Coding and Billing Updates

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Today's Presentation:

- Value Components of a CPT code
- Medicare Physician Fee Schedule Updates
- Hospital Outpatient Prospective Payment System Updates
- Drugs and Biologicals Updates
- CPT, HCPCS, and ICD Updates
- Coding and Billing Issues

Value Components of a CPT Code

How does CMS determine the monetary value of a CPT code?

You may be familiar with this formula:

Work RVU x Work (GPCI) +
Practice Expense (PE) RVU x PE GPCI +
Malpractice (PLI) RVU x PLI GPCI
= The Total RVU

Total RVU x CY 2015 Conversion Factor of $28.22
= Medicare Payment

Value Components of a CPT Code

- What are each of those components?
- Who decides what the values are?
- How are the values determined?

Value Components of a CPT Code

Using CPT ® code **96413** (*Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug*) as an example, I will take you through the components of the formula.

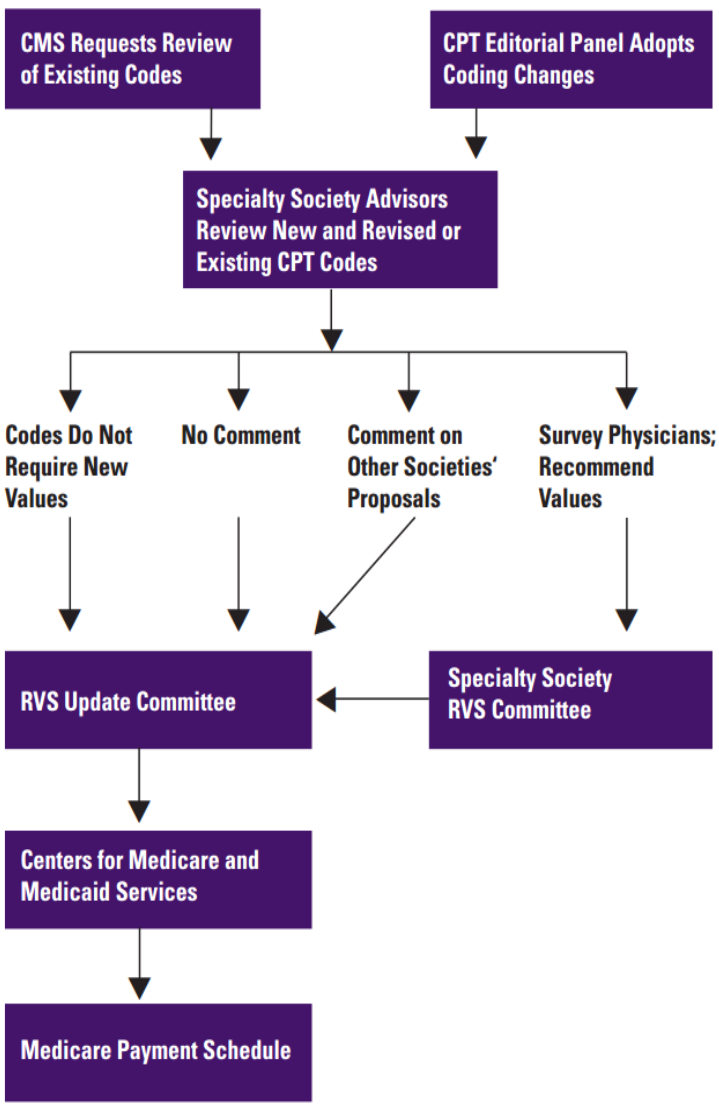
The Relative Value Scale Update Committee (RUC)

Annual updates to the physician work relative values are based on recommendations from a committee involving the AMA and national medical specialty societies.

The Relative Value Scale Update Committee (RUC)

- The AMA formed the AMA/Specialty Society Relative Value Scale Update Committee (RUC) to act as an expert panel in developing relative value recommendations to CMS.

- The AMA established a process in the course of its activities to develop relative values for new or revised CPT codes.


The RUC Process
CMS Requests Review of Existing Codes
CPT Editorial Panel Adopts Coding Changes
Specialty Society Advisors Review New and Revised or Existing CPT Codes
Codes Do Not Require New Values
No Comment
Comment on Other Societies' Proposals
Survey Physicians; Recommend Values
RVS Update Committee
Specialty Society RVS Committee
Centers for Medicare and Medicaid Services
Medicare Payment Schedule

Value Components of a CPT Code

Relative Values

Each CPT® code is assigned a relative value, measured in relative value units (RVU), which usually consists of three components:

1) The ***physician work component*** (Work RVU) measures the amount of physician work involved (i.e., time and intensity).

2) The ***practice expense component*** (PE) measures the costs of non-physician staff, supplies, equipment, overhead, etc., involved in furnishing the service.

3) The ***malpractice expense component*** (PLI) measures the cost of malpractice insurance associated with the service.

Value Components of a CPT Code

Relative Values

The fee schedule uses a resource-based relative value scale (RBRVS). This means that the relative values are intended to reflect the amount of resources used in furnishing a service and not factors such as the value of the service to the patient.

Value Components of a CPT Code

Physician Work Component (Work RVU)

"Work RVUs reflect the relative time and intensity associated with furnishing a Medicare PFS service and account for approximately 50 percent of the total payment associated with a service."

Work RVU for 96413: **.28**

Value Components of a CPT Code

Practice Expense Component

“PE RVUs reflect the costs of maintaining a practice (such as renting office space, buying supplies and equipment, and staff costs).”

Practice Expense RVU for 96413: **3.39** (Non Facility)

Value Components of a CPT Code

Practice Expense Component 96413- Labor

Staff Labor: .79 (RN/OCN)

Pre -Time: 2 minutes

Intra-Time: 88 minutes

Post -Time: 6 minutes

Value Components of a CPT Code

Practice Expense Component 96413- Equipment

Equipment Description	Price	Time
Chair, medical recliner	$829.03	88 minutes
Hood, biohazard	$6,884.25	20 minutes
IV infusion pump	$2,384.45	88 minutes

Value Components of a CPT Code

Practice Expense Component 96413- Supplies

Supply Description	Unit	Price	Quantity
cover, thermometer probe	Item	.038	1
gloves, non-sterile	Pair	.084	1
gloves, non-sterile, nitrile	Pair	.188	3
gown, staff, impervious	Item	1.186	1
iv infusion set	Item	1.112	2
iv tubing (extension)	Foot	.53	1
needle, Huber point	Item	3.328	1
syringe 10-12ml	Item	.184	1
syringe 1ml	Item	.14	1
syringe 20ml	Item	.558	1
syringe 50-60ml	Item	.881	1
syringe w-needle, OSHA compliant (SafetyGlide)	Item	.435	3
dressing, 4in x 4.75in (Tegaderm)	Item	1.771	1
heparin 1,000 units-ml inj	Ml	.193	1
sodium chloride 0.9% inj (250-1000ml uou)	Item	1.708	1
sodium chloride 0.9% inj bacteriostatic (30ml uou)	Item	.7	1
swab-pad, alcohol	Item	.013	2
swab, patient prep, 3.0 ml (chloraprep)	Item	1.81	1

Value Components of a CPT Code

Malpractice Expense Component (PLI)

"MP RVUs reflect the costs of malpractice insurance."

Liability Insurance RVU: **.05**

Value Components of a CPT Code

Geographic Pricing Cost Index (GPCI)

GPCIs are adjustments that are applied to each of the three relative values used in calculating a physician payment, as described above. The purpose of these adjustments is to account for geographic variations in the costs of practicing medicine in different areas within the country.

Work GPCI for Princeton, NJ: 1.023

PE GPCI for Princeton, NJ: 1.126

MP GPCI for Princeton, NJ: 1.068

Value Components of a CPT Code

Medicare Payment for 96413

Work RVU x Work (GPCI) +

.28 x **1.023**

Practice Expense (PE) RVU x PE GPCI +

3.39 x **1.126**

Malpractice (PLI) RVU x PLI GPCI

.05 x **1.068**

= **The Total RVU**

= **4.15698**

Value Components of a CPT Code

Medicare Payment for 96413

Total RVU x CY 2015 Conversion Factor of **$28.22**

4.15698 x **$28.22**

= Medicare Payment

= $117.31

Medicare Physician Fee Schedule (MPFS)

- The CY 2015 conversion factor (CF) will remain at $35.80 from January 1, 2015 to March 31, 2015 as mandated by the Protecting Access to Medicare Act.

- If there is no change in the law, the conversion factor will be $28.22 as of April 1, 2015 (representing a 21.2% decrease).

- The estimated CY 2015 payment increase for oncology is +1%

2015 Claims Hold

"In order to implement corrections to technical errors discovered after publication of the MPFS rule and process claims correctly, Medicare Administrative Contractors will hold claims containing 2015 services paid under the MPFS for the first 14 calendar days of January 2015…"

Medicare Physician Fee Schedule (MPFS)

Potentially Misvalued Codes

- For several years, CMS has been engaged in an effort to identify and review potentially misvalued codes.

- In the 2015 proposed rule, the following services (among others), were deemed to be “high expenditure/potentially misvalued):

Medicare Physician Fee Schedule (MPFS)

Potentially Misvalued Codes (cont'd)

- 96372: Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
- 96375: Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug
- 96401: Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic
- 96409: Chemotherapy administration; intravenous, push technique, single or initial substance/drug

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Medicare Physician Fee Schedule (MPFS)

Potentially Misvalued Codes (cont'd)

- The review of the services has been delayed, due to the review of services with global periods.
- ***Global Period*** *is a time frame following surgery during which routine care by the physician i.e., all necessary services normally furnished by a physician [before (Pre-operative), during (Intra-Operative), and after (Post-operative) the procedure] are included in the reimbursement of the original surgery and they cannot be separately reported.*
- CMS has finalized the proposal to transition and revalue all 10- (minor procedures/endoscopies) and 90- (major procedures) day global services with 0- (minor procedures) day global periods.
- CMS still feels the high expenditure screen is an effective tool for identifying potentially misvalued codes, but needs to focus on the global period issue.

Hospital Outpatient Prospective Payment System (HOPPS)

- CMS will continue the policy of providing additional payments to the 11 designated cancer hospitals so that the hospitals' payment to cost ratio, with the adjustment, is equal to the weighted average for the other OPPS hospitals.

- CMS is "examining various alternative payment policies for drug administration services, including the associated drug administration add on codes."

- CMS emphasizes "hospitals should report all HCPCS codes for all services, including those for packaged services, according to correct coding principles."

Hospital Outpatient Prospective Payment System (HOPPS)

Place of Service Codes

- Due to the increased number of hospitals acquiring physician practices (therefore also increasing the delivery of physician services in a hospital setting), CMS has decided to implement place of service codes for physician/practitioner claims.
- New Modifier-PO: Services, procedures, and/or surgeries provided at off-campus provider-based outpatient departments.
- Applies to hospital claims
- Reporting of the modifier will be *voluntary* until CY 2016, then it will become **mandatory**
- Providers will append the modifier to every code for all outpatient hospital services furnished in an off-campus provider based department of a hospital
- Questions as to whether a particular location requires the modifier should be referred to the CMS regional offices.

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Drugs and Biologicals Update

- For CY 2015, payment for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals that do not have pass through status continue to be set at the statutory default of average sales price (ASP) + 6 percent.

- Section 1833 of the Social Security Act permits CMS to make pass-through payments for a period of at least two, but not more than three years after the product's first payment as a hospital outpatient service under Medicare B.

Drugs and Biologicals Update

Drugs for which pass-through status will expire on December 31, 2014:

J9019

Injection, asparaginase (erwinaze), 1000 iu

J9306

Injection, pertuzumab, 1 mg

Drugs and Biologicals Update

Drugs and Biologicals with pass through status as of January 1, 2015:

J9301
Injection, obinutuzumab, 10mg

J9047
Injection, carfilzomib, 1mg

J9262
Injection, omacetaxine mepesuccinate, 0.01

J9354
Injection, ado-trastuzumab emtansine, 1mg

J9371
Injection, vincristine sulfate liposome, 1mg

J9400
Injection, Ziv-Aflibercept, 1mg

Coding and Billing Updates

Care Management Services

- Significant revisions have been made to the E&M codes chapter in the 2015 AMA CPT Professional Edition
- The E&M services chapter now includes a new section entitled “Case Management Services.”
- This section now encompasses four types of services.

Coding and Billing Updates

*Transitional Care Management Codes (CPT Codes **99495** and **99496**)*

Transitional Care Management (TCM) Codes were developed to describe services provided by a physician or other qualified healthcare professional to patients following a discharge from a hospital, SNF, or CMHC stay, outpatient observation, or partial hospitalization.

*Chronic Care Management Services (CPT Code **99490**)*

These services are provided to patients with two or more chronic or episodic conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation /decompensations, or function decline.

*The subsection "Chronic Care Management Services" as well as CPT code **99490** is new for 2015.*

Coding and Billing Updates

*Complex Chronic Care Management Services (CPT codes **99487** and **99489**)*

These services are similar to Chronic Care Management Services. However, the complex services require at least 60 minutes of staff time and decision making of moderate or high complexity.

*The descriptors for CPT codes **99487** and **99489** have been revised to include the required elements for reporting these codes.*

*Advance Care Planning (CPT codes **99497** and **99498**)*

Advance Care Planning services involve counseling and discussing advance directives for a patient related to his/her medical treatment in the event that they will lack decisional capacity.

Advance Care planning codes are new for 2015.

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Coding and Billing Updates

Prevention Medicine, Individual Counseling

In 2014 The Department of Health and Human Services (HHS) has released specifications regarding the tobacco cessation services that health insurers are required to cover under the Affordable Care Act of 2010 (ACA).

Health insurers are required to cover the following with no patient co-insurance:

- Screening for tobacco use.
- For those who use tobacco, two cessation attempts per year, each composed of four tobacco cessation counseling sessions, and access to all Food and Drug Administration (FDA)-approved tobacco cessation drugs (both prescription and over-the-counter).

Smoking and tobacco use cessation counseling can be reported with CPT codes 99406 and 99407.

Coding and Billing Updates

HCPCS Codes

New HCPCS Modifiers

- PO: Services, procedures, and/or surgeries provided at off-campus provider-based outpatient departments.
- XE: Separate encounter, a service that is distinct because it occurred during a separate encounter.
- XP: Separate practitioner, a service that is distinct because it was performed by a different practitioner.
- XS: Separate structure, a service that is distinct because it was performed on a separate organ/structure.
- XU: Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

Coding and Billing Updates

HCPCS Codes

- Modifiers XE, XP, XS, and XU are intended to replace modifier -59 for Medicare patients.
- Each Medicare contractor will post information on when and how these modifiers are to be applied.
- According to the Novitas website, the use of the modifiers are optional for now and providers may continue to use modifier -59 (January 2015 Quarterly Release Overview)

Coding and Billing Updates

NCCI Modifier -59 Clarification

- The modifier -59 is used to indicate a distinct procedural service from another service performed the same day.
- The Medicare National Correct Coding Initiative (NCCI) released an article which details the basic tenets of modifier -59 and examples.
- Its purpose is to clarify the appropriate use of the code, as it is frequently misused.

Coding and Billing Updates

Excerpt from “Modifier -59 Article.”

1. Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

2. Modifier 59 is used appropriately when the procedures are performed in different encounters on the same day

3. Modifier 59 is used inappropriately if the basis for its use is that the narrative description of the two codes is different.

Coding and Billing Updates

4. Other specific appropriate uses of modifier -59

- Modifier 59 is used appropriately for two services described by timed codes provided during the same encounter only when they are performed sequentially.

- Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.

- Modifier 59 is used appropriately for a diagnostic procedure which occurs subsequent to a completed therapeutic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure.

"Modifier -59"

http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

Coding and Billing Updates

Deleted HCPCS codes Effective 12/31/14

J9265

Injection, paclitaxel, 30mg

C9201

Injection, obinutuzumab, 10 mg

Coding and Billing Updates

New HCPCS codes Effective 1/1/15

J9301

Injection, Obinutuzumab, 10mg

J9267

Injection, paclitaxel, 1mg

Coding and Billing Updates

ICD-10

The implementation of ICD-10 was once again delayed from October 1, 2014 to **October 1, 2015**.

Coding and Billing Updates

ICD-10

Providers and practices should continue to prepare for the implementation:

- Review ICD-9 to ICD-10 crosswalks.
- Ensure administrative processes are in place to address the ICD-10 implementation.
- Take advantage of end to end testing opportunities offered by Medicare or private payers.
- Confirm technology will be up to date for the transition.

Coding and Billing Updates

ICD-9 and ICD-10 Codes

- HIPAA covered entities may continue to use ICD-9 codes until **September 30, 2015**.

- As of **October 1, 2015**, ICD-10 goes into effect, and covered entities may no longer report ICD-9 codes.

Coding and Billing Updates

Partial Coding Freeze

- The ICD-9-CM Coordination and Maintenance Committee implemented a partial freeze ICD-9-CM and ICD-10 (ICD-10-CM and ICD-10-PCS) codes and prior to the enactment of ICD-10 (currently scheduled for October 1, 2015).

- A partial freeze means that no new ICD-9 or ICD-10 codes will be created and no updates or changes to current codes will be made (except on a limited basis).

- The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made on October 1, 2011.

Coding and Billing Updates

Partial Coding Freeze

- On October 1, 2012, October 1, 2013, and October 1, 2014 only limited updates were made to both the ICD-9-CM and ICD-10 code sets in order to capture new technologies and diseases as required by section 503(a) of Pub. L. 108-173.

- On October 1, 2015, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses as required by section 503(a) of Pub. L. 108-173. There will be no updates to ICD-9-CM, as it will no longer be used for reporting.

- On October 1, 2016 (one year after implementation of ICD-10), regular updates to ICD-10 will begin.

Coding and Billing Issues

E&M and Chemotherapy

Frequently asked question: Can an Evaluation and Management (E&M) Service be billed on the same day as a chemotherapy services?

Coding and Billing Issues

E&M and Chemotherapy

- Often, an office visit which includes the provision of drug infusion services will *also* involve a visit with the physician.

- The work of the physician in providing these “face-to-face” services may include:
  - taking a history,
  - conducting a physical examination,
  - reviewing laboratory and radiology data, making decisions about the proper course of action,
  - discussing these recommendations with the patient and family,
  - and obtaining consent if required.

Coding and Billing Issues

E&M and Chemotherapy

- If the plan is to proceed with the administration of chemotherapy or other therapeutic agents in the outpatient setting, the patient then goes to the drug infusion suite where the actual therapeutic is administered, often on the same day.

- Therefore: the work provided by the physician during the direct face-to-face encounter *may* appropriately be coded by using the E&M code that most accurately describes the level of service provided.

Coding and Billing Issues

E&M and Chemotherapy

What raises red flags for payers?

Examples:

- Billing an E&M service with *every* chemotherapy administration visit.
- Frequently billing a high level E&M service (such as 99215).
- Documentation that does not substantiate the use of the code

Coding and Billing Issues

E&M and Chemotherapy

Background on Evaluation and Management Services and Drug Infusion

ASCO's Letter to CMS on Coverage of Evaluation and Management Services with Chemotherapy

Billing and Coding Resources

http://www.asco.org/practice-research/billing-and-coding

Resources

Oncology Reimbursement Update 2015

http://www.accc-cancer.org/oncology_issues/articles/JF15/JF15-COMPLIANCE-Published-before-Print-12-11-14.pdf

Medicare Physician Fee Schedule

Payment System Fact Sheet Series

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedcrePhysFeeSchedfctsht.pdf

Physician Fee Schedule

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html?redirect=/physicianfeesched

ASCO Resources

Medicare Physician Fee Schedule and Hospital Outpatient Prospective System

Comment letters and summaries on the MPFS and HOPPS.

http://www.asco.org/practice-research/medicare-physician-fee-schedule-and-hospital-outpatient-prospective-payment-system

Billing and Coding

Information regarding important coding and reimbursement topics.

http://www.asco.org/practice-research/billing-and-coding

Coding and Reimbursement Service

Submit questions to ASCO staff regarding coding and reimbursement issues.

http://www.asco.org/advocacy-practice/coding-and-reimbursement-service

ICD-10

Resources and information regarding ICD-10.

http://www.asco.org/practice-research/icd-10

ASCO Resources

Types of Questions	Contact
Coding, billing, and reimbursement	billingandcoding@asco.org
General practice related questions	practice@asco.org

Questions?

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