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FEATURE ARTICLE

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Start your New Year off right by understanding and incorporating the OIG initiatives into your organizations' compliance plans for 2011, advises Debra Downs, CPC, in her article this month. Compliance plans evolve each year based upon various RAC, CERT, MIC and OIG initiatives, notes Downs. Understanding the OIG's focus areas and determining their priority as they relate to your organization will give you a head start in developing your annual plan.

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New Medicare "Q" Codes to Take Effect January 1

Alas, the flu season is upon us, notes Denise Nash, MD, CCS, CIM. Effective for claims with dates of service on or after Jan. 1, 2011, CPT® code 90658 (Influenza virus vaccine, split virus, when administered to individuals three years of age and older, for intramuscular use), will no longer be payable by Medicare. Alas, indeed.

TALKING POINTS



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Fraud and the False Claims Act

Lack of medical necessity is now one of the leading areas of healthcare fraud in the Medicare system, reports Paul Paulson, CHN, CNOR. Documentation, he writes, must be reflective of the severity of illness among patients.

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ICD-10-PCS: Know the Approach

Character five of the ICD-10-PCS code identifies the "approach," writes Darnacea Harris, MHA, RHIT, CCS. And the approach is defined as the technique used to reach the site of the procedure. But there's more.

MODIFIERS CORNER



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New Modifier PT

Sandy Palmer, RHIT, reports on a new modifier—Modifier PT—and explains its use when reporting a diagnostic procedure that is performed during the same clinical encounter as a result of a planned colorectal cancer screening test.

ALSO...

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THE OIG 2011 WORK PLAN

Did You Include This in Your New Year's Resolutions?

EDITOR'S NOTE: Denise Nash MD, CCS, CIM, authored an article in the Oct. 2010 publication of the CCFN regarding the 2011 Work Plan as it relates to physicians. This article focuses on the new hospital initiatives defined within Work Plan.

Start your New Year off right by understanding and incorporating the OIG initiatives into your organizations' compliance plans for the year.

Understandably, organizations' compliance plans grow and evolve each year based upon the various RAC, CERT, MIC and OIG initiatives. Understanding the OIG's focus areas and determining their priority as they relate to your organization will certainly give you a head start in the development of your annual plan. New Year's resolutions are typically made to improve a situation while looking forward to the upcoming year. It is not too late to make a resolution to create and improve your compliance plan and incorporate your understanding of the OIG's Work Plan. To accomplish your new resolution and goals you must also have a plan with well-defined steps in order to be effective.

OIG Mission

The OIG defines its mission "to protect program integrity and the well-being of program beneficiaries by detecting and preventing waste, fraud, and abuse; identifying opportunities to improve program economy, efficiency, and effectiveness; and holding accountable those who do not meet program requirements or who violate Federal laws." This is accomplished through the various audits, evaluations and investigations and by providing industry guidance and civil monetary penalties and sanctions when necessary.

New Focus Areas for 2011

Noninpatient Prospective Payment System Hospital Payments for Nonphysician Outpatient Services

Review the appropriateness of payments for nonphysician outpatient services that were provided to beneficiaries shortly before or during Medicare Part A-covered stays at non-IPPS hospitals. For non-IPPS hospitals the inpatient claim should include diagnostic services performed one day prior to the admission and the date of admission. Expected start date FY 2011.

Medicare Outlier Payments

Review Medicare outlier calculations to determine whether outlier reconciliation was accurate. Expected start date FY 2011.

Hospital Occupational Mix Data Used To Calculate Inpatient Hospital Wage Indexes

Determine whether hospitals accurately reported hospital occupational mix data used to calculate inpatient wage index. Expected start date FY 2011.

Medicare Secondary Payer/Other Insurance Coverage

Review Medicare payments for beneficiaries who have other insurance to evaluate the effectiveness of inappropriate payment for Medicare services. Evaluation of procedures for identifying and resolving credit balances which occur when payments from Medicare and other insurers exceed providers'

charges or the allowed amounts. Expected start date FY 2011.

Reliability of Hospital-Reported Quality Measure Data

Evaluate the accuracy and validity of quality data submitted to Medicare. As long as hospitals report the required quality data this prevents a two percent reduction in payment however the validity of the data has not been evaluated in the past. Expected start date FY 2011.

Hospital Reporting for Restraint- and Seclusion-Related Deaths

Review hospital-reported restraint and seclusion-related deaths to determine the volume of reports and their outcome. The OIG will also determine state investigations and their outcomes. Expected start date FY 2012.

Hospitals' Compliance With Medicare Conditions of Participation for Intensity-Modulated and Image-Guided Radiation Therapy Services

Review hospitals' compliance with Medicare requirements concerning the safety and quality of intensity modulated radiation therapy (IMRT) and image-guided radiation therapy (IGRT) services. Assessment of CMS' oversight of IMRT and IGRT services provided in hospitals. Expected start date FY 2012.

Observation Services During Outpatient Visits

Review observation services payments for outpatient hospital visits. Assess whether and to what extent hospitals' use of observation services affects the care Medicare beneficiaries receive and their ability to pay out-of-pocket expenses for healthcare services. Expected start date FY 2012.

Partial Hospitalization Program Services

Review the appropriateness of Medicare payments for partial hospitalization program (PHP) psychiatric services. Determine whether Medicare payments for PHP psychiatric services in hospital outpatient departments and freestanding community mental health centers met Medicare requirements based on documentation supporting psychiatric services, including patient plans of care, and physician supervision and certification requirements. Expected start date FY 2012.

Appropriateness of Medicare Payments for Polysomnography

Review the appropriateness of Medicare payments for sleep studies. Due to the significant increase in costs over the years and the increased level of coverage, the OIG will also focus on the reasons for the increased costs and whether providers are in compliance with the Federal regulations. Expected start date FY 2012.

Excessive Payments for Diagnostic Tests

Determine if medical necessity was met for payment associated with high-cost diagnostic tests. OIG will evaluate if the same diagnostic tests were ordered for a beneficiary by primary care physicians and physician specialists for the same treatment. Expected start date FY 2011.

Medicare Part B Payments for Glycated Hemoglobin A1C Tests

Review contractors' procedures for screening the frequency of clinical laboratory claims for glycated hemoglobin A1C tests. Due to variations identified in contractor procedures, the OIG will determine the appropriateness of payment for the hemoglobin A1C. Expected start date FY 2011.

Trends in Laboratory Utilization

Due to a 92 percent increase in laboratory reimbursement over the last 10 years, the OIG will evaluate trends associated with laboratory services. The OIG will also evaluate the types and number of tests being ordered and the impact of physician specialties and geographic areas have on the overall orders. Expected start date FY 2011.

Lab Test Payments: Comparison of Medicare with Other Public Payers

The OIG considers the \$10 billion spent on Laboratory tests in 2009 to be excessive. Due to these excessive costs, the OIG will evaluate the utilized top 10 ordered tests and payments with other public payers including state Medicaid and Veterans Affairs. Expected start date FY 2012.

Error-Prone Providers: Medicare Part A and Part B

Review of Part A and Part B claims submitted by error-prone providers. Utilizing expected dollar error amounts and matching selected providers against the National Claims History file to determine the total dollar amount of claims paid. The validity of sample claims will be reviewed via medical review with a projection of a provider's population and a requested refund due to overpayment. Expected start date FY 2011.

Comprehensive Error Rate Testing Program: FY 2010 Error Rate Oversight

In order to reduce improper payments and ensure the accuracy of the 2010 error rate, certain aspects of the CERT program will be reviewed. Expected start date FY 2011.

Medicare Payments for Part B Drugs

Review claims of Part B drugs to determine if drugs were administered and associated with a physician service and in accordance with Medicare requirements. Expected start date FY 2011.

Billing for Immunosuppressive Drugs

Review Medicare Part B immunosuppressive drug claims to determine whether they were billed according to their Food and Drug Administration (FDA) -approved labels. Additionally, the OIG will monitor whether immunosuppressive drugs were used in combination with other immunosuppressive drugs. Expected start date FY 2011.

Payments for Off-Label Anticancer Pharmaceuticals and Biologicals

Review of Medicare payment for drugs and biologics used on an off-label basis in anticancer chemotherapeutic regimens. The drugs reviewed will be identified in the DrugDex, a drug compendium, as being medically accepted even though the given tests or treatments are indicated in only some cases and even where evidence and/or expert opinions argue against efficacy.

Determine whether patients with certain indications were ordered drugs approved by the FDA before being prescribed the off-label anticancer drug and whether there were improvements in the patient's condition before the off-label drug. Determine how much Medicare would have saved if the off-label drug had not been provided if the patient's condition had improved. Expected start date FY 2011.

Quality Improvement Organization's Hospital Quality Improvement Projects

Review hospitals quality improvement projects (QIOs). The OIG will also work to determine if, at the conclusion of the program, there was continued improvement. Expected start date FY 2011.

Recovery Act Reviews

On March 23, 2010, the Affordable Care Act (ACA) was signed into law and is hailed as one of the most significant healthcare reforms in the United States. Healthcare fraud, abuse and program integrity make up 32 different sections of this law. There is a 10-year, \$350 million investment from this law to fight fraud and abuse. With that said, it is no wonder that the Department of Health and Human Services (HHS) and the OIG have incorporated various measures into the 2011 OIG Work Plan. Below are additional new measures from the ACA

Medicare and Medicaid Incentive Payments for Electronic Health Records

Review Medicare and Medicaid incentive payments to prevent errors associated with payments made to professionals and hospitals utilizing electronic health records. Medicaid expected start date FY 2011, whereas Medicare has an expected start date of 2012.

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New Medicare "Q" Codes to Take Effect January 1

Alas, the flu season is upon us and effective for claims with dates of service on or after Jan. 1, 2011, CPT® code 90658 (Influenza virus vaccine, split virus, when administered to individuals three years of age and older, for intramuscular use) will no longer be payable by Medicare.

CMS has created new specific HCPCS codes for Medicare billing purposes.

Effective for dates of service on or after Oct. 1, 2010, the following new influenza "Q" codes are payable by Medicare, which establishes separate billing codes for each brand-name influenza vaccine product:

- Q2035** – influenza virus vaccine, split virus, when administered to patients age 3 and older, for intramuscular use (Afluria)
- Q2036** – influenza virus vaccine, split virus, when administered to patients age 3 and older, for intramuscular use (Flulaval)
- Q2037** – influenza virus vaccine, split virus, when administered to patients age 3 and older, for intramuscular use (Fluvirin)
- Q2038** – influenza virus vaccine, split virus, when administered to patients age 3 and older, for intramuscular use (Fluzone)
- Q2039** – influenza virus vaccine, split virus, when administered to patients age 3 and older, for intramuscular use (not otherwise specified)

However, these HCPCS codes will not be recognized by the Medicare claims processing systems until Jan. 1, 2011, when CPT code 90658 will no longer be recognized. The administration code for the new influenza Q codes code is the same "G" code: G0008—administration of influenza virus vaccine. Code G0008 is used to report the administration of influenza virus vaccine to

a Medicare beneficiary, in addition to the CPT code for the vaccine itself.

Although your office may have started to bill as instructed, CMS has instructed Medicare contractors to hold all claims containing the influenza Q codes with dates of service on or after Oct. 1, 2010, until their systems are able to accept them for processing. Medicare contractors' systems will be ready to process claims containing the Q codes no later than Feb. 7, 2011. Translation: your reimbursement will be delayed for all claims that were coded correctly as per the instructions.

Medicare institutional providers also have the option to hold their claims containing the new influenza Q codes until Feb. 7, 2011. Medicare institutional providers should not submit claims with the new influenza Q codes with dates of service on or after Oct. 1, 2010, via roster billing. Medicare systems are unable to hold roster claims submitted by institutional providers. Therefore, Medicare institutional providers may submit their roster claims on an individual claim basis or hold their roster claims until Feb. 7, 2011, and then submit as a roster bill at that time.

The Medicare Part B payment allowance limits for seasonal influenza and pneumococcal vaccines are 95 percent of the Average Wholesale Price (AWP) except where the vaccine is furnished in a hospital outpatient department.

Below are the reimbursements for Dates of Service between Sept. 1, 2010 and Dec. 31, 2010.

CPT 90658..... \$11.368

Dates of Service between Oct. 1, 2010 and Aug. 31, 2011 (processing of claims will start no later than Feb. 7, 2011)

Q2035 (Afluria)	locally priced
Q2036 (Flulaval)	\$7.439
Q2037 (Fluvirin)	\$13.253
Q2038 (Fluzone)	\$12.593
Q2039 (N.O.S.)	locally priced

For additional information regarding the 2010 Influenza Vaccines coding and pricing please refer to MLN Matters® MM7120 and MM7234.

About the Author

Denise M. Nash, MD, CCS, CIM, is the Medical Director and Product Owner for Episodes of Care for MedAssets. Denise has over 20 years experience in the healthcare industry. She has worked for CMS in hospital auditing and has expertise in negotiation and implementation of risk contracting for managed care plans. Denise has also worked with individuals as well as physician groups on utilization improvements to improve financial performance for the risk-based contracts. She has worked with both hospitals and physician practices on the legal aspects of adding new services to the respective facilities. Denise is a consultant on compliance/HIPAA at physician practices, hospitals, and insurance plans and has worked for the OIG of New Hampshire for its Fraud and Abuse Division. ■

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www.cms.gov/MLN MattersArticles/downloads/MM7120.pdf

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Fraud and the Federal False Claims Act

Fraud is defined as making false statements or representations of material facts in order to obtain some benefit or payment for which no entitlement would otherwise exist. These acts may be committed either for the person's own benefit or for the benefit of some other party. In order to prove that fraud has been committed against the Government, it is necessary to prove that fraudulent acts were performed knowingly, willfully, and intentionally. – Medicare General Information, Eligibility and Entitlement Manual

Examples of fraud include, but are not limited to, the following:

- Billing for services that were not furnished and/or supplies not provided. This includes billing Medicare for appointments that the patient failed to keep.
- Altering claims forms and/or receipts in order to receive a higher payment amount.
- Duplicating billings that include billing both the Medicare program and the beneficiary, Medicaid, or some other insurer in an effort to receive payment greater than allowed.
- Offering, paying, soliciting, or receiving bribes, kickbacks, or rebates, directly or indirectly, in cash or in kind, in order to induce referrals of patients or the purchase of goods or services that may be paid for by the Medicare program.
- Falsely representing the nature of the services furnished. This is like describing a non-covered service in a misleading way that makes it appear as if a covered service was actually furnished.

Lack of medical necessity is now one of the leading areas of healthcare fraud in the Medicare system. While it is the physician who determines and documents medical necessity, it is the hospital that must verify that the medical records support the determination of the physicians who are admitting patients to inpatient status and observation status in its facility and that the documentation is reflective of the severity of illness among patients.

The Office of Inspector General (OIG) has made this clear. In *OIG Compliance Program Guidance for Hospitals* (February 1998), the OIG stated.

“The OIG recognizes that licensed healthcare professionals must be able to order any services that are appropriate for the treatment of their patients.

However, Medicare and other government and private health care plans will only pay for those services that meet appropriate medical necessity standards (in the case of Medicare, i.e., “reasonable and necessary” services). Providers may not bill for services that do not meet the standards.

The hospital is in a unique position to deliver this information to the healthcare professionals on its staff. Upon request, a hospital must be able to provide documentation, such as patients’ medical records and physicians’ orders, to support the medical necessity of a service that the hospital has provided.

The compliance officer should ensure that a clear, comprehensive summary of the “medical necessity” definitions and rules of the various government and private plans is prepared and disseminated appropriately. It is when hospitals knowingly fail to be the medical necessity gatekeepers of their own hospital doors that government healthcare programs such as Medicare and Medicaid incur unnecessary costs.”

The False Claims Act

The term “healthcare fraud” is often mentioned in the same sentence as the Federal False Claims Act (the “Act”). It is suggested that the Act is one remedy employed by the government to attack billing for ghost patients, up coding, unbundling, and billing for inadequate or unnecessary care. Since 1988, nearly \$2 billion have been recovered from healthcare providers and others who have cheated government health programs. In the war on healthcare fraud, law enforcement agencies consider the Act a powerful civil weapon.

The Act permits a person with knowledge of fraud against the United States Government, in this case Medicare or Medicaid, to file a lawsuit on behalf of the government against the person or business that committed the fraud (the defendant). This person may be referred to as the “qui tam plaintiff” or “whistleblower.” If the action is successful, the qui tam plaintiff is rewarded with a percentage of the recovery.

The qui tam plaintiff's share of the damages recovered depends on whether the Justice Department intervenes and takes over the case. If the U.S., Department of Justice (DOJ) takes over, the qui tam plaintiff is entitled to between 15 and 25 percent of the recovery. If the DOJ does not intervene, and the qui tam plaintiff pursues the action individually, the qui tam plaintiff is entitled to between 25 and 30 percent of the recovery.

The Act also provides protection to employees against retaliation by an employer because of the employee's participation in a qui tam action. The protection is available to any employee who is fired, demoted, threatened, harassed or otherwise discriminated against by his or her employer because the employee investigates, files or participates in a qui tam action.

Under the Act, those who knowingly submit, or cause another person or entity to submit, false claims for payment of government funds are liable for three times the government's damages plus civil penalties of \$5,500 to \$11,000 per false claim.

Stop guards for Protection

With the potential for significant financial losses associated with fraud compensation, it is imperative that providers have in place stop guards to identify potential billing and compliance issues. These measures include nurse auditors, compliance teams and claim scrubbers. Additionally, hospital coding staff should be fully trained in reviewing the medical record for any medical necessity concerns or billing issues.

There should also be a system of protocols in place when documentation in the medical record does not support the procedures reported. For example, a hospital representative may contact the practitioner(s) associated with the patient's medical record to obtain any pertinent data to help support the medical necessity requirements. Rotating physicians into the Medical Documentation or Denials committees may assist in provider recognition of the importance of supportive documentation. The organization's legal advisors should also be involved to a certain degree as needed.

The vast majority of providers and suppliers who provide services to Medicare beneficiaries are committed to providing high quality care to their patients and to billing the program only for the payments they have earned. It is only a small percentage of providers who account for the billions of dollars lost or stolen from the federal government's healthcare insurance plan called Medicare/Medicaid.

With increased scrutiny from federal programs such as the Recovery Audit Contractors (RACs) and Medicaid Integrity Contractors (MICs), we are provided with a doorway of opportunity to improve our internal safeguards.

About the Author

Paul Paulson CHN, CNOR, currently serves as a Senior Review Analyst with the CCA group for MedAssets. Paul has more than 35 years in the health care industry and has worked as a Dialysis Nurse, Operating Room Nurse and critical care Nurse Specialist. Paul has been employed at MedAssets for eight years in various roles from mapping consultant to manager for initial projects in the mapping department to Charge Master Consultant in the compliance department. ■

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FEATURED ARTICLE The OIG 2011 Work Plan

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Medicaid Disproportionate Share Hospital Payments

Review disproportionate share hospital (DSH) payments to determine whether the expenditures claimed met Medicaid requirements. Expected start date FY 2011.

Medicare and Medicaid Health Information Data Privacy

Review Medicare and Medicaid program providers' implementation of the Privacy Rule standards of HIPAA.

Implementing and Monitoring of Your Compliance Plan

Incorporating the various measures of the OIG plan into your annual compliance program demonstrates an understanding and willingness to ensure an effective compliance plan. Understanding the new initiatives while continuing to monitor ongoing initiatives is critical to the success of the program.

Planning is a major part of the process but also it is equally important to execute the plan. Execution includes monitoring, auditing, reporting and education of personnel and implementing process changes when necessary.

Start the New Year off right and make sure your organization and staff are on the right compliance track for 2011.

About the Author

Debra Downs, CPC, is Manager Data Integrity and Medical Necessity Compliance, with Integrity Services of MedAssets. In this role she utilizes her numerous years of experience in clinical hospital management, coding, compliance, and revenue cycle management with a focus on CMS and regulatory issues. She has provided training and educational presentations on both a local and national level regarding various coding, reimbursement, and regulatory issues. ■



ICD-10-PCS: Know the Approach

As reported in the October 2010 edition of *CCFN*, ICD-10-PCS provides an improved system for code expansion and allows for greater specificity in procedure classifications. Each of the seven characters that make up the seven-digit ICD-10-PCS classification system has specific meaning, with values dependent upon the clinical procedure performed.

Character five of the ICD-10-PCS code identifies the approach. The approach is defined as the technique used to reach the site of the procedure.

Character 1	SECTION
Character 2	BODY SYSTEM
Character 3	ROOT OPERATION
Character 4	BODY PART
Character 5	APPROACH
Character 6	DEVICE
Character 7	QUALIFIER

When developing the approach character of ICD-10-PCS, three components were considered: the access location, the method and the type of instrumentation.

Access location

Access locations for internal body parts specify the external site through which the site of the procedure is reached. There are two general types of access locations; skin or mucous membranes, and external orifices. Procedure sites can be accessed through the skin or mucous membranes

by cutting or puncturing the entrance site. Creating an incision in the abdomen for an open cholecystectomy, for example, requires access through the skin or mucous membranes. All open and percutaneous procedure approaches use this access location. External openings are accessed through an existing external opening like the mouth, ear, or anus. Some external openings are artificially created, but are still considered an external opening. A colostomy stoma is an artificial external opening.

Method

Procedures performed on an internal body part require specification of the method used to access the external location. The method essentially asks the question: How was the body part accessed? Two general methods are typically used: the open method and the instrumentation method. The open method is defined as cutting through the skin or mucous membrane and any other intervening layers necessary to expose the site of the procedure.

The instrumentation method specifies the entry of instrumentation through the access location to the internal procedure site. Instrumentation can be introduced through puncture or minor procedure, and should not be confused with an open approach as instrumentation does not expose the site of the procedure. A laparoscopic cholecystectomy would

require an instrumentation approach method. One approach can be defined by multiple methods, like instrumentation for visualization and placement of instrumentation for the procedure.

Type of Instrumentation

In some cases, procedures performed on internal body parts will require specialized equipment. Specialized equipment is referred to as instrumentation. However, for all internal approaches other than the basic open approach, instrumentation is used. Instrumentation permits the procedure site to be visualized, as in endoscopic procedures like Colonoscopy.

Seven Approaches

ICD-10-PCS identifies seven different approaches. These include the following:

Open:

Cutting through the skin or mucous membrane and any other body layers necessary to expose the site of the procedure.

Example: Abdominal hysterectomy

Percutaneous:

Entry, by puncture of minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to reach the site of the procedure.

Example: Needle biopsy of liver, Liposuction

Percutaneous Endoscopic:

Entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to reach and visualize the site of the procedure.

Example: Arthroscopy, Laparoscopic cholecystectomy

Via Natural or Artificial Opening:

Entry of instrumentation through a natural or artificial external opening to reach the site of the procedure.

Example: Endotracheal tube insertion, Foley catheter placement

Via Natural or Artificial Opening Endoscopic:

Entry of instrumentation through a natural or artificial external opening to reach and visualize the site of the procedure.

Example: Sigmoidoscopy, EGD, ERCP

Via Natural or Artificial Opening Endoscopic with Percutaneous Endoscopic Assistance:

Entry of instrumentation through a natural or artificial external opening to reach and visualize the site of the procedure, and entry, by puncture or minor incision, of instrumentation through the skin or mucous membrane and any other body layers necessary to aid in the performance of the procedure.

Example: Laparoscopic-assisted vaginal hysterectomy

External:

Procedures performed directly on the skin or mucous membrane and procedures performed indirectly by the application of external force through the skin or mucous membrane.

Example: Closed fracture reduction, Resection of tonsils

Identification of the approach in ICD-10-PCS is essential for proper code assignment. The addition of the approach within the code set contributes to the goal of expandability, and allows for improved procedure reporting and tracking. The approach character provides for better consistency in code structure and specificity. Such improvements in structure and specificity will facilitate the development of more sophisticated codes.

In the future coders will find the elasticity and expandability of ICD-10-PCS easier to use as compared to ICD-9-CM.

Test Yourself

Identify the approach for the procedures listed below:

1. Open Abdominal Hysterectomy

Approach: _____

2. Laparoscopic-assisted Vaginal Hysterectomy

Approach: _____

3. Colonoscopy

Approach: _____

4. Arthroscopy

Approach: _____

5. Caution of Nosebleed

Approach: _____

6. Needle Biopsy of Liver

Approach: _____

7. Endotracheal Intubation

Approach: _____

(ANSWERS: 1. Open 2. Via Natural or Artificial Opening Endoscopic with Percutaneous Endoscopic Assistance 3. Via Natural or Artificial Opening Endoscopic 4. Percutaneous Endoscopic 5. External 6. Percutaneous 7. Via Natural or Artificial Opening)

About the Author

Darnacea Harris MHA, RHIT, CCS, is an AHIMA approved ICD-10-CM/PCS Trainer with more than 20 years experience in the coding, compliance and reimbursement industry. Darnacea has previously held such positions CCA Rules Manager, Assistant Director HIM, HIM Manager, Coding Manager, and Consultant. She has also held teaching positions at several colleges and universities where she taught coding, billing, HIM and supporting courses. ■

Trade Shows & Events

JANUARY 12-14**ALTHA 2011 National Clinical Conference
Acute Long Term Hospital Association**

Orlando, FL • Booth: 107 • View [Website](#)

JANUARY 19**Metropolitan Chicago Healthcare Council
(MCHC) Webinar**

10–11:30 a.m. CST • [Website](#)

“The Effects of Healthcare Reform on Supply Chain Management” presented by Nick Sears, M.D., Chief Medical Officer, MedAssets

JANUARY 21**HFMA MA/RI Chapter Annual Revenue
Cycle Conference**

Foxborough, MA • Booth: TBD • [Website](#)

JANUARY 23-26**13th Annual HFMA Region 11 Healthcare
Symposium**

Las Vegas, NV • Booth: TBD • [Website](#)

FEBRUARY 8-9**ANAE 2011 Equipment Planner, Architect
and Construction “Double Reverse”
Tradeshaw and Conference**

Dallas, TX • View [Website](#)

Keynote Session presented by Rand Ballard, Senior Executive Vice President, COO and CCO, MedAssets

MARCH 13-16**ASHE International Summit and
Exhibition on Health Facility Planning,
Design & Construction**

Tampa Bay, FL • Booth: 221 • View [Website](#)

APRIL 13-16**AONE 44th Annual Meeting and
Exposition - The American Organization
of Nurse Executives**

San Diego, CA • Booth: 918 • View [Website](#)

New Modifier PT

The Centers for Medicaid and Medicare Services (CMS) have created a new modifier to be used when reporting a diagnostic procedure that is performed during the same clinical encounter as a result of a planned colorectal cancer screening test.

CMS announced this modifier and guidance related to its use in the 2011 OPSS Final Rule (see References for sections and pages). This new modifier becomes effective Jan. 1, 2011:

Modifier PT - Colorectal cancer screening test; converted to diagnostic test or other procedure

Modifier PT was created as a result of section 4104(c)(2) of the Affordable Care Act (ACA). Section 1833(b) of the Act was amended to waive the Medicare Part B deductible when a planned colorectal cancer screening test becomes diagnostic due to findings during the test. The current colorectal cancer screening codes applicable for these screening tests are the following:

- G0104** – Colorectal cancer screening; flexible sigmoidoscopy
- G0105** – Colorectal cancer screening; colonoscopy on individual at high risk
- G0106** – Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema
- G0121** – Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

Modifier PT should not be reported with the screening code. Instead, append Modifier PT to the code that is billed for the procedure performed to establish diagnosis of the findings during a colorectal screening test.

The diagnostic procedure would generally be a colonoscopy that could include the removal of a polyp or other tissue, a biopsy, or any other procedure that is performed in connection with and during the same encounter as the planned screening test for colorectal cancer.

CMS, however, has stated that it views all surgical services furnished to the patient on the same day as a planned colorectal screening test to have been performed in connection with that test. CMS feels it would be a “very rare” for an unrelated surgery to be performed on the same date as a scheduled screening test.

When Modifier PT is reported with a diagnostic procedure code in these cases, the Part B deductible will be waived for all surgical services on that day. Coinsurance or copayments will still apply to the diagnostic test or other services performed during that encounter.

Example:

A patient with no symptoms related to colorectal cancer is referred by his or her physician for a screening colonoscopy. The planned procedure is G0121 - Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk.

During the colonoscopy procedure a polyp is found in the ascending colon. The polyp was removed by snare technique and sent to pathology.

The procedure would be reported with CPT® code 45385 - Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique. Modifier PT should be appended

to indicate that the diagnostic colonoscopy with snare was performed as a result of the screening exam where the polyp was found during the same encounter.

Beginning in 2011, remember to append Modifier PT to the diagnostic procedure code when a colorectal screening exam is converted to a diagnostic procedure so that the Part B deductible is waived by Medicare for your patients on these claims.

About the Author

Sandy Palmer, RHIT, is a Coding and CDM Analyst for MedAssets, Integrity Services. Her expertise includes inpatient and outpatient facility coding with a specific emphasis on the Outpatient Prospective Payment System (OPPS). She has more than 12 years experience in Health Information Management and is currently responsible for researching and responding to complex facility coding inquiries as well as database maintenance and management. ■

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CMS-1504-FC I Final Changes to the Hospital Outpatient Prospective Payment System and CY 2011 Payment Rates
edocket.access.gpo.gov/2010/pdf/2010-27926.pdf

XII. OPSS Nonrecurring Technical and Policy Changes and Clarifications

- B. Payment for Preventive Services
 2. Coinsurance and Deductible for Preventive Services [Page 72014]
 3. Extension of Waiver of Part B Deductible to Services Furnished in Connection With or in Relation to a Colorectal Cancer Screening Test That Becomes Diagnostic or Therapeutic [Pages 72019-72020]
- B. Effects of OPSS Changes in This Final Rule With Comment Period [Pages 72115-72116]

CMS Transmittal R739OTN-Waiver of Coinsurance and Deductible for Preventive Services, Section 4104 of the Patient Protection and Affordable Health Care Act (the Affordable Care Act), Removal of Barriers to Preventive Services in Medicare
www.cms.gov/transmittals/downloads/R739OTN.pdf



FREQUENTLY ASKED QUESTIONS

In this section, MedAssets has reviewed and analyzed the questions that are received via our compliance help desk. We offer some of the most frequently asked questions and the MedAssets response for your convenience.

Q Can you explain "Safe Harbor Regulations" to me?

MedAssets Response

Generally speaking, a safe harbor is a provision most commonly referred to under the Anti-Kickback Statute. Safe harbor provisions can provide exceptions or exclusions to hospitals and/or physician group practices under certain circumstances from criminal penalties related to making referrals for healthcare services paid by Medicare to an entity in which there is a financial relationship. Types of services that could be affected include DME, Pharmaceuticals, Devices, Ambulance services etc.

We recommend that you seek advice from your Compliance Department for specific guidance.

The website oig.hhs.gov/fraud/safeharborregulations.asp may be helpful for additional information on Safe Harbor regulations.

Q Is it appropriate to charge CPT® 60699 Unlisted Procedure-Endocrine along with CPT 79005, radiopharmaceutical therapy oral? I heard that the reimbursement for 60699 is much better than that for CPT 79005. I also heard that they can be coded together.

MedAssets Response

There are no CCI edits evoked between the unlisted procedure code 60699 and the oral radiopharmaceutical code 79005. However, your facility documentation must support the assignment of any CPT code.

If your facility documentation describes an endocrine procedure that does not have a specific CPT code, then reporting the unlisted code may be appropriate. But reporting a code without documentation merely for "better reimbursement" would be considered fraudulent.

MedAssets Coding & Compliance Presentations

MedAssets Coding and Compliance Presentations are free to MedAssets clients and employees. For online registration, please [click here](#).

2011 Outpatient Prospective Payment System (OPPS) Final Rule

January 5, 2011 at 2:00 PM (EST)
 January 11, 2011 at 11:00 AM (EST)
 January 19, 2011 at 2:00 PM (EST)

If you were unable to attend the 2011 CPT Update webinar it is not too late.

A recording of the 2011 MedAssets Compliance CPT Update webinar is now available. The recording will be available for playback through January 31, 2011. The recording will allow you view and listen to the 2011 CPT Update webinar at your convenience. Please note: we are not offering CEUs for the recorded webinar.

If you are interested in listening and viewing the recorded 2011 CPT Update webinar, please contact your MedAssets Account Manager or e-mail productsupport@medassets.com for additional information.

CCFN CROSSWORD DECEMBER 2010

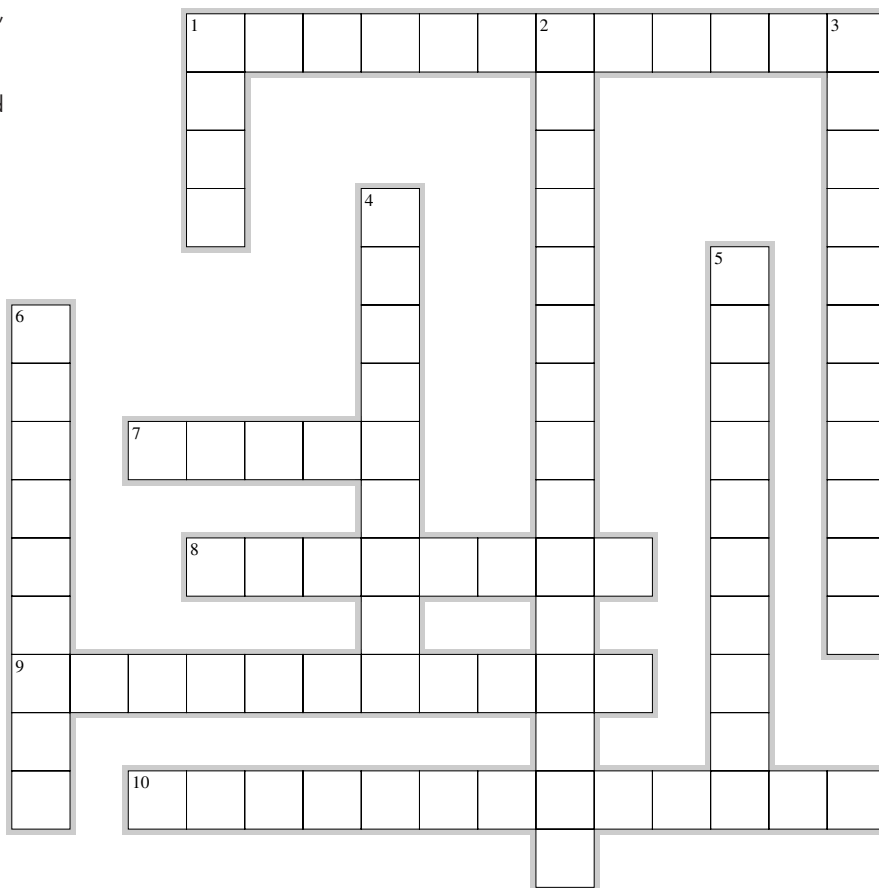
By Toueria Morris, CPC-H

Across

- To determine whether outlier reconciliation were accurate, the OIG will be reviewing Medicare outlier ____.
- Part B claims will be reviewed to determine if ____ were administered and associated with a physician service and according to Medicare requirements.
- The ____ of Medicare quality data has not been evaluated in the past.
- A focus area for 2011 will be the review of hospitals quality ____ projects QIOs.
- The OIG will evaluate trends associated with laboratory service, due to a 92 percent increase of laboratory ____ over the last 10 years.

Down

- To ensure the accuracy of the 2010 error rate and in order to reduce improper payments, certain aspects of this program will be reviewed.
- Significant increases in costs and increased level of coverage for polysomnography will be the basis for the review of the ____ of Medicare payments for sleep studies.
- The Affordable Care Act (ACA) was signed into law on March 23, 2010, and is hailed as one of the most ____ healthcare reforms in the United States.
- In 2009, \$10 billion was spend on laboratory tests which the OIG considers to be ____.
- One focus area for the OIG will be reviews, with an expected start date of FY 2012, of hospitals' ____ with Medicare requirements concerning the safety and quality of intensity modulated radiation therapy (IMRT) and image-guided radiation therapy (IGRT) services.
- "To protect program integrity and the well-being of program beneficiaries by ____ and preventing waste, fraud, and abuse; identifying opportunities to improve program economy, efficiency and effectiveness; and holding accountable those who do not meet program requirements or who violate Federal laws," is how the OIG defines their mission.



ANSWERS
 ACROSS 1. CERT 2. APPROPRIATENESS 3. SIGNIFICANT 4. EXCESSIVE 5. COMPLIANCE 6. DETECTING
 DOWN 1. CALCULATIONS 7. DRUGS 8. VALIDITY 9. IMPROVEMENT 10. REIMBURSEMENT

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