Successful appeals can actually lead to CMS policy changes. Facilities have been successfully appealing to receive Part B payments after a Medicare review contractor denied a Part A stay as not medically necessary. As a result, CMS is changing its policy on rebilling for Part B services.

CMS issued a ruling and a proposed rule March 13 outlining its new policy for Part B payments after Part A payment is denied as not reasonable and necessary.

“It is important to note that any denials under appeal as of now fall under the guidance of the ruling. After the proposed rule is finalized, the guidance of the proposed rule is in effect,” says Valerie Rinkle, MPA, vice president of revenue integrity informatics for Health Revenue Assurance Associates in Plantation, Fla.

Hospitals have an important opportunity to look at any appeals they have and decide whether they should withdraw those appeals and resubmit Part B claims because the one-year timely filing deadline will not apply until this provision is finalized with the publication of the final rule, Rinkle says.

Hospitals have appealed Part A inpatient claim denials to the Administrative Law Judges (ALJ) and the Medicare Appeals Council. The ALJs often upheld the Medicare review contractor’s determination that the

Molecular pathology reimbursement still unclear

In the second article in a series, we look at how facilities are being reimbursed for the new molecular pathology codes.

CMS adds, deletes APCs, deletes modifiers

Learn what changes CMS made to the I/OCE for April.

This month’s coding Q&A

Our experts answer questions about modifiers for diagnostic interventional procedures, Medicare recognition of CPT code 90661, reporting add-on code for psychotherapy with interactive complexity, reporting G0378 for all payers, and wound care coding.

The number of codes added to the conditionally bilateral list in the April I/OCE update.

The number of additions to the procedure/device code pair requirements as part of the April I/OCE update.

### Quick Hits

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**FROM THE FIELD**

“Since this interim rule is binding on all MACs and Recovery Auditors and effective on March 13, it immediately suspends the current procedure and opens the door for providers to have another opportunity to collect payment for medically necessary services that would have otherwise been written off.”

Debbie Mackaman, RHIA, CHCO

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inpatient admission was not reasonable and necessary. However, the ALJs ordered CMS to pay for the services as if they were rendered at an outpatient or “observation level” of care.

As a result, Medicare then paid for all Part B services that would have been payable if the beneficiary had been treated as an outpatient. In the past, CMS only paid for a limited set of Part B inpatient services that are designated in the Medicare Benefits Policy Manual, Chapter 6, Section 10.

“Since this interim rule is binding on all MACs and Recovery Auditors [RAs] and effective on March 13, it immediately suspends the current procedure and opens the door for providers to have another opportunity to collect payment for medically necessary services that would have otherwise been written off,” says Debbie Mackaman, RHIA, CHCO, regulatory specialist for HCPro, Inc., in Danvers, Mass.

The ruling

The ruling is a temporary measure until CMS can address issues raised by the ALJ and decisions made by the Medicare Appeals Council.

Under the ruling, hospitals may submit a Part B inpatient claim for payment for the Part B services that would have been payable to the hospital had the beneficiary originally been treated as an outpatient rather than admitted as an inpatient. Again, this only applies if the Part A claim was denied because the admission was not reasonable and necessary.

“Unlike inpatient Part B-only claims to date, which paid a very limited set of services, under this ruling Part B payment on an inpatient-only claim will be made for both diagnostic and therapeutic services,” Rinkle says.

This is especially important for a case where surgical services were rendered. These will now be paid under Part B. Only those services that require an explicit outpatient status when they are delivered in order to be covered will not be paid under Part B, such as:

- Outpatient visits
- ED visits
- Observation services

Providers should note that the timely filing requirement does not apply during the ruling. “Hospitals have a big window to file medically necessary services under Part B claims as long as they make the decision within 180 days of the MAC’s or RA’s decision to deny payment as an inpatient,” says Mackaman.

Both Mackaman and Rinkle stress the importance of hospitals using the time provided under the ruling—and before the proposed rule is finalized—to consider rebilling old claims.

“Providers have an opportunity now to submit Part B claims for denials on very old cases—three years back,” Rinkle says.

Once the proposed rule is final and the one-year timely filing limit is set, then the hospitals would not be able to file a Part B claim.

“This is key—they have an opportunity within the next 90 days or so to withdraw appeals of older claims and submit Part B inpatient-only claims,” Rinkle says.

Providers can still file an appeal after the determination by a MAC or RA, Mackaman adds. This interim rule doesn’t prevent this option; however, if a hospital chooses to appeal, it cannot bill for Part B services until after a decision is made.

After the decision is made at that level of appeal, the provider will have 180 days to submit the Part B claim for those services that have been deemed to not be medically necessary in the inpatient setting, regardless of meeting timely filing requirements for the Part B claim.

The ruling is complex and will require hospitals to carefully read and consider what actions to take. For example, between now and when the proposed rule is finalized, the one-year timely filing requirement is not being enforced, so hospitals should carefully decide whether to withdraw appeals of denied inpatient stays that are older and resubmit inpatient Part B claims under this ruling, Rinkle says.

With the ruling and proposed rule, CMS is ending the Part A to Part B Demonstration Project. That means all providers can rebill under Part B, not just those providers who were participating in the demonstration project, Mackaman says.

The ruling clarifies that services delivered when the patient was in an outpatient status (i.e., the three-day or one-day bundling window) can be billed as regular 13x Part B claims for payment and only those services
rendered after the date and time of the inpatient order are billed on the inpatient-only 12x Part B claim, Rinkle says.

Providers should also note that the ruling does not apply to a denial where the time frame to appeal has expired or if the hospital has determined through its own review processes that the inpatient admission was not reasonable and necessary, Mackaman says.

**The proposed rule**

At the same time CMS released the ruling on Part A to Part B rebilling, it also released a proposed rule, Medicare Program; Part B Inpatient Billing in Hospitals. Once the rule is finalized, after a 60-day comment period and CMS review, it will replace the ruling for denials as of the date of the final rule and beyond.

The main difference between the ruling and the proposed rule is the enforcement of the timely filing requirement.

If a provider receives a decision by a MAC or RA that the services were not medically necessary in the inpatient setting and that decision falls beyond one year from the date of the inpatient stay, the provider will not be able to file a Part B claim because the new claim would not meet timely filing requirements.

In these cases, the provider would not be able to collect any outpatient payment even when it is appropriate to do so, Mackaman says.

Because of the timely filing requirement, hospitals will need to consider the time it will take a contractor to respond to an appeal, Rinkle adds.

“Effectively, hospitals have to choose between Part B payment or no payment should they fail to prevail with an appeal because the appeal process takes so much time,” she says.

CMS discussed the increased time many patients are spending in observation in the 2013 OPPS Final Rule, as well as the proposed rebilling rule. One reason for the increased length of stay in observation may be that hospitals are taking a conservative approach to admitting patients. Instead of admitting a patient, the physician decides to place the patient in observation.

The proposed rule may not change the thought process for when to admit a patient or place the patient in observation, but it may get hospitals thinking about their processes.

“I hope hospitals are working with their computerized physician order entry sets and their medical staff to help ensure documentation of the severity of illness and intensity of service and risks associated with not being an inpatient are accurately captured at the time of the decision to admit the patient as an inpatient,” Rinkle says.

The proposed rule makes it clear that services delivered while the patient is an outpatient, including observation services, can be billed for full Part B coverage and payment, she adds. Only those services rendered after the time and date of the inpatient admission order are to be considered for potential inpatient-only Part B billing.

For those accounts “self-audited” by the hospital (i.e., not denied) before a hospital can file a Part B inpatient claim, the hospital must first submit a “no-pay” Part A claim.

The facility can only rebill the claim as a Part B inpatient claim if that claim is denied because the MAC or RA determined the inpatient admission was not medically necessary or after a “no-pay” Part A claim is submitted.

Billing self-administered drugs as non-covered and any associated drug administration services for these drugs such as insulin injections is likely to trip up providers.

It is a time-consuming billing process, Rinkle says. “This is why the ultimate answer is to get the patient status correct from the outset with good and defensible documentation to support it.”

The proposed rule was published in the Federal Register March 18. CMS is accepting comments on the proposed rule until May 17.

Facilities may submit comments electronically, via first class or express mail, or via hand delivery to CMS.

Visit [www.regulations.gov](http://www.regulations.gov) and search for Medicare Program; Part B Inpatient Billing in Hospitals. Look for the Submit Comment link above the name of the document. Click on this link, input the requested information, and click Submit. This completes the process and provides a tracking number for comments.
Molecular pathology reimbursement still unclear

Editor’s note: Facilities need to address coding, payment, and coverage issues for molecular pathology. This article is the second in a series and discusses reimbursement for molecular pathology.

The AMA revised the molecular pathology codes in the CPT® Manual in 2012, but at that time CMS did not adopt the codes as it was still debating whether and how to change the reimbursement system for these services going forward. For CY 2013, CMS elected to recognize the codes, which meant it had to finalize how to pay for them. While CMS did not change payment for these services under the Clinical Laboratory Fee Schedule (CLFS) despite industry pressure, its change to the new codes means a change in the payments providers can expect this year and in the future.

In the past, facilities reported stacking codes for molecular pathology, meaning they reported a different code for each step of the procedure required to perform the test, rather than being able to report the actual test (e.g., KRAS) that was performed.

As a result, payers could not know from the claims data exactly what they were paying for, which made it almost impossible for them to deny claims for coverage reasons, says Jugna Shah, MPH, president and founder of Nimitt Consulting.

With the new test-specific molecular pathology CPT codes, payers now know exactly what tests are being performed and have begun releasing guidance as to what they will and will not cover, resulting in increased denials for providers.

“Payers are beginning to release coverage decisions that are all over the board,” Shah says. “Providers will be able to appeal denials and they may win when they show the clinical rationale behind the test, but this increases provider burden and cost.”

For certain tests, such as KRAS, payers seem to be on the same page allowing coverage, but in general providers are definitely seeing a wide range of payer policies right now, says Michelle L. Ruben, project manager of revenue and rate setting strategy at M.D. Anderson Cancer Center in Houston.

Payment in 2013

Medicare did not recognize the new molecular pathology codes in 2012, but it does for 2013, and payment comes from the CLFS. Because these are new codes, each MAC will come up with its own rates this year, primarily using what’s called the gap-fill method, Shah says.

Gapfilling is used when no comparable existing test is available. In the first year, carrier-specific amounts are established for the new test code using the following sources of information to determine gapfill amounts, if available:

- Charges for the test and routine discounts to charges
- Resources required to perform the test
- Payment amounts determined by other payers
- Charges, payment amounts, and resources required for other tests that may be comparable or otherwise relevant

In the second year the test code is paid at the national limitation amount, which is the median of the carrier-specific amounts.

Contractors are required to submit their payment rates to Medicare by April 1, and CMS will post interim carrier-specific amounts on its Web site by April 30. CMS will accept written comments on those rates for 60 days. After reviewing the comments, CMS will post final carrier-specific amounts on its website.

CMS will then accept reconsideration requests for 30 days. After reviewing the reconsideration requests, CMS may decide to change the payment amount or revise the national limitation amount for the test. If CMS revises the payment amount, the new amount of payment is final and is not subject to further reconsideration.

In the meantime providers haven’t received any payment from Medicare for their molecular pathology services, says Shah.

Providers are definitely frustrated by having to wait to receive payment from Medicare given that CMS issued a final rule last year indicating these services
will be paid under the CLFS, Shah says. It may be that Medicare wants to sign off on the rates contractors come up with before allowing them to pay providers, but in the meantime providers are seeing their molecular pathology line items go unpaid.

What is unclear is whether providers will have to resubmit claims containing molecular pathology services once payment rates are released in order to get paid or whether the MACs will simply reprocess claims. It’s going to be administratively burdensome if providers have to resubmit their claims in order to get paid, Shah says.

In addition, each MAC issues its own coverage policy regarding which molecular pathology tests it will and will not cover. “Not all MACs or commercial payers have released their policies as they are probably still creating them, but we can definitely expect to see more coverage restrictions now that the codes are test specific,” says Shah.

In the past, payers did not write a significant number of policies regarding molecular pathology tests because it wasn’t easy to enforce them without knowing what tests were being reported with the stacking codes, yet some medical policies may have existed, says Ruben. “What we are starting to see is that unless someone has proactively written a policy to cover a specific test, payers are denying the test,” Ruben says.

The reimbursement landscape is murky at present. Some payers currently have very few policies.

Other payers created policies stating that unless the payer has written a specific policy covering a test, the payer will not cover it.

As a result, payers are denying tests that should be covered, Ruben says. They might end up being covered, but someone within each facility must track current and future payer policies, monitor denials, and work through appealing them if payment is to be seen, she says.

**Tracking payment and denials**

Individual laboratories and facilities need to track what payment rates their contractor is paying and also what tests the contractor is denying.

M.D. Anderson has been inundated with denials from payers since January 1, Ruben says.

A lot of the payers have started putting out new policies, but the process is not complete. Ruben sees gaps where tests should be covered, but the payer hasn’t created a specific policy.

M.D. Anderson is currently working to determine which denials to focus their appeal efforts on to close the coverage gap, she says.

Just because a payer denies the test doesn’t necessarily mean they won’t cover it. But facilities and laboratories are going to have to appeal denials and make a case for why the tests should be covered, Shah says.

Because different payers send payment at different rates—some faster than others—Ruben and the M.D. Anderson team haven’t uncovered any across-the-board trends for denials and payments yet.

“We are seeing payments from our commercial payers,” Ruben says. Not everything is being denied, but the number of denials is higher than the M.D. Anderson team thinks they should be.

“So we are sifting through the denials and prioritizing which ones to address with the payers based on revenue, volume, and the overall impact to the organization,” Ruben says.

Don’t forget that all of this is new to the payers as well, which may contribute to some of the unexpected denials. For example, when a payer set up its edits or wrote its medical policy it may not have realized that facilities used to report several different codes to test for a specific gene and now that has changed so its edits also need to change.

“We have to identify where those issues are and work on them,” Ruben says.

Most facilities likely have a process in place to track denials and spot trends. If not, then the facility needs to create a system to log denials and analyze which ones are appropriate versus the ones that need to be appealed.

Providers may need to spend time and effort educating their payers on the importance and cost-effectiveness of molecular pathology tests in order to see more favorable coverage decisions, says Shah.

**Tier 2 codes**

The AMA divided the new molecular pathology codes into two tiers:

- Tier 1 (CPT codes 81200–81383) represents gene-specific and genomic procedures and are more
commonly performed tests.

- Tier 2 codes (84000–81408) describe molecular pathology procedures not listed in Tier 1. These codes are categorized according to the level of technical resources and interpretive professional work required.

Tier 2 codes can include up to 50 different analytes, which could complicate the contractor’s ability to craft a payment policy.

What happens when a contractor wants to allow two or three of those analytes to go through under its medical policy, but wants to deny the others?

That’s one area that remains unclear. Contractors could deny everything under the Tier 2 code and force the facility to appeal to prove that the analyte should be covered, Ruben says.

“Even though it’s not an unlisted code, it may be treated the same way when it goes through the payer’s system,” she says.

One solution is to include the gene name for any Tier 2 or unlisted code, and M.D. Anderson’s MAC, Novitas, has already asked facilities and laboratories to submit this information on the claim.

While that option requires additional work on the front end, it’s better than having the payer deny all Tier 2 codes and forcing the provider to appeal.

Some payers may allow a certain Tier 2 code to always go through the system because the payer knows that it would pay for most of the tests under that code, Ruben says.

Still other payers may deny all Tier 2 codes and force providers to appeal, says Shah.

Setting charges

Another piece of the reimbursement puzzle for molecular pathology tests is actually within the provider’s control.

Payers determine reimbursement rates, but providers know their costs and need to set their charges appropriately.

Facilities can’t simply cross-walk their old stacked codes to the new Tier 1 or Tier 2 codes. They will need to put some thought into how they charged for stacked codes and how they will charge for the new molecular pathology CPT codes, says Shah.

Start by looking at the historic data. Determine how much reimbursement the facility received in the past for claims related to certain high-volume tests that were ordered. This will require looking at medical records to identify claims for certain tests rather than just looking at claim with certain codes, since stacked codes were used and they weren’t test specific.

This will take some work but is an important exercise to undertake if charges are going to be set accurately for the new molecular pathology gene-specific test codes, says Shah.

Ask what resources were used to perform the service, and here the stacked codes may help because providers can see the different steps that were involved in the past to perform a specific test that was ordered.

Facilities need to know what the total charge was for the service so they can thoughtfully develop charges for each single code, Shah says.

Designate a tracker

Ruben and the staff at M.D. Anderson have been tracking the molecular pathology changes for years because M.D. Anderson performs a large volume of molecular pathology tests.

Other facilities may not be as on top of the problem, especially if the facility or laboratory does not perform a very high volume of molecular pathology tests.

At facilities that do provide a high volume of these services, the question should be raised now about who is managing the coding, tracking denials, and embarking on appeals. Is it just denials management dealing with denied claims, or is the laboratory getting involved?

“People need to be asking and addressing these questions now since denials for these services has not occurred in the past in the manner it’s happening now,” Shah says.

“For some payers, it’s not easy to track what’s not getting paid since payments are made at the claim-level versus the molecular test CPT line level.” Ruben says. “Unless you have a robust denials tracking system, it can be a lot of work to track.”

“We’ll have to keep monitoring what’s happening throughout this year since the reimbursement environment for molecular pathology is changing and we’ll know more once Medicare contractors start making payments,” says Shah. 

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May 2013 HCPRO.COM
April I/OCE updates

CMS corrects edit 84, deletes modifiers

CMS corrected edit 84, added five APCs to the I/OCE, deleted two APCs, and changed the description of another as part of the April updates to the I/OCE. In addition, CMS deleted all of the genetic testing modifiers, retroactive to January 1.

In the January release, edit 84 was set up with five add-on codes:
- 33225, insertion of pacing electrode, cardiac venous system, for left ventricular pacing, at time of insertion of pacemaker [including upgrade to dual-chamber system] [list separately in addition to code for primary procedure]
- 90785, psychotherapy, complex interactive
- 90833, psychotherapy, 30 minutes with patient and/or family member when performed with an evaluation and management service [List separately in addition to the code for the primary procedure]
- 90836, psychotherapy, 45 minutes with patient and/or family member when performed with an evaluation and management service [List separately in addition to the code for the primary procedure]
- 90838, psychotherapy, 60 minutes with patient and/or family member when performed with an evaluation and management service [List separately in addition to the code for the primary procedure]

Codes 90785, 90833, 90836, and 90838 were added in January. For these four codes edit 84 was only to surface if they were used with an outpatient hospital when they were billed on a claim with bill type 013x with condition code 41x, says Dave Fee, MBA, product marketing manager of outpatient products at 3M Health Information Systems in Murray, Utah.

For the first quarter of 2013, edit 84 worked fine for revenue code 076x, but would surface whenever bill type 013x was used, regardless of the condition code, Fee says.

It is being corrected for the April 2013 release. CMS added the following APCs to the I/OCE:
- 01458, ophthalmic mitomycin
- 01449, Talymed®
- 09130, injection, IVIG Bivigam
- 09297, omacetazine mepesuccinate
- 09298, injection, ocriplasmin

All five APCs have a status indicator G (pass-through drugs and biologicals). The change was effective April 1.

CMS added the following HCPCS codes to the I/OCE:
- C90948, ophthalmic mitomycin
- C90949, Talymed®
- C90297, omacetazine mepesuccinate
- C90298, injection, ocriplasmin
- C9734, focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with or without magnetic resonance (MR) guidance
- C9735, anoscopy; with directed submucosal injection(s), any substance
- Q0507, miscellaneous supply or accessory for use with an external ventricular assist device

Effective April 1, CMS added the following HCPCS codes to the I/OCE:
- C9130, injection, IVIG Bivigam
- C9297, omacetazine mepesuccinate
- C9298, injection, ocriplasmin
- C9734, focused ultrasound ablation/therapeutic intervention, other than uterine leiomyomata, with or without magnetic resonance (MR) guidance
- C9735, anoscopy; with directed submucosal injection(s), any substance
- Q0507, miscellaneous supply or accessory for use with an external ventricular assist device
• Q0508, miscellaneous supply or accessory for use with an implanted ventricular assist device
• Q0509, miscellaneous supply or accessory for use with any implanted ventricular assist device for which payment was not made under Medicare Part A

Codes C9130, C9297, C9298, C9734, and C9735 are all subject to edit 55 (non-reportable for site of service). Codes C9130, C9297, and C9298 have status indicator G. C9734 has a status indicator S (significant procedure, not discounted when multiple) and C9735 has a status indicator T (significant procedure, multiple reduction applies).

Codes Q0507, Q0508, and Q0509 all have status indicator A (Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS).

CMS also deleted HCPCS code C9367 (Endoform Dermal Template) retroactive to January 1 and HCPCS code Q0505 (miscellaneous supply or accessory for use with ventricular assist device) effective April 1.

**Status indicator and edit changes**

Codes 90661 (influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use) and L0430 (spinal orthosis, anterior-posterior-lateral control, with interface material, custom fitted (dewall posture protector only) are among several with status indicator changes. What should be noted about these two is relative to the coverage dates, Fee says.

CPT code 90661 has a status indicator change from an E to an L. This is a vaccine now paid a reasonable cost and not subject to copayments or deductible payments. That change is effective 1 Oct 2012. However, the FDA approval date is 20 Nov 2012. CMS had to make the SI change effective with the start of the 4th quarter in 2012 so it could pay at any point in the quarter. The outcome is that if one bills this code on a claim, before 20 November 2012, an edit 67 (“Service provided prior to FDA approval).

HCPCS code L0430 is the reverse. It is changing from SI of A (payable by fee schedule) to an SI of E (not covered by Medicare). That change is effective Jan 2013. It has a non-coverage date, when it would be no longer covered by Medicare of 17 November. The implementation of this is that if this service is billed after the non-coverage date, edit 83 (“Service provided on or after effective date of NCD non-coverage”) will surface.

CMS changed the status indicator for the following HCPCS codes from E (not paid under OPPS) to N (items and services packaged into APC rates):

- L8680, implantable neurostimulator electrode, each
- L8682, implantable neurostimulator radiofrequency receiver
- L8685, implantable neurostimulator pulse generator, single array, rechargeable, includes extension
- L8686, implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
- L8687, implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
- L8688, implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension

The change is retroactive to January 1 and the codes are no longer subject to edit 28 (code not recognized by Medicare; alternate code for same service may be available).

CMS reassigned the following HCPCS codes from status indicator E to status indicator A:

- L8683, radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver
- L8684, radiofrequency transmitter (external) for use with implantable sacral root neurostimulator receiver for bowel and bladder management, replacement

The change is retroactive to January 1 and the codes are no longer subject to edit 28.

HCPCS code L0430 spinal orthosis, anterior-posterior-lateral control, with interface material, custom fitted (dewall posture protector only) moved from status indicator A to status indicator E and is now subject to edit 9 (non-covered for reasons other than statute).
Modifier for diagnostic interventional procedures

Our physicians perform diagnostic interventional procedures in the head and neck, represented in the past by CPT® codes 36215–36217. Previously, the cath lab personnel assigned the appropriate 70000 series code to reflect the appropriate supervision and interpretation. With the new 2013 bundled codes, our HIM department is responsible for the assignment of the procedure codes. They are confused about which modifier they should append to the codes defined as unilateral. For procedures performed on the lower extremities, we were instructed to use modifier -59 (distinct procedural service) when the same procedure is performed bilaterally. Which modifier is appropriate?
Previously, facilities reported a catheter placement procedure (CPT codes 36215–36218) with the appropriate 70000 series code for supervision and interpretation when a diagnostic procedure of the head and neck was performed.

Effective January 1, the AMA bundled the catheter placement and supervision and interpretation components into one CPT code. CPT codes 36221–36228 now represent the total procedure performed.

With the exception of CPT 36221, these new codes are defined as unilateral procedures. The 2013 CPT coding guidelines state that when the same procedure is performed on both sides, append modifier -50 (bilateral procedure) to codes 36222–36228.

However, if the providers performed a procedure on both sides, but the procedures are not identical, then you should use modifier -59. If the procedures are not identical, it is not a “true” bilateral study, but rather a study of different arteries on different sides.

CPT codes 36221–36228 did not replace CPT codes 36215–36218 (selective catheter placement above the diaphragm). Coders should still report these codes for catheter placement when the procedure performed requires separate reporting of the catheter placement plus a surgical procedure code, plus a supervision and interpretation code—for example, a therapeutic procedure.

Medicare recognition of CPT code 90661

Q We have been providing Flucelvax® to non-Medicare patients when prescribed by their physicians. Is Medicare going to recognize this as a reportable drug (CPT code 90661)?

A CMS acknowledges CPT codes for procedures/tests/services, but may not provide coverage or payment for them.

The AMA established CPT code 90661 in 2008, but the FDA did not approve the vaccine until November 20, 2012.

In Transmittal R2664CP, CMS announced that beginning April 1, 2013, it will recognize this CPT code as a covered and reimbursable service. The status indicator will change from E to L and be effective retroactive to November 20, 2012.

Reporting add-on code for psychotherapy with interactive complexity

Q When should we use new add-on code 90785 for interactive complexity for psychotherapy?

A The term “interactive complexity” means that the provision of psychiatric services has been complicated by a dysfunction of the patient’s ability to communicate with the physician and participate in the process of diagnosis and treatment. Factors that may interfere with the delivery of psychological services include:

- Emotional and/or acrimonious family members
- Verbally impaired or undeveloped patient
- Patients with a third-party involvement such as those with another individual legally responsible for the patient’s care, the need for an interpreter (language translator), child welfare agency

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representative, parole/probation officer, school official, etc.

The AMA has identified four qualifiers. The provider must document at least one of these to support the reporting of add-on code 90785:

- Need to manage maladaptive communication among participants that complicates delivery of care
- Caregiver emotions or behavior that interferes with the caregiver’s understanding and ability to assist in the implementation of the treatment plan
- Evidence or disclosure of a sentinel event and mandated report to a third party with initiation of discussion of the sentinel event and/or report with patient and other visit participants
- Use of play equipment, other physical devices, interpreter, or translator to communicate with the patient to overcome barriers to therapeutic or diagnostic interaction between the physician, or other qualified healthcare professional, and a patient who:
  - Is not fluent in the same language as the physician or other qualified healthcare professional
  - Has not developed, or has lost, the ability to explain his or her symptoms, the ability to understand the physician, or is unable to respond to treatment

This add-on code to report interactive complexity (90785) may be used in conjunction with almost any other psychotherapy codes except 90839 and 90840 (psychotherapy in crisis). This code may not be reported accompanying an E/M service code without the concurrent provision of psychotherapy services codes.

**Reporting G0378 for all payers**

Q Should we use the observation code G0378 when billing all payers, Medicare and commercial?

A You’re going to have to check with each individual payer. Physicians use E/M codes to bill for their professional services when the patient is in observation or even when they’re an inpatient and are admitted and discharged the same day.

Some commercial payers want the hospital to use those same physician E/M codes, and some payers want them to use the G0378.

The same thing is true with Medicaid, but it varies by state. It seems that more of the Medicaid payers want you to use the same codes that Medicare uses, but there’s no pat answer. You’re just going to have to check with the payer to determine its expectations.

**Billing for separate wounds during one visit**

Q I work at a critical access hospital (CAH) and we have just recently started our outpatient wound care department. We have a patient who is being treated for two separate wounds with two separate types of treatments on the same patient visit.

• Wound #1: The physician treats this wound with a skin substitute graft.
• Wound #2: The wound care nurse is responsible for the wound care and dressings.

In this scenario, are we able to bill/code both services since it is for two separate wounds?

A In the scenario you described, you would bill the skin substitute application for the first wound and an E/M code for the second one. Remember to append modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M code.

**Wound care in the postoperative setting**

Q If the surgeon turns the postoperative care over to the wound clinic, would we use modifier -55 (Postoperative services only) and use the surgical procedure code?

For example, the surgeon does an appendectomy (CPT code 44950). Then the wound clinic takes over care and performs a debridement (CPT 97597).

Would the wound clinic bill 44950 with modifier -55 or bill 97597?

A If the debridement procedure is related to appendectomy surgery, use modifier -55.

In my experience, most wound clinics bill 97597 with any postoperative-related modifier.