

APC Answer Letter

ANSWERS TO YOUR CHALLENGING CODING, COMPLIANCE, AND REIMBURSEMENT QUESTIONS

Condition code 44

Utilization review committee agreement

Q Can you explain when you would need one physician on the utilization review (UR) committee to agree that the admission was not medically necessary and when you need two physicians from the committee to agree?

A I think that's been a very important question as we think about condition code 44.

The initial *Conditions of Participation* guidelines say that we need two physicians on our UR committee. That way, if the attending physician disagrees that the patient should not be an inpatient, those two physicians can override the attending physician; however, that instruction is for the UR committee looking at cases post-discharge.

In the condition code 44 scenario, it has been less clear as to whether two physicians can override

the attending physician and still allow the hospital to bill condition code 44.

My opinion is that they cannot. Two cannot override one for condition code 44; that's based on the wording of *Transmittals 1760 and 1803* that are now part of the *Medicare Claims Processing Manual*.

It says that the concurring physician must be the physician responsible for the care of the patient. So

then the hospital is at a catch-22. If you have one of those physicians who is uncooperative and thinking you're looking for the flavor of the month as far as level of care and does not agree to change the status, you're stuck.

You have a case in which you cannot change that physician's order, and as we interpret the guidelines, neither can two physician advisors overturn the attending physician and use condition code 44.

I believe the instruction is saying that, if the attending refuses to agree during the patient's hospitalization to change to outpatient status, then our recourse is to go to the UR committee function post-discharge where two physicians can override the attending and allow the hospital to bill a compliant claim.

Unfortunately, that prevents the hospital from receiving payment for all of the services it provided. The hospital will be able to bill only for the diagnostic services.

This month's tip—Did you know that packaged services and bundled services represent different concepts? Turn to p. 5 to learn more about how these two concepts differ.

IN THIS ISSUE

ED

- p. 2** Non-incisional removal of foreign body
- p. 3** Charging for drug administration in ED by nurse
- p. 3** E/M and HCPCS L-code

HCP Pro

Modifiers

- p. 4** Correct use of modifier -JW
- p. 4** Modifiers -58 and -78

Observation

- p. 5** Billing for 40 hours

Packaged and bundled services

- p. 5** Concepts are different

APC Answer Letter 2010 index

- p. 7** Easily access last year's questions and answers

ED

Non-incisional removal of foreign body

We have assigned the non-incisional removal of a foreign body to an ED tier level.

If a digital block is also performed, should this be assigned a CPT code? If so, what are your recommendations for the CPT code?

The appropriate assignment of a CPT code for foreign body removal from the integumentary system hinges on the approach to the foreign body removal. Specifically, if the foreign body removal requires the clinician to make an incision into the integumentary system as part of the removal process, and the removal is simple, the appropriate CPT code for the incision and removal of the foreign body would be CPT code 10120.


Another CPT code, 10121, designates a complicated removal. The differentiation between “simple” and “complex” is the inherent difficulty or complicating factors associated with the incision and foreign body removal as described by supporting clinical documentation of the procedure performed, such as the need to perform dissection of underlying tissue to successfully remove the underlying tissue. Look to the supporting documentation to determine the appropriate code assignment.

If the physician did not need to make an actual incision of the integumentary system as part of the removal process, it would not be appropriate to assign a surgical CPT code to capture the foreign body removal. Instead, as stated in your question, the proper capture of this procedure is to include the procedure as part of your hospital-defined ED facility E/M criteria.

As for your question of assigning a separate code for the digital block, if the foreign body removal requires an incision as part of the removal process and digital block is used, the digital block is included as part of the definition of surgical package, according to the CPT surgery guidelines as follows:

In defining the specific services “included” in a given CPT surgical code, local infiltration, metacarpal/metatarsal/digital block or topical anesthesia is always included in addition to the operation per se.

Accordingly, the digital block service would not be billed in addition to the CPT code for incision and removal of foreign body. Conversely, if a digital or peripheral nerve block is provided in conjunction with a non-incisional removal of a foreign body, CPT code 64450 may be assigned in addition to the facility-guided E/M criteria since it has not been provided as part of a bundled procedure code. This guidance adheres to official CPT surgical package and general coding guidelines.

Monthly Contributors	APC Answer Letter
	Group Publisher: Lauren McLeod Executive Editor: Ilene MacDonald, CPC Managing Editor: Gerl Spanek, gspanek@hcpro.com Contributing Editor: Frank J. Freeze, LPN, CCS, CPC-H Principal, The Wellington Group Independence, OH
Andrea Clark, RHIA, CCS, CPC-H <i>President</i> Health Revenue Assurance Associates Plantation, FL	Gale D. Robinson, CPC <i>Chargemaster Coordinator</i> Knox Community Hospital Mount Vernon, OH
Kimberly Hoy, JD, CPC <i>Director of Medicare and Compliance</i> HCPro, Inc. Danvers, MA	Candace E. Shaeffer, RHIA, RN, MBA <i>Chief Compliance Officer</i> LYNX Medical Systems, Inc. Bellevue, WA
Glenn Krauss, RHIA, CCS, CCS-P, CPUR <i>Independent HIM consultant</i> Madison, WI	Denise Williams, RN, CPC-H <i>Director of Revenue Integrity Services</i> Health Revenue Assurance Associates, Inc. Plantation, FL
Valerie Rinkle, MPA <i>Revenue Cycle Director</i> Asante Health System Medford, OR	
<small> APC Answer Letter (ISSN: 1535-7945 [print]; 1937-7665 [online]) is published monthly by HCPro, Inc., 75 Sylvan St., Suite A-101, Danvers, MA 01923. Subscription rate: \$299/year. • Copyright © 2011 HCPro, Inc. All rights reserved. Printed in the USA. Except where specifically encouraged, no part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro, Inc., or the Copyright Clearance Center at 978/750-8400. Please notify us immediately if you have received an unauthorized copy. • For editorial comments or questions, call 781/639-1872 or fax 781/639-2982. For subscription information, call customer service at 800/650-6787, fax 800/639-8511, or e-mail customerservice@hcpro.com. • Occasionally, we make our subscriber list available to selected companies/vendors. If you do not wish to be included on this mailing list, please write to the marketing department at the address above. • Opinions expressed are not necessarily those of APCAL. Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions. <i>Current Procedural Terminology (CPT)</i> is Copyright © 2010 American Medical Association (AMA). All rights reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. </small>	

Charging for drug administration in ED by nurse

Q A patient comes into the ED and the nurse administers drugs as an injection or IV. Do we charge an administration fee for this? Would the nurse need to document a start and stop time? Or would it be a specific charge determined by what the drug is and how it is administered? Would the charge be a part of the drug charge itself? I want to make sure we are charging this appropriately to Medicare.

If Medicare does pay for an administration fee, how much would it pay in a percentage figure?

A Medicare recognizes the drug administration codes in the *CPT Manual*, and hospitals should use them in accordance with their definitions and the documentation for the services they render. Because drug administration codes are time-based codes, the nurse or the physician must document information to support the code reported. Time-based administration services require start and stop times to accurately reflect the total time. Depending on other services rendered during the same encounter, payers sometime consider drug administration services as an integral part of the other service. For example, the administration of pain medication following a procedure is an integral part of that procedure and is not separately reportable. You must follow these coding rules when assigning codes for an encounter.

If the drug administration is considered integral to another service such that it cannot be coded separately, the charge representing the cost of the services should be reflected on the claim. This can be accomplished either by including the cost/charge in the other service or by reporting a separate line without the drug administration HCPCS code. Not reporting the HCPCS code ensures that the charge/cost is reflected for future rate-setting but no separate payment is received for a service that is paid as part of another service.

For the episode you mention, if a covered drug is administered, the facility would charge for the drug and its administration as long as the documentation in the record supports the service provided. Medicare reimbursement is based on the APC for hospitals subject to OPPS; for facilities not subject to APC reimbursement, the usual payment methodology would hold.

E/M and HCPCS L-code

Q A patient presents to the ED, and after a medical screening exam, the provider determines that a pre-fabricated "off-the-shelf" splint needs to be applied. Is it appropriate to code both an ED E/M along with a HCPCS L-code that describes the device, fitting, and adjustment? If not, please describe how this type of billing encounter should be coded.

A Generally speaking, after the medical screening exam, a diagnosis would be made for which the splint is a recommended treatment. If any other treatment, manipulation, or service of this diagnosis is provided, the application of the splint is included and would not be reported separately.

CPT guidelines state the following:

If cast application or strapping is provided as an initial service (e.g., casting of a sprained ankle or knee) in which no other procedure or treatment (e.g., surgical repair, reduction of a fracture, or joint dislocation) is performed or is expected to be performed by a physician rendering the initial care only, use the casting, strapping, and/or supply code (99070 for physician billing only) in addition to an evaluation and management code, as appropriate.

Therefore, if no other treatment or service is provided by this physician, and none is expected to be performed for this diagnosis, then you would report the E/M code plus the appropriate splint application code [29000–29590] and/or 99070 (physician billing only, hospitals would bill as a supply item in 27x revenue code without a HCPCS code).

Modifiers

Correct use of modifier -JW

Q We're hearing much about modifier -JW (drug amount discarded/not administered to any patient). How does this affect outpatient Medicare billing?

A Review *Change Request (CR) 7095*, which is being issued in response to inquiries related to *CR 6711* pertaining to the use of the -JW modifier (drug or biological amount discarded/not administered to any patient) for discarded drugs and biologicals.

Medicare instructs that each Medicare contractor (FI/MAC):

- ▶ Has the individual discretion to determine whether the -JW modifier is required for any claims with discarded drugs, including the specific details regarding how the discarded drug information should be documented and applied on the claim
- ▶ Will notify its respective providers of such requirements associated with the use of the -JW modifier

Most FIs/MACs have made clear that, regardless of whether modifier -JW is required for reporting purposes, documentation of the discarded amount must be present in the patient's record. Work closely with your revenue cycle department to include pharmacy personnel and clinicians to ensure that they can produce medical record documentation for audits. In addition, review your local coverage determinations, particularly those for drugs and skin substitutes, because they may contain additional instructions regarding modifier -JW and documentation requirements.

Modifiers -58 and -78

Q Must a physician plan to return to the operating room (OR) for us to append modifier -58 (staged or related procedure or service by the same physician

during the postoperative period) to a claim? For example, a physician performs a breast biopsy and diagnoses the patient with breast cancer. One week later, the same physician performs a modified radical mastectomy on the right breast. In this case, should we append modifier -58 to the code for the modified radical mastectomy, or use modifier -78 for return to the OR for related procedure during the postoperative period (same day), since the return to the OR wasn't planned?

A You can use modifier -58 even when the physician did not plan the staged or related procedure, if it is more extensive than the original procedure.

Append modifier -58 for the following:

- ▶ Procedures that are planned or anticipated (staged)
- ▶ Therapy following a surgical procedure
- ▶ Procedures that are more extensive than the original procedure

In some situations, a physician may plan or stage second procedures for a patient that fall within the original procedure's global period. For example, a physician performs a debridement of a patient's burn. The physician knows he or she will need to perform additional debridements and documents this in the patient's chart. When the physician performs the additional debridement, append modifier -58.

The physician may also need to perform a more extensive procedure than the original one.

Do not use modifier -58 if the physician returns the patient to the OR because of unplanned complications to a procedure. For example, a surgeon removes polyps from a patient's colon. Several hours later, the physician returns the patient to the OR and performs a colonoscopy with electrocautery to control postoperative bleeding. In this case, append modifier -78.

Observation

Billing for 40 hours

Q With the new rules changing, if an observation patient stays more than 24 hours, possibly as much as 40 hours, may we bill for all 40 hours?

A Yes. Medicare says that all medically necessary observation hours are covered. The key is the words “medically necessary.” If the patient should have been an inpatient instead of an observation patient, then that would not be a covered observation service. If the patient was there for the convenience of the patient, the family, or the physician, then those hours would not be covered. So the carve-outs for observation hours

can be fairly time-consuming. You need to carve out any time that was not medically necessary or any time in which the patient was receiving another Part B service. For example, if a patient was receiving a blood transfusion, you would carve out that time because that’s separately payable under Part B. If the patient was having an EGD or a colonoscopy, you would have to carve out those observation hours because that’s a separately payable Part B service that requires active monitoring. So, just because the patient comes in and leaves in 40 hours does not necessarily mean we get to bill all 40 hours. We must evaluate the services provided and perform the carve-outs necessary.

Packaged and bundled services

Concepts are different

Q Staff in our hospital use the terms “bundling” and “packaging” interchangeably. Are they the same thing?

A No. Bundling is a coding concept, and packaging is a payment concept. A bundled service is one that is considered to be an inclusive component of another service from a coding perspective. The NCCI edits specify bundled codes, and under normal circumstances coders should not separately report codes for these services. The charges for these services should be reported as part of the charge for the coded line to which they are bundled, or they may appear separately on an appropriate revenue code line without a HCPCS code.

Packaging is a payment concept that indicates an item or service is not separately paid, but rather

paid as part of another service. Unlike bundled items and services, packaged items and services may, and sometimes are required to, be reported separately on the claim with a HCPCS code.

Packaged services are subdivided into status indicators N, Q1, Q2, and Q3, which differ as follows:

- ▶ Status indicator N: Packaged codes. These codes are always packaged.
- ▶ Status indicator Q1: STVX-packaged codes. These codes are packaged when billed with another service with the same date of service and status indicator S, T, V, or X. Otherwise, they are paid separately under the APC specified in Addendum B of the OPSS.
- ▶ Status indicator Q2: T-packaged codes. These codes are packaged when billed with another

> *continued on p. 6*

Quick coding quiz answers (from p. 6)

Answer 1: d. Answer 2: b. Answer 3: a. Answer 4: c. Answer 5: c.

Packaged and bundled services

< continued from p. 5

service with the same date of service and status indicator T. Otherwise, they are paid separately under the APC specified in Addendum B of the OPPS.

- ▶ Status indicator Q3: These codes may be paid through a composite APC. Addendum M of the OPPS final rule specifies the individual APC for payment when the composite is not triggered, as well as the composite APC that will be paid if the service is billed under circumstances that trigger composite payment. See the Outpatient Code Editor, Appendix K for information on composite payment assignment.

If a code is bundled, it is improper to report it unless there is a clinical circumstance that justifies overriding the bundling rule. However, you can, and should, bill separately for packaged services in a manner that does not generate separate payment. ■

Questions? Comments? Ideas?

Contact Managing Editor

Geri Spanek

Telephone 781/639-1872, Ext. 3168

E-mail gspanek@hcpro.com



Quick coding quiz

Try your hand at this coding quiz based on this month's APC Answer Letter

Questions

- Question 1:** Which CPT modifier denotes an unplanned return to the operating/procedure room by the same physician following initial procedure for a related procedure during the postoperative period?
 a) -57 b) -58 c) -77 d) -78
- Question 2:** What is the correct CPT code for a complex incisional removal of a foreign body, subcutaneous tissues?
 a) 10120 b) 10121 c) 10124 d) 10199
- Question 3:** Which status indicator is used for codes that are always packaged?
 a) N b) Q1 c) Q2 d) Q3
- Question 4:** What is the correct modifier for drug amount discarded/not administered to any patient?
 a) -BL b) -GA c) -JW d) -RC
- Question 5:** Which CPT modifier denotes a staged or related procedure or service by the same physician during the postoperative period?
 a) -25 b) -57 c) -58 d) -78

Answers to the quiz are at the bottom of p. 5.

APC Answer Letter 2010 index

2011 V codes

Notable changes for 2011. Dec., p. 6.

Cardiac

Services, setting determine stress test code. Jan., p. 1.

Condition code 44

Determining when observation time begins. Oct., p. 1.

Patient must meet four criteria. July, p. 1.

Conscious sedation

NCCI edits determine code selection. Jan., p. 2.

Diagnosis codes

Guidelines address conflicting data. Feb., p. 1.

ED

Billing for critical care services. July, p. 1.

Coding 23 hours fracture observation. Feb., p. 2.

Critical care documentation and CPT criteria. Dec., p. 1.

Determining code for abandoned newborn. April, p. 1.

Distinguish cardioversion, defibrillation. Jan., p. 3.

Guidelines for critical care billing. Aug., p. 1.

High acuity patients and critical care criteria. Oct., p. 1.

Reporting revenue codes correctly. May, p. 1.

Understand the 72-hour bundling rule. June, p. 1.

E/M

Calculating visit level. Oct., p. 2.

Hospital guidelines and clinic visits. Oct., p. 1.

ESRD

Components are thrombectomy, catheterization. Sept., p. 1.

Fetal monitoring

Is physician consulting or attending. April, p. 3.

Reporting Unna boot application, debridement. May, p. 3.

Free samples

Don't charge when you don't pay. Jan., p. 4.

H1N1

Don't report free vaccine. April, p. 4.

HBO therapy

Follow requirements; payer rules may vary. Sept., p. 1.

HIV

New screening codes added. Sept., p. 3.

Injections and infusions

Adding time for hydration not appropriate. Oct., p. 4.

Correct coding requires details. Aug., p. 2.

Declotting code describes service. Dec., p. 2.

Documentation must support code selection. Aug., p. 3.

Facilities should follow hierarchy. March, p. 2.

Hydration time requirement and report 96360. July, p. 2.

IO generally inpatient procedure. Oct., p. 3.

Know when to report CRNA service. May, p. 3.

Observation during chemotherapy. Oct., p. 3.

On-Q pump placed during main procedure. Aug., p. 3.

Medication prior to blood transfusion. Oct., p. 3.

No MUE limits published for 96372. April, p. 4.

PICC line has one initial infusion. July, p. 2.

Port, pump, and PICC flush code. Jan., p. 5.

Proper coding of multiple lumen catheters, June, p. 1.

Reporting fluids with hydration codes. Sept., p. 3.

Steroids with fluoroscopic guidance. March, p. 3.

Transfusions not part of hierarchy. July, p. 3.

VIG administration during dialysis. June, p. 4.

Lumbar

Insurer requirements and use of modifier -59. Oct., p. 4.

Medical necessity

Reducing denials. April, p. 5.

Medication therapy

No pharmacist guidelines for ED, observation. Dec., p. 3.

> *continued on p. 8*

APC Answer Letter 2010 index

< continued from p. 7

Modifiers

- 25. Sept., p. 4; Oct., p. 4.
- 50. Oct., p. 5.
- 73. March, p. 3.
- GZ. Oct., p. 4.

Nuclear medicine

- Medicare revisions for reporting PET scans. May, p. 4.

Observation

- Analysis for same-day surgery patients. July, p. 5.
- ESRD and emergency dialysis. March, p. 4.
- MAC guidelines for critical access hospitals. Oct., p. 5.
- Monitoring simultaneous procedures. Dec., p. 3.
- Post-surgery billing generally prohibited. Oct., p. 5.
- Revenue codes and telemetry monitoring. March, p. 5.
- Signed order necessary for coverage. Dec., p. 5.
- When are drugs separately chargeable? June, p. 5.
- When is drug administration preoperative? Sept., p. 4.

Orthopedics

- Anatomy and knee procedures. June, p. 6.

Packaged drugs

- Revenue code and line-item detail. Aug., p. 5.

Physician orders

- Be wary of manipulating system. Oct., p. 6.

Physician queries

- Address documented conditions. Oct., p. 6.

PICC

- Report complete procedures. March, p. 5.
- Rules complex without infusion service. Dec., p. 5.

Radiology

- Fetal position ultrasound. Feb., p. 6.
- Know when to append modifier -26. Oct., p. 6.
- Know which regulations apply to hospitals. Aug., p. 5.

- Reporting cardiac procedures. May, p. 5.
- Same-day multiple MRIs unusual. Sept., p. 6.

Recovery

- Time can vary according to circumstances. Oct., p. 7.

Self-administered drugs

- Billing for insulin sometimes permissible. Dec., p. 5.
- CMS transmittal addresses exclusions. April, p. 5.

Skin grafts

- Temporary wound closure code selection. Aug., p. 7.

Specimen collection

- Proper revenue code selection explained. Sept., p. 7.

Time-based PT codes

- Remember to apply eight-minute rule. July, p. 5.

Tracheotomy

- E/M level includes routine tube change. March, p. 6.

Transfusions

- When Medicare won't pay for second unit. July, p. 7.

Tumor excision

- Codes require more specificity. June, p. 7.

Unlisted codes

- Information in circumcision operative report. April, p. 6.

Unused supplies/implants

- When is billing permissible. Oct., p. 7.

Wound care

- CPT code and supply charge. April, p. 7.
- Evaluation of separate complaint. May, p. 7.
- Practitioner, procedure determine code. Feb., p. 6.
- Several factors determine code. March, p. 7.
- Who provided service and where? Sept., p. 7. ■