women
➢ G8832, aneurysm minor diameter 5.6–6.0 cm for women

CMS added 11 codes to the conditionally bilateral list, meaning coders can now append modifier -50, when applicable:
➢ 0282T–0238T, percutaneous or open implantation of neurostimulator electrode array(s)
➢ 20527, injection of an enzyme
➢ 26341, manipulation of the palmer fascial cord
➢ 29582–29584, application of multi-layer compression system
➢ 64633–64636, destruction by neurolytic agent, paravertebral facet joint nerve(s) with imaging guidance

CMS also added two codes for central motor evoked potential studies (95928 and 95929) to the inherently bilateral list. Coders should not report modifier -50 with these codes.

**Reordering blood products**

Certain blood products cost more than others, and each Medicare patient has a blood deductible amount in his or her benefit, says Fee. When all of the new APC weights and rates are released, CMS reorders the blood products to ensure the most expensive ones are processed first, he says. This priority processing satisfies patients’ deductibles. This isn’t a big issue, but it is something facilities should be aware of, Fee says.

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**This Month’s Coding Q&A**

**Reporting molecular pathology codes**

Q Addendum B of the APC updates for 2012 indicates the new molecular pathology codes have status indicator E (noncovered service, not paid under OPPS). Our laboratory director said we should report these new codes in addition to the codes that are payable. Can you explain why?

A Providers use molecular pathology tests to detect the presence of specific genes. Currently, coders report these tests with multiple CPT® codes to describe the specific testing the provider performs. Codes reported in this manner are sometimes referred to as “stacked” codes.

The AMA created new CPT codes for these tests to reflect the service with a single code for CY 2012. Claims data reflects the stacked codes that have historically been reported for these services. No one-to-one relationship maps the old codes to new codes. Therefore, no easy crosswalk between them exists.

Multiple current CPT codes map to one new code, and one current CPT code will map to several new codes because they are reported for several types of testing. The result is multiple-to-one and multiple-to-multiple mapping that must be considered before payment rates can be determined.

CMS relies on providers to report both sets of codes to facilitate mapping the new CPT codes to the current cost and pricing information. Assignment of status indicator E should allow this line item to pass through the I/OCE without delaying claims. CMS will not reimburse providers for the new codes; however, reporting in this manner will result in claims that include both the new code and the current codes for the service. This will allow CMS to analyze the claims with the individual codes and the combination of codes that were reported for future rate setting under the Clinical Diagnostic Laboratory Fee Schedule. **Transmittal 2386** provides the following guidance:
Effective January 1, 2012, under the hospital OPPS, hospitals are advised to report both the existing CPT “stacked” test codes that are required for payment and the new single CPT test code that would be used for payment purposes if the new CPT test codes were active.

The word “advised” suggests this reporting is voluntary. However, providers must carefully consider the future impact of not reporting both sets of codes. If providers don’t report both sets of codes, incomplete and insufficient claims data will be used to determine the payment amount for these services.

These molecular pathology tests are complex. If providers don’t report both sets of codes, the resulting payment determination could be insufficient for the services provided. Providers should be sure to read the entire section of the transmittal pertaining to reporting these codes.

Note that Transmittal 2386, which was published January 13, replaces Transmittal 2376.

Correct use of modifiers -FB and -FC

Our billing office is concerned about reports that the OIG is auditing for appropriate use of the following modifiers:

➢ -FB (Item provided without cost to provider, supplier or practitioner, or credit received for replacement device [examples, but not limited to, covered under warranty, replaced due to defect, free samples])
➢ -FC (Partial credit received for replaced device)

We know these audits may be related to pacemaker recalls. Our billing office doesn’t typically know whether pacemakers are replaced due to a recall or because the battery simply needed replacement. No one seems to know at the time of the procedure whether the cost is discounted and whether modifier -FC is applicable. Billing office staff members say they know this information only when the invoice arrives.

Can you help us sort this out?

CMS has required hospitals to append modifiers -FB and -FC since 2007 and 2008, respectively, to reflect the reporting of a device that the provider obtains at no cost (modifier -FB) or at a discounted cost (modifier -FC).

The modifiers are appropriate for reporting devices related to a recall, among other situations. Append modifier -FB when a facility incurs no cost for replacing a device or receives full credit for the cost of a device. For example, a patient has a previously placed pacemaker in 2009 and the device’s battery is failing based on tests done in the physician’s office. The manufacturer is required to provide a new device free of charge since the battery is covered under warranty for five years. The hospital will get paid to replace the device; however, the vendor should supply the device free of charge since it is under warranty.

Append modifier -FC when a facility receives a manufacturer credit of 50% or more of the cost of a device. For example, a patient has a previously placed dual-chamber pacemaker and presents to have it removed due to a recent recall. The physician decides at the time of implantation that, due to other symptoms, he or she will place an automatic implantable cardioverter-defibrillator (AICD) instead of replacing the dual-chamber pacemaker. In this scenario, the hospital has to identify what the upgraded cost is due to the AICD versus the original dual-chamber pacemaker.

Contributors

We would like to thank the following contributors for answering the questions that appear on pp. 10–12:

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When CMS packaged the cost of devices into the APC payment for the procedures, the total APC payment is largely due to the cost of the device. In the 2007 and 2008 OPPS final rules, CMS stated it believes a facility should receive reduced payment when it obtains a device at a decreased cost.

CMS believes that the Medicare program or a beneficiary should not pay for something that a facility receives at a substantially discounted cost. As a result, the agency created these modifiers for use in these instances. Report the appropriate modifier with the HCPCS code for the procedure—not the device. Appending the modifier triggers a reduced APC payment.

Establish a communication process to ensure that the appropriate parties know how to identify situations in which one of these modifiers is applicable.

We suggest that the hospital develop an internal strategy for identifying these situations before they are scheduled. Have the staff ask at the time of scheduling whether the procedure being scheduled is due to a recall or warranty issue. If so, is it considered an upgrade to the previously placed model? Additionally, since the modifier can be placed by different people in each institution, you should create a sticker that flags this situation and is in the permanent record so the coder or other person can easily identify when this type of scenario occurs. After placing the -FB or -FC modifier, e-mail a chain notification to materials management and billing so they can manually adjust the cost/charge based on the appropriate charge scenario described above.

CMS realized providers may not know information about partial discounts at the time a procedure is performed, so it published the following instructions in the January 2008 update to OPPS in Transmittal 1417:

Because hospitals may not know at the time the device replacement procedure takes place whether or how much credit the manufacturer will provide for the device, hospitals have the option of either: (1) submitting the claims immediately without the FC modifier and submitting a claim adjustment with the FC modifier at a later date once the credit determination is made; or (2) holding the claim until a determination is made on the level of credit.

The modifiers do not apply to every scenario in which a facility receives an item at a discounted cost. CMS provides a specific list of devices and APCs for which the cost of a device accounts for the majority of the APC payment and for which these modifiers are applicable based on the percentage of payment related to the device at www.cms.gov/HospitalOutpatientPPS/HORD/list.asp. Select the Final Changes to the Hospital Outpatient Prospective Payment System and CY 2009 and then the file titled “OPPS Final Without Cost or With Credit Device Information.”

CMS provides additional instructions in the Medicare Claims Processing Manual, Chapter 4, §§20.6.9, 20.6.10, and 61.3 for reporting the modifiers and charges.