Chargemaster Updates for 2014
by
Glenda Schuler

November 18, 2013
Registration/ 8:00 a.m.
Session 8:30 a.m. – 3:30 p.m.
Radisson Hotel - Bismarck ND

A number of changes
Plenty of changes have occurred since publication of the 2013 edition. The new 2014 edition contains close to 350 CPT changes. This program will cover those changes affecting the facility’s chargemaster as well as the surgical CPT code changes assigned by HIM Coding Staff. Faculty also will review the new, deleted and revised CPT and healthcare common procedure coding system codes, as well as the revised CPT modifiers. The OPPS Final Rule’s reporting challenges will also be incorporated into each clinical area’s discussions. Suggestions for implementation and attendee comments and questions will be addressed.

Who should attend
This seminar is targeted to individuals responsible for APCs, Billing Revenue Cycle Management and Chargemaster Maintenance. The following individuals are encouraged to attend: Coders/Managers/Directors; Chargemaster/APC Coordinators; Revenue Cycle Managers; Perioperative Services Directors; Health Information/Medical Records Managers/ Director of Patient Financial Services; Billing Office/Business Office Managers; Pharmacy Directors; Supply Chain and Purchasing Managers; Ancillary Departments; Nurse Auditors; Compliance Auditors

OBJECTIVES:

Upon completion with the program, participants will be able to:
• Incorporate 2014 codes to individual facility’s chargemasters
• Describe reporting scenarios for reporting new CPT/HCPCS Codes
• Understanding reporting requirements and impact on reimbursement by Medicare
• Identify impact of new reimbursement levels for ambulatory payment classification payments
• Understand the impact of status indicator changes for 2014
• Provide departmental specific guidance in the proper reporting and utilization of the new codes
I. New Updates Impacting Chargemaster
   a. Laboratory - Another Exciting Year
      • Chemistry, Immunology, Pathology and Microbiology Revisions
      • Molecular pathology – additional new codes
   b. Radiology
      • The consolidation of additional S & I codes
   c. Endoscopy/GI Lab
      • Start from scratch – all new codes
   d. New Category III Codes
      • Review of the new Codes for 2014
   e. Observation Challenges in 2014
      • New HCPCS Codes
   f. Impact on reimbursement for hospitals
   g. Respiratory Therapy
      • Minimal impact for 2014

II. Infusions and Injections – Anything new?
   a. Injections/Immunizations
   b. Chemotherapy/therapeutic administration

III. Wound Therapy and Hyperbaric Oxygen Therapy

IV. Transitioning of more Surgical CPT codes from Inpatient Only
   a. Payment for use of modifier – CA
   b. Review of inpatient only list and CDM requirements

V. Rehabilitation Services
   a. Review of new CPT/HCPCS coding requirements for 2014

VI. Changes for Supplies, Devices, Biologicals and Pharmaceuticals
   a. Pharmaceutical Reimbursement Impacts
      • Review of payment changes and financial forecasts
      • HCPCS changes – Pharmacy
      • Self-Administered versus Supply Drugs – anything new?
      • Billing/documentation for discarded products
      • Anticipation of modifier JW
      • Contrast Updates
      • Radiopharmaceutical Updates
      • Supplies and Biologicals
      • Procedure-to-device/Device-to-Procedure Edits
      • New Technology and Pass-Through Payments
      • Chargemaster Required Revisions for CY 2014
      • DMEPOS Updates
      • Incorporating new Biological Products into the Chargemaster

VII. Pulmonary Rehab/Intensive Cardiac Rehabilitation

VIII. Evaluation and Management Codes
Glenda J. Schuler, RHIT, CPC, CPC-H

Glenda is a Senior Consultant in the Health Care Solutions and Delivery Practice and joined Ingenix in 1998. Currently, Glenda is a Healthcare Consultant/Project Specialist for various consulting engagements, including ICD-9/DRG validation; CPT coding audits; APC education; APC Impact and Implementation and hospital chargemaster audits/engagements for health care facilities ranging from 30 bed to 900+ bed size. In her current role, Glenda is responsible for providing technical assistance and solutions for stand-alone hospitals and integrated health care organizations. She conducts chargemaster reviews based on Medicare and other third-party payers reporting requirements for small acute care hospitals as well as large university teaching facilities. She provides follow-up assistance, supporting Ingenix clients in maintaining a Medicare compliant chargemaster, offering advice for proper CPT, HCPCS and revenue code assignment.

Glenda is part of the American Health Information Management Association and gained her Certification as a Registered Health Information Technician from the American Health Information Management Association in Chicago, Illinois. She belongs to the American Academy of Professional Coders and is a Certified Professional Coder (CPC) and a Certified Professional Coder-Hospital (CPC-H.) She is also an AHIMA Approved ICD-10-CM/PCS Trainer.

She is a preferred educator/speaker on Medicare’s Outpatient Prospective Payment System (HOPPS) for national organizations and numerous state hospital associations and a requested speaker for HFMA, state hospital associations, and healthcare facilities for chargemaster, CPT coding and APC educational seminars, as well as a selected speaker for the national conferences of the American Academy of Professional Coders (AAPC) as well as the American Health Information Management Association (AHIMA).

Schedule

Registration begins at 8:00 a.m.; program begins at 8:30 a.m. and concludes at 3:30 p.m. including time for questions/answers. Continental Breakfast, lunch and breaks are provided.

Program Site

Radisson Hotel, 605 E Broadway Avenue, Bismarck ND 58501, 701 255-6000

Room rate of $104.00 if booked before October 18th. Be sure to mention the North Dakota Hospital Association (NDHA) block of rooms.

Registration

NDHA/HFMA Member Fees:

1st and 2nd Registrant $179.00 per person
Additional Registrants $159.00 per person

Non-member Fees $300.00 per person

A member hospital is referred to as an individual facility, not a hospital system. Fees reflect the cost of program development, administration, promotion, faculty expenses, materials, lunch and break items. A late fee of $25 will be added if registration is received after November 11, 2013.

NDHA wishes to take those steps required to ensure no individual with a disability is excluded, denied service, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services.

NDHA reserves the right to cancel or reschedule due to an insufficient number of registrants or other unforeseen circumstances. Registration fees, less a $25 cancellation fee are refundable if notice is received five working days prior to the program date. Registrants unable to attend may send an alternate. No shows will be billed. Space is limited!!

Certificates of attendance will be provided for all participants.
For additional information, contact Linda Simmons (701) 224-9732. You may register for this program in any of the following ways:

**Mail** this completed form to:
North Dakota Hospital Association
PO Box 7340
Bismarck ND  58506

**Fax** this form to (701) 224-9529    **Online** at [http://www.ndha.org](http://www.ndha.org), under Education

If you do not receive a confirmation e-mail, please contact our office.
BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) finalized policies related to inpatient admission and review criteria, including physician certification and admission order requirements, in the fiscal year 2014 hospital inpatient prospective payment system final rule. On Sept. 5, CMS issued guidance further clarifying physician certification and order requirements for inpatient admissions. These AHA talking points address the requirement set forth in the guidance requiring physicians at critical access hospitals (CAHs) to certify that a beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.

TALKING POINTS

CAH Physician Certification Requirements

Talking Points

- CMS’s guidance specifically sets for the following condition of payment for inpatient CAH services: The physician must certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.

- This condition of payment also is set forth in 42 CFR 424.15(a), a provision that was enacted in October 1997. Therefore, this is not a new requirement for CAHs.

- There is some confusion between this condition of payment and the 96-hour annual average length of stay condition of participation for CAHs.
  - The condition of participation related to length of stay for CAHs appears in Section 42 CFR 485.620 and states: The CAH provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient. That is, CAHs must maintain an annual average length of stay of 96 hours in order to maintain CAH certification.
  - The condition of payment related to length of stay for CAHs appears in 42 CFR 424.15(a) and states: Medicare Part A pays for inpatient CAH services only if a physician certifies that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. In other words, CAHs must meet this condition in order to be paid for a specific claim under Medicare Part A.
  - The conditions of payment and conditions of participation must then be read together. For example, if a physician has certified that an individual is reasonably expected to be discharged or transferred within 96 hours and the individual ends up staying longer, as long as the statutory annual average 96-hour length of stay requirement is met, the CAH will receive Medicare Part A reimbursement.

- CAHs may satisfy this condition of payment by including a physician certification form or statement in the medical record. If physician certification forms or statements are not included in the medical record, CMS’s guidance also specifies that this condition of payment may be met by either physician notes or by actual discharge within 96 hours.

- For further questions, contact Priya Bathija, senior associate director, at (202) 626-2678 or pbathija@aha.org
American Hospital Association, American College of Healthcare Executives and the Organ Donation and Transplantation Alliance present:

**Creating and Maintaining a Culture of Donation Excellence through Leadership**

**JOIN US!**

**Who:**
CEOs and Senior Leadership from State Hospital Associations, Hospitals, Organ Procurement Organizations, and Transplant Centers.

**What:**
CEO Leadership Webinar
- Learn how executive leadership of state hospital associations, hospitals, OPOs, and Transplant Centers work together to save lives
- Learn how effective partnerships build and support an effective organ donation process
- Find new ways to create and maintain a culture of donation and effective donation systems

**When:**
October 28, 2013
4:00 – 5:00 pm ET

**Registration Information:** There is no fee to join the Webinar, but registration is required. To register, visit: www.organdonationalliance.org and select Conference and Events tab, then Upcoming Conferences.

**ACHE credit:** The U.S. Department of Health and Human Services, Health Resources and Services Administration (HHS/HRSA) is authorized to award 1 hour of pre-approved ACHE Qualified Education credit for this program toward advancement, or recertification in the American College of Healthcare Executives. Participants in this program wishing to have the continuing education hours applied toward ACHE Qualified Education credit should indicate their attendance when submitting application to the American College of Healthcare Executives for advancement or recertification.
AGENDA

4:00 - 4:05 PM Welcome and Framing
George F. Bergstrom, FACHE
Vice President, Member Relations
American Hospital Association, Chicago, IL

LeAnn Swanson, MPH
Executive Director
Organ Donation and Transplantation Alliance

4:05 – 4:25 PM Role of Executive Leadership: How Hospitals, the AHA and State Hospital Associations Can Work Together to Save Lives
Rich Umbdenstock, FACHE
President and CEO
American Hospital Association

Deborah J. Bowen, FACHE, CAE
President and CEO
American College of Healthcare Executives

4:25 – 4:35 PM One Hospital’s Commitment to Creating and Maintaining a Culture of Donation
Eileen Whalen, MHA, RN
Executive Director and CEO
Harborview Medical Center

4:35 – 4:45 PM A State Hospital Association’s Involvement in Creating Effective Donation Systems
Bo Ryall
President and CEO
Arkansas Hospital Association

4:45 – 4:55 PM Partnering with your Organ Procurement Organization
Susan Stuart, RN, MPM
President, Association for Organ Procurement Organizations (AOPO)
President and CEO
Center for Organ Recovery and Education

4:55 - 5:00 PM Q&A Session and Wrap Up Discussion
Call to Action!
George Bergstrom
LeAnn Swanson
OCT. 10, 2013

HEALTH ADVISORY

Department of Health Investigating Hepatitis C Cases in Ward County
Providers Encouraged to Consider Acute Hepatitis When Diagnosing Patients

The North Dakota Department of Health (NDDoH) is working with various health-care providers in Ward County to investigate a cluster of hepatitis C virus (HCV) cases and is encouraging all providers to consider acute hepatitis in their differential diagnosis, as appropriate.

We are asking providers to maintain a high index of suspicion for acute hepatitis cases in patients of all ages. Hepatitis testing should be performed on all patients presenting with:

- Jaundice or icterus.
- Sudden rise in ALT and AST levels, even if they might be explained by other factors.
- Past or present injection drug users who present with non-specific flu-like or GI symptoms.

Providers making a diagnosis of viral hepatitis with laboratory confirmation are encouraged to report those cases directly to the Division of Disease Control. Reports can be made by calling 800.472.2180.

In August 2013, the NDDoH initiated a full-scale investigation of an unusual cluster of acute hepatitis C infections among patients with no discernible risk factors. Upon testing, it was discovered that seven patients were infected with the same genotype and quasi-species of hepatitis C virus, which indicates a single source of infection. It has been determined that the match between these viruses is greater than 96 percent identical. All of the cases are elderly (age 60 years and older) and have complex health histories.

Test results are currently pending from the Centers for Disease Control and Prevention for another 29 individuals who screened positive for antibody to HCV or have detectable HCV RNA to determine whether they are part of this cluster.

Nationwide, hepatitis C outbreaks have typically been related to breakdowns in health-care delivery. However at this time, the source for these infections is unknown and we are looking at all possibilities. Furthermore, it is unknown how long transmission has been occurring since it is difficult to discern between chronic and acute infection with hepatitis C. Also unknown is whether there is a point source for all the cases or if there is some propagated transmission. The NDDoH in conjunction with the local health department and area health-care facilities will continue to conduct surveillance testing of people from selected populations in order to help better understand how and where transmission is occurring.

At the request of some patients, providers may receive test results on their patients for tests conducted by the health department. Results may include hepatitis C antibody results, hepatitis C RNA qualitative and quantitative results, hepatitis C genotype, hepatitis B surface antigen, hepatitis B core antibody total, hepatitis B surface antibody and HIV results. In addition to case finding and enhanced
surveillance, the NDDoH initiated observation of patient care practices at local health-care facilities to better understand patient flow from acute to transitional to long-term care, individual health-care needs, assessing high-risk activities (i.e., pain management, medications, blood draws, etc.) and transfer of individuals between all facilities.

We also encourage providers to perform screening tests on those in the general population deemed to be high risk:

- Current or former injection drug users, including those who injected only once many years ago
- Recipients of clotting factor concentrates made before 1987, when more advanced methods for manufacturing those products were developed
- Recipients of blood transfusions or solid organ transplants before July 1992, when better testing of blood donors became available
- Chronic hemodialysis patients
- Persons with known exposures to HCV, such as:
  - Health-care workers after needlesticks involving HCV-positive blood
  - Recipients of blood or organs from a donor who tested HCV-positive
- Persons with HIV infection
- Children born to HCV-positive mothers
- Individuals who receive tattoos or body piercings from an unregulated entity
- Baby boomers born between 1945 and 1965 who have never been tested

Categories of Health Alert messages:

- **Health Alert** conveys the highest level of importance; warrants immediate action or attention.
- **Health Advisory** provides important information for a specific incident or situation; may not require immediate action.
- **Health Update** provides updated information regarding an incident or situation; no immediate action necessary.
- **Health Information** provides general information that is not necessarily considered to be of an emergent nature.

This message is being sent to local public health units, clinics, hospitals, physicians, tribal health, North Dakota Nurses Association, North Dakota Long Term Care Association, North Dakota Healthcare Association, North Dakota Medical Association, and hospital public information officers.
2013-2014 North Dakota Flex RFP Released

The North Dakota Medicare Rural Hospital Flexibility Program is pleased to announce that its annual request for proposals is now open to critical access hospitals. Applications are due on October 18, 2013. Electronic applications are required. The Flex guidance and application are similar to last year.

The Flex Steering Committee will review the grant applications in early November. Award notifications will be made on November 4, 2013.

All information including the RFP is posted on our website at ruralhealth.und.edu/projects/flex/grants

If you have any questions concerning the Request for Proposal, please feel free to contact Angie Lockwood at 701.777.5381.

Primary Care Week at UND School of Medicine & Health Sciences

Come meet your potential new workforce! The Center for Rural Health is hosting the Community Meet and Greet at The University of North Dakota’s School of Medicine and Health Sciences (SMHS) in conjunction with the 2013 Primary Care Week activities. Primary Care Week is an annual event, coordinated by the North Dakota American Medical Student Association, which highlights the importance of primary care and brings health care professionals together to discuss and learn about generalist and interdisciplinary health care, particularly its impact on and importance to underserved populations.

This event will provide an opportunity to promote your community, facility and any health care openings to UND students in health care programs. This event will take place Tuesday, November 5 from 11:00 am to 1:00 pm in the Vennes Atrium at the School of Medicine and Health Sciences in Grand Forks.

If you would like to participate in the 2013 Community Meet and Greet, please contact Kylie Nissen to get a registration form via e-mail.

Questions? Contact Mark Barclay, Workforce Specialist, at 701.777.3300 or Kylie Nissen. The registration deadline is October 14, 2013.

Community Healthcare Association of the Dakotas Resources

The following resource is from the Community Healthcare Association of the Dakotas (CHAD) which supports the work of community health centers in North and South Dakota. The information addresses the Health Insurance Marketplace which opened on October 1, 2013. It is not specific to CHCs and can be beneficial to rural hospitals. There are approximately 60,000 to 70,000 North Dakotans without health insurance and the level of health insurance coverage in rural North Dakota is below that found in the urban centers.

There will likely be questions regarding the Marketplace, Medicaid Expansion, and other features of the Affordable Care Act that will be asked of hospital and primary care clinic personnel and providers. The information below may help you to better meet the needs of your clients and patients. You may use it for community education. The Center for Rural Health is participating in the Navigator weekly updates and as more resources are made available they will be conveyed to the North Dakota hospitals.

www.communityhealthcare.net/?page=HIM
New Briefing Paper and Policy Brief on Skilled Nursing Facility Services and Critical Access Hospitals

The Flex Monitoring Team is pleased to share with you findings from their study on factors influencing Critical Access Hospital decisions to close or retain their skilled nursing facility (SNF) units.

Why Do Some Critical Access Hospitals Close Their Skilled Nursing Facility Services While Others Retain Them?
Click to download the Briefing Paper and/or the Policy Brief

Key Findings

• Critical Access Hospitals (CAHs) that closed Skilled Nursing Facility (SNF) units cited a range of financial challenges related to payer mix, operating costs, cost allocation methods, and service utilization patterns.

• The availability of alternative local long term care services, including swing beds, often contributed to hospitals’ decisions to close their SNF units.

• CAHs that continued to operate SNF units were driven primarily by community need, despite the financial disincentive for doing so.

• Hospitals reported substantial variation in their strategies for using swing beds for SNF, rehabilitation, and post-acute services.

• Given ongoing concerns about financial viability and low census rates among some CAHs, further research on the ability of CAHs to expand patient services and revenues through swing bed use is warranted as is research on the quality and outcomes of skilled care delivered by CAHs in SNF and swing beds.

Authors of the Briefing Paper and Policy Brief are John A. Gale, Zachariah T. Croll, Andrew F. Coburn, from the University of Southern Maine, and Walter R. Gregg from the University of Minnesota.

North Dakota Hospital City Tax Rates - 2013

Sales tax is levied on three different geographies. There is a 5% state sales tax applicable to all cities. There is a range of 1% to 3% city sales tax applicable to cities. There are currently four counties that have a range of 0.25% to 1% county sales tax applicable to those counties.

Example: The city of Grafton has a tax rate of 7.25%. Of that, 5% is state, 2% is city, and 0.25% is county. Cass County sales tax is 0.5%. Steele County sales tax is 1%. Walsh County sales tax is 0.25%. Ward County sales tax is 0.5%.

Sales tax amounts are representative of changes effective 10/1/2013.

If you would like a pdf copy of this map, please contact Angie Lockwood.
ORHP Funding Opportunity Announcement: Rural Health Network Development Program (HRSA-14-044)

The Federal Office of Rural Health Policy (ORHP) is pleased to announce the release of the FY 2014 Rural Health Network Development Grant Program (announcement number: HRSA-14-044). ORHP’s Network Development Program supports rural integrated health care networks that have combined the functions of the entities participating in the network in order to: achieve efficiencies; expand access to, coordinate, and improve the quality of essential health care services; and strengthen the rural health care system as a whole.

Applicants must be mature and/or established networks consisting of at least three members. The network should have a skilled and experienced staff as well as a highly functioning network board with the capability of offering integrated products and services. ORHP has taken a new approach with the program for this upcoming competitive cycle to better align with the legislation, and the current healthcare environment. The authorizing legislation identifies three primary charges for integrated health care networks: achieve efficiencies; expand access to, coordinate and improve the quality of essential health care services; and strengthen the rural health care system as whole. Applicants to the Rural Health Network Development Program will be required to select at least one activity from a prescribed topical area from one legislative charge outlined by the authorizing legislation.

The application can be downloaded off of [www.grants.gov](http://www.grants.gov) and entering in the announcement number (HRSA-14-044) or by clicking on this link: [www.grants.gov/view-opportunity.html?oppId=243713](http://www.grants.gov/view-opportunity.html?oppId=243713)

Applicants may propose funding for up to three (3) years from May 1, 2014 to April 30, 2017. The maximum award an applicant can request is up to $300,000 per year. ORHP expects to fund approximately 15 grantees.

The deadline to submit an application in [www.grants.gov](http://www.grants.gov) is November 22, 2013. ORHP strongly recommends that applicants submit their applications prior to the due date to avoid any technological problems. All applications have to be submitted electronically in [www.grants.gov](http://www.grants.gov), and waiver request to submit a paper copy application will not be accepted.

There will be a technical assistance call on Thursday, October 10, 2013 at 2:00 PM EST to assist applicants in preparing their applications. The Adobe Connect webinar and call-in information is as follows:

**Meeting Name:** Rural Health Network Development Program  
**To join the meeting as a guest:** [hrsa.connectsolutions.com/ruralhealthnetwork/](http://hrsa.connectsolutions.com/ruralhealthnetwork/)  
**Toll-free call in number:** 1.888.946.3411  
**Participant Passcode for call in number:** Network  

The purpose of the call is to go over the grant guidance, and to provide any additional or clarifying information that may be necessary regarding the application process. There will be a Q&A session at the end of the call to answer any questions. While the call is not required, it is highly recommended that anyone who is interested in applying for the Rural Health Network Development Program plan to listen to the call. It is most useful to the applicants when the grant guidance is easily accessible during the call and if questions are written down ahead of time for easy reference. For your reference, the Technical Assistance call will be recorded and available for playback within one hour of the end of the call and will be available until November 22, 2013. The phone number to hear the recorded call is 800-813-5525, Passcode, 5169.

If you have any further questions about this funding opportunity, please contact Leticia Manning, 301.443.8335.