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Centers for Medicare and Medicaid Services

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TRAINING THE TRAINER: QUESTIONS AND ANSWERS

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Wednesday, February 5, 2003

PARTICIPANTS

MODERATOR:

Suzanne Lewis

CMS REPRESENTATIVES:

Cindy Read, Division of Outpatient Care
Deborah Hunter
Anita Heygster
Faith Ashby, Division of Institutional Claims Processing
Joan Sanow, Division of Outpatient Care
Janet Wellham, Division of Outpatient Care
Jean Stellara [ph] of Outpatient Care
Darryl [ph] Lee, Division of Outpatient Care
Melissa Dean, Division of Outpatient Care
Ms. Moore, Provider Communications
Lynn Merritt-Nixon, Division of Quality Management
Stuart Barranco
Charlotte Benson
Lana Price
Karen Allen
Antoinette Johnson, Division of Institutional Claims Processing
Nicole Atkins, Division of Institutional Claims Processing

1 **P R O C E E D I N G S**

2 [1:30 p.m.]

3 MS. LEWIS: I want to give you a little bit of
4 background on what is happening with provider education.
5 Actually, today there is a videotape that is being taped
6 for you that we will be sending to you in the last week
7 of February. This tape will include a lot of unusual,
8 difficult claims examples, and we are hoping that that
9 will be very helpful and clarify things for you, things
10 that are in the PM.

11 We also are preparing a training guide that
12 will be online, as well as a PowerPoint presentation that
13 you will be able to use when you train your providers.
14 All this info will be outlined in the PM that we will be
15 sending out. I will have information at our next call,
16 which is February 19th, to give you a better idea of when
17 to expect the PM, but when we have the PM sent, we will
18 also have the URL information where you can download all
19 those resources.

20 So I just want to now open the call up to
21 questions that you may have. Just before we do that, I
22 would like to let you know who is here around the table
23 at CMS, and so we will go around the table and people

1 will introduce themselves and will also let you know what
2 component they are from at CMS.
3 **Introductions**
4 MS. ASHBY: Faith Ashby. I am with the
5 Division of Institutional Claims Processing.
6 MS. WELLHAM: Janet Wellham at the Division of
7 Outpatient Care.
8 MS. _____: Jean Stellara [ph] of Outpatient
9 Care Jean Stellara [ph] of Outpatient Care.
10 MS. READ: Cindy Read, Division of Outpatient
11 Care.
12 MS. _____: [Inaudible], Division of Outpatient
13 Care.
14 MR. _____: Darryl Lee, Division of Outpatient
15 Care.
16 MS. DEAN: Melissa Dean, Division of Outpatient
17 Care.
18 MS. MOORE: [Inaudible] Moore, Provider
19 Communications.
20 MS. SANOW: Joan Sanow, Division of Outpatient
21 Care.
22 MS. LEWIS: Thank you.
23 Operator, if you could please open up the lines

1 for the first question.

2 **Question-and-Answer Session**

3 DR. McKINNEY: This is Greg McKinney. I am a
4 physical intermediary medical director for Cahaba GBA. I
5 had a question about under Section 12: Billing for active
6 wound care procedures. I want to make sure I understand
7 what the OPPS release is instructing us to do.

8 No. 97602, which is generalized wound care is
9 not reimbursable under OPPS. It is packaged into the E&M
10 visit. The PM states that if 97602 is the only procedure
11 billed, then the hospital may bill 99211.

12 Could I clarify? We have interpreted that as,
13 they need to bill 97602 in addition to that E&M visit
14 that the hospital bills, not just 99211 alone. The
15 reason we have interpreted as together 97602 and 99211
16 is, there would be no way to track that from a data
17 purpose down the road to identify utilization of that
18 code, and I was wondering what the interpretation from
19 CMS was.

20 MS. READ: Dr. McKinney, this is Cindy Read.
21 Unfortunately, while we have a room full, and we just
22 added several new people to the room, we don't have
23 everybody in this room who had a hand in preparing that

1 particular instruction. This is an issue which we need
2 to consult our medical officer.
3 I don't recall whether Suzanne explained this,
4 but we will try to answer as many questions during this
5 call that we can. Those that we cannot answer will be
6 answered later. We have a transcriber who is recording
7 the entire conversation, so any questions that we can't
8 get to, we will have a record of and will be answer to
9 respond to later.
10 So I don't have, in short, an answer for you
11 right now, Dr. McKinney, but thank you for raising that
12 as an issue, and we will address that either in a
13 subsequent call or another medium.
14 DR. McKINNEY: Okay, thank you. Just to
15 clarify, I appreciate this being addressed in the OPPS
16 update. I think it is, though, a little unclear as to if
17 they are to bill both codes or the 99211 alone. I would
18 advocate that we ask them to bill the 97602 along with
19 the 99211 for data purposes, so that we can track
20 specific services that they are performing.
21 MS. READ: Okay, thanks.
22 OPERATOR: Ms. Lewis, at this time, there are
23 no further questions.

1 MS. LEWIS: It will be a very short call if you
2 don't have questions. We are also open to hear comments
3 about anything that may need more clarification.
4 MS. FRICK: Hi, this is Madonna Frick from Blue
5 Cross. Since we don't have any questions, we are going
6 to ask this one, just to keep us busy this morning.
7 On the new 2003 HCPCS Code, there seems to be a
8 discrepancy between the instructions between the carriers
9 and the FIs. The carriers are being told to hold all of
10 their 2003 new HCPCS, and that when the new rate goes in
11 they will be paid, and if any are paid incorrectly, if
12 they send them in under the 2002 HCPCS, they are going to
13 go back and do math adjustments.
14 The FI's instructions are that we are to RTP
15 them, and it is our understanding that the new 2003 HCPCS
16 Code effective date for the rate actually does not go in
17 until March the 1rst of 2003, and not January the 1st of
18 2003.
19 Is that correct?
20 MS. _____: This is not an OPPS issue, Madonna,
21 and so we don't have anyone here that can address your
22 question or your concern.
23 MS. FRICK: Well, aren't they outpatient codes?

1 MS. ASHBY: This is Faith Ashby. You can call
2 me offline if you want to talk about this. I can
3 probably help you --
4 MS. FRICK: Okay, Faith. What is your --
5 MS. ASHBY: -- but since it's not OPPS-related,
6 we don't want to address it here. I am at (410) 786-
7 6145.
8 MS. FRICK: Okay, thank you.
9 MS. LEWIS: Thanks, Madonna.
10 DR. McKINNEY: Could someone update us on
11 Section, I guess it is 14, if I am reading my Roman
12 numerals correctly, drug-eluding stents, if we have any
13 update of what is going to transpire with FDA approval
14 and what we are to tell providers, if we know anything at
15 this point?
16 MS. READ: Now, I had a conversation yesterday
17 with Johnson & Johnson. At the moment, they still do not
18 have FDA approval. They are expecting it sometime this
19 quarter, but our ability to implement the code in that
20 particular APC and OPPS is dependent upon the date of the
21 FDA approval. We are going to see what we can do, but at
22 the moment, it is not been approved.
23 DR. McKINNEY: As of now, Option 1 is off the

1 books. So only Option 2 or 3, as far as the Board.
2 MS. READ: Well, we are working towards
3 finalizing our April release. At the moment, it is just
4 status quo. We are just waiting for the FDA approval.
5 Once that occurs, we will implement it as soon as we can.
6 DR. McKINNEY: Okay, thank you.
7 MS. LEWIS: Thanks, Cindy.
8 MS. DUNCAN: This is Kitt Duncan from Blue
9 Cross Blue and Shield of Georgia. On Section 3, it
10 addresses outpatient billing for dialysis, which, we
11 really appreciate this change. This is great, but we are
12 wondering what is the revenue code that they should bill
13 the dialysis treatment under.
14 MS. _____: The dialysis people are going to be
15 here a little later in the call, but we are looking to
16 see if we can help you in the meanwhile. So if you hang
17 on for a minute.
18 MS. DUNCAN: We think our choices are probably
19 either the emergency room or perhaps a clinic. I
20 wouldn't think we would bill it under 360. So I think we
21 are kind of limited, but we just wondered if you all had
22 a preference or a recommendation.
23 MS. _____: I would say we don't have a

1 recommendation. We usually leave it up to the writers to
2 bill it under the comp center that they want the comp to
3 show up for it. There is not a particular dialysis place
4 to bill it under, so a clinic or wherever the service is
5 performed.
6 MS. DUNCAN: All right. Thank you.
7 MS. LEWIS: Thank you.
8 MS. ALLEN: This is Karen Allen from CMS. I
9 don't have a question, actually I have a response to the
10 person from Blue Cross Blue Shield of Arizona regarding
11 the fee schedule.
12 The statement that you made regarding the
13 differences between the carrier and the intermediaries is
14 correct. CMS knowingly made this distinction in how to
15 handle the claims. Those claims subject to the physician
16 fee schedule will begin being payable March 1st for new
17 HCPCS. Will begin being paid March 1st.
18 MS. LEWIS: Thank you, Karen.
19 MS. CLEVELAND: This is Nona Cleveland, United
20 Government Services, California. We just got the answer
21 to the question regarding the carrier and the FIs, but we
22 would like to know, which PM are we referencing today on
23 this call, which CR or change request?

1 MS. _____: The CR is 2503, the PM is 02-129.
2 MS. CLEVELAND: Thank you.
3 MS. LISEBERG: Karen, this is Lisa in Arizona
4 again. So let me just clarify. The new HCPCS that are
5 effective January 1st, the providers cannot use them on
6 claims with dates of service January or February. They
7 will have to use, what, an unlisted HCPCS code?
8 MS. LEWIS: Karen Allen can call back in. She
9 is actually not in this room. This is the only room here
10 at CMS that has an open mic. So in order for Karen to
11 answer that question, she will call back in.
12 MS. LISEBERG: Okay. Or, I can always talk to
13 her on the side. Can I ask one more question while I am
14 cued in?
15 MS. LEWIS: Yes.
16 MS. LISEBERG: There has been a lot of
17 discussion in the Federal Register on the surgical
18 procedures that are on the Inpatient Only List. If the
19 patient dies, the facility can bill an inpatient on
20 those. If the patient has to be transferred, then I
21 believe those can also be billed on an inpatient basis.
22 So that, basically, we are going from an outpatient to an
23 inpatient claim.

1 However, we still have a lot of providers here
2 that are reviewed with the pro, and the pro is looking at
3 inpatient claims, and they are stating that these short
4 stays really should not have been inpatient, they should
5 have been outpatient.
6 The question, I guess, that we have had is,
7 when can physician's orders be changed from inpatient to
8 outpatient, or outpatient to inpatient, vice versa?
9 MS. SANOW: This is Joan Sanow. I'm sorry, I
10 didn't catch your name.
11 MS. LISEBERG: Lisa Liseberg.
12 MS. SANOW: Lisa. Okay, this is a question
13 that was received repeatedly. It appears to be a source
14 of considerable confusion. We are in the process of
15 working with the folks who issue the inpatient CPS, and
16 going back and looking at our manuals to determine this
17 matter of timing.
18 I think we have kind of taken the position that
19 the physician issues an order which is documented at some
20 point in the medical record. Our manuals are not real
21 explicit on this point and we are trying to pull together
22 internally, across the various components, a sense of
23 what the appropriate response would be in terms of when a

1 physician is allowed to change an order.

2 Clearly, physicians shouldn't be changing

3 orders to circumvent payment requirements.

4 MS. LISEBERG: We would agree with that.

5 MS. SANOW: We are also aware of the fact that

6 physicians sometimes sign orders, perhaps, after the

7 fact. An order may be issued verbally or by phone, and

8 then the physician comes in and catches up with the

9 paperwork and signs it.

10 The confusion seems to rest, in part, among

11 physicians understanding what an Order To Admit is.

12 MS. LISEBERG: I have got to agree with that,

13 too.

14 MS. SANOW: And that an Order To Admit as an

15 inpatient has a certain significance, whereas an Order To

16 Admit into observation or whatever, does not have any

17 meaning under Medicare.

18 So, as I say, this is a matter of some

19 confusion. It may rest, in part, in educating

20 physicians, when they say "admit," do they intend that to

21 be admitted as an inpatient to receive inpatient services

22 because the patient's condition warrants that, or is

23 their intention that the patient be observed for a

1 certain period of time. It would seem that physicians
2 don't always make those fine distinctions.
3 MS. LISEBERG: I would have to agree with you
4 on that. Would it help if we sent to you some of the
5 issues that we have gotten from providers, as far as
6 examples?
7 MS. SANOW: It would help enormously. We've
8 got several, and we know that there is a problem when the
9 -- QYO, is it?
10 MS. LISEBERG: Yes.
11 MS. SANOW: Or the internal hospital review
12 committee goes back and reviews an admission and says,
13 well, this wasn't really necessarily, then how does the
14 hospital get paid, and so on.
15 Real-life examples would be most valued in
16 helping us to evaluate the extent of this problem and
17 where we need to address it.
18 MS. LISEBERG: Okay. Could I get your Email?
19 MS. SANOW: Sure. It is jsanow@cms.hhs.gov.
20 MS. LISEBERG: Okay, great. Thank you very
21 much.
22 MS. SANOW: Thank you, and I will look forward
23 to receiving the examples. I mean, it is much easier for

1 us to look at actual occurrences than hypothetical.

2 MS. LISEBERG: Okay, great. Thank you so much.

3 MS. SANOW: Thank you.

4 MS. ALLEN: This is Karen Allen, and I am back

5 again. The services that are payable under Outpatient

6 PPS that had new HCPCS codes that were supposed to be

7 effective January 1, 2003, are indeed effective January

8 1, 2003, and should be processed for payment. Services

9 that are subject to the Medicare Physician C Schedule

10 database, those new HCPCS codes are not effective until

11 March 1st. I think that might be the clarifying

12 information that Arizona was looking for.

13 Also, I sent out to all of the data centers,

14 which they should have shared with you, basically a list

15 of all the new HCPCS codes and whether or not those HCPCS

16 match to the APC, or if they were paid under the fee

17 schedule so you would be able to separately identify

18 which codes had to be active 1/1, and which ones had to

19 be active on 3/1.

20 That's the end of my story and I'm sticking to

21 it.

22 MS. LEWIS: Thanks for calling back, Karen. I

23 hope that this does clarify to the caller from Arizona.

1 MS. READ: I just wanted to say one other thing
2 in further clarification of that. Under the Outpatient
3 Prospective Payment System, we do many of the same codes
4 that are used by the physician fee schedule. Whether or
5 not the service is paid under the physician fee schedule
6 and whether or not it is paid under OPPS determines the
7 implementation date of the new codes that occurred. As
8 Karen indicated, under OPPS we updated with the new 2003
9 CPT codes on January 1st.
10 MS. _____: Right. Whereas, last year we were
11 delayed for three months.
12 MS. LEWIS: Thanks, Cindy.
13 DR. McKINNEY: I had a question involving
14 Section 9 and the section that deals with billing for
15 devices for which C codes have expired. Section 9 is
16 billing for prostrate brachytherapy. I wonder if I could
17 get clarification. The new G codes for brachytherapy,
18 according to the PM, includes the trends of peritoneal
19 placement of the needles, et cetera, et cetera, and the
20 brachytherapy sources.
21 Has that G code been priced to include those C
22 codes, which now have expired? Is that the premise for
23 the expiration of the brachytherapy C codes? And if so,

1 do we not want them to build a specific radioisotope,
2 i.e. the C code, after the 1st?
3 MS. _____: This is [inaudible]. We have two G
4 codes, one for brachytherapy with iodine, and the other
5 one with palladium. The G code payments that we will
6 make for those C codes does include the cost of the
7 respective brachytherapy fees.
8 DR. McKINNEY: Okay, so that is why they were
9 rolled off, and then A, B, C was inflated to incorporate
10 the price of the fees?
11 MS. _____: No.
12 DR. McKINNEY: Okay. Great.
13 QUESTION: Back to the inpatient versus
14 outpatient question or issue. Our hospitals have been
15 asking for a policy on that as well, specifically, when
16 can a physician change an order. They have gotten some
17 response from the CMS that said the physician can change
18 the status of the patient at any time before discharge.
19 We have had a lot of back-and-forth about it,
20 because the section in the manual that still is there in
21 the hospital manual, 230.7, says that it is the intent at
22 the time that the physician makes the determination. So
23 we had asked that question of CMS, and just the other day

1 I got a response back from Steven Phillips. He says that
2 this is being reviewed and the American Hospital
3 Association has agreed to coordinate the issue as far as
4 an answer to that.
5 We don't know when the decision will come, but
6 we have some providers who are adamant about getting some
7 kind of an answer. They admit a person, the QY
8 coordinator comes in the next day and says, uh-uh, it
9 doesn't meet inpatient, and wants it changed. So we are
10 in a real dilemma with that.
11 MS. SANOW: Right. This is Joan Sanow again.
12 That is exactly right. We understand this predicament,
13 and in fact, as I said, Steve Phillips is involved with
14 the inpatient PPS. This is a cross-cutting issue and we
15 are consulting the HA on this to try and resolve the
16 apparent contradiction.
17 QUESTION: All right. Thank you.
18 MR. COPE: Jim Cope from UGS/CMD. I would like
19 to go back to Greg McKinney's question about Section 12.
20 I don't know if there is anyone on the call that can
21 answer this, but again, it is the billing of this 97601
22 and 602. The first sentence under that heading says
23 97601 is a physical therapy service. I am certainly in

1 agreement with that. There seems to be some discrepancy
2 around the country as to who can use and bill that code.
3 In other words, are those codes only for
4 therapists, be they physical or otherwise, or can that
5 code be used by other providers, specifically nurses?
6 MS. READ: Again, I don't think we have the
7 right person or people in the room to answer that
8 question, but we have made note of it. Again, as I said,
9 it will be in the transcript. I apologize for the fact
10 that we don't have everybody here to answer every
11 question today.
12 MR. COPE: I understand. If I could just add
13 that Rory Feinberg has told me that not only are these
14 codes only for physical therapists, but the 97 series of
15 codes in general are only for therapists, not just
16 physical. I am still searching for where there is
17 written, apparently somewhere in the Federal Register,
18 but my colleagues and I have yet to find it.
19 If I could add a comment on the last caller,
20 also. This observation-versus-inpatient, et cetera,
21 issue is a big one. I have gotten lots of these issues
22 in the Midwest also. I think it was Joan, you can count
23 on getting some Email from me, too.

1 MS. SANOW: Great. I will look forward to it.
2 Thanks.
3 MS. READ: Another thing I will say, too, is
4 that we have mandatory payment classifications and an
5 advisory panel, who were just in a couple of weeks ago.
6 They also raised a number of issues related to
7 observation services, and they have agreed to form a
8 subcommittee that is going to be looking at these issues.
9 So any further insight that you wish to share
10 with us through Joan, or any further discussions of the
11 problems that you all are seeing out there in the field
12 will certainly be helpful as the workgroup tries to
13 address some of these issues and looks to present the
14 recommendations to us. So we would funnel any of that
15 information to the agency subcommittee. Thanks.
16 MS. LEWIS: Thanks, Cindy.
17 MS. MEYERS [ph]: This is Janet Meyers from
18 Noridian. It kind of relates back to the ESRD and the
19 dialysis services with No. 3. We have a lot of providers
20 and consultants that have been asking this question. I
21 think we did send it in to CMS, but we have not received
22 a response yet from our regional office. What their
23 question is, a lot of these patients from skilled nursing

1 facilities, or their beneficiaries that are out in the
2 community, and they are not renal dialysis patients but
3 they are treating them in their treatment rooms.
4 Is it appropriate for them to actually place
5 these beneficiaries for EPO injections or some ESRD
6 services, and even some of the chemotherapy
7 administrations, in a treatment room, along with billing
8 for the administration of those services, too. We are
9 not positive if they should actually be billing for them
10 in the treatment room because they, a lot of times, are a
11 scheduled visit in an outpatient department, which, they
12 are bringing them in through their emergency room, and
13 that really doesn't fit the true definition of an
14 emergency room service either.
15 MS. MERRITT-NIXON: This is Lynn Nixon. Are
16 you stating that these individuals are categorized as
17 ESRD patients? They are acute patients?
18 MS. MEYERS: Right now they are stating that
19 they do not have the chronic renal diagnosis at this
20 time. So I don't know if they are patients that they are
21 trying to newly diagnose and they are trying some
22 different treatment with them. We have tried to get the
23 providers to be a little bit more explicit, but I don't

1 know if they are kind of withholding some information
2 because they don't want to give us any more than they do
3 not have the chronic renal dialysis diagnosis.
4 Sometimes, back and forth with our calls, we
5 were asking -- sometimes they may be going to another
6 facility because it is so many miles for them to go to
7 where their primary physician is, so they might be going
8 to a facility that is not related to the ESRD treatment
9 center either.
10 So we are just trying to find some information
11 if they should actually even put them in a treatment, or
12 if it should be considered more of an office visit.
13 MS. MERRITT-NIXON: Well, the categorization
14 whether they are ESRD or acute is going to make a big
15 difference in what the response is for that. So we need
16 to get a little more information as to what type of
17 patients these are, what category they are going to fit
18 into before I can actually give you a correct response on
19 that.
20 Can I give you my phone number and Email
21 address, and we can talk about this a little further?
22 MS. MEYERS: You sure can.
23 MS. MERRITT-NIXON: Again, it is Lynn Nixon,

1 N-I-X-O-N. My number is (410) 786-4652, and my Email
2 address is lmerritnixon@cms.hhs.gov.
3 MS. MEYERS: Thank you.
4 MS. VENA [ph]: Hi. This is Barbara Vena from
5 the -- Hospital Service. I have, actually, two
6 questions. One is, we received a lot of calls from
7 providers that are questioning the issue around self-
8 administrable drugs, and when it is an integral part of a
9 procedure. You can spell it out as a package service,
10 even though the patients are taking the rest of the stuff
11 home. An example would be [inaudible] -- and then they
12 use some from the tube, then the patient takes that home.
13 They bill it out as a package service. Or, the inhaler
14 situation, where the patient takes the inhaler home with
15 them.
16 We basically provide one interpretation, that
17 if they order and prescribe and present to the patient a
18 brand new tube or a brand new inhaler, then that is when
19 it becomes a self-administrable drug. You could almost
20 classify it as [inaudible] and it would be something they
21 could bill under 250 and it would be packaged into the
22 actual treatment procedure.
23 Then they got into big discussions about, when

1 do I have to bill something that is packaged, and when
2 don't I. So for instance, if they are treating a patient
3 in the clinic and the patient is getting the supplies
4 that are integral to the service but they are a small,
5 tiny dollar amount, do they have to, if they have never
6 billed stuff out like that before -- I think inhalers are
7 in that category. I don't bill out on a claim form
8 before they tell me. It has always been part of the E&M
9 service that they have provided to the patient.
10 Is there any CMS requirement that the provider
11 has to bill out as a package service?
12 MS. WELLHAM: This is Janet Wellham. There is
13 no requirement. If I understand your question, Barbara,
14 it is that the hospital has to show it on a separate
15 line?
16 MS. VENA: That is the question, Janet, yes.
17 MS. WELLHAM: As far as the packaging, or
18 including the charge as part of the clinic charge.
19 MS. VENA: Okay. What we have thought of in
20 the past is the impact on future rate-setting if we don't
21 capture those charges, but if it is insignificant, I
22 don't think the provider should revamp their --
23 MS. WELLHAM: Barbara, I was meaning to say

1 that the charge should be captured either separately, or
2 it was already reflected in the charge for the clinic
3 visit, not to lose track of those charges of a rate-
4 setting.
5 MS. VENA: Right. So they shouldn't lose track
6 of it, but there is no requirement that they bill it out
7 on a separate line.
8 MS. WELLHAM: Right.
9 MS. VENA: Good answer. The other question I
10 have is, discrepancies between Addendum B as published in
11 the Federal Register. Will CMS be providing any kind of
12 errata PM that will identify what was in the Federal
13 Register, as opposed to what actually made it through the
14 OCE in the pricing program?
15 MS. WELLHAM: There are a couple of answers to
16 that. First of all, we expect that there will be a
17 correction notice published in the Federal Register for
18 some of the items that we became aware of that were
19 discrepancies, technical mistakes and so forth, soon
20 after publication of the November 1st Final Rule.
21 So that may account for some of the
22 discrepancies that you see between the current Addendum B
23 and what is currently in OCE on pricing, because we

1 caught them in time to get the changes implemented in
2 January 1, through the OCE in prices.
3 We have been told that the correction of this
4 is going to go on display on the 7th, on Friday the 7th.
5 So it should be published sometime next week. Then we
6 will have something. I expect, as we usually do, put
7 that up on our website, or have a link to it on our
8 website.
9 MS. VENA: Thank you.
10 MS. WELLHAM: You're welcome.
11 MS. MARTLETT: This is Angie Martlett for Blue
12 Cross Blue Shield of Kansas. Vicky is sitting beside me.
13 We have a question, also, about the drugs treated as
14 supplies.
15 With respect to any oral medications, other
16 than antiemetics with chemo patients, but oral
17 medications that may be administered to a patient that
18 could be considered directly related to maybe an
19 outpatient surgery, our interpretation is that wouldn't
20 happen, that if it is an oral medication, it is still not
21 covered and it should be billed to the patient. But from
22 looking at the PM, we kind of got the impression that
23 maybe there are cases that oral meds would be treated as

1 a supply and should not be billed to a patient.
2 Could we have an answer on that one?
3 MS. WELLHAM: Well, in our Final Rule and PM, I
4 think we gave some examples of some items that we felt
5 were integral. I interpret the phrase "related to" and
6 "integral to" as somewhat different. "Related to" could
7 mean any number of drugs that might be covered or might
8 not be, and "integral" in our minds relates to drugs or
9 items without which the surgery can't be performed.
10 We placed this discussion in our Final Rule
11 largely because of some questions we had received
12 regarding eye drops that are absolutely essential to
13 reticular ophthalmologic surgeries, cataract surgeries, I
14 believe. So those were the sort of things that we were
15 referring to. We don't have a definitive list of
16 everything that we -- but it doesn't say to exclude oral
17 drugs. If an oral drug is an integral part of a
18 procedure or service, then they would fall under this
19 category of drugs treated as a supplies.
20 MS. MARTLETT: We have asked our hospitals to
21 give us specific examples. Without being completely
22 clinical, I am not sure I know, but a couple of examples,
23 and if you could respond to those. A surgical patient

1 who during the recovery process is having incisional pain
2 and needs -- is that integral to a procedure?
3 MS. WELLHAM: An oral painkiller?
4 MS. MARTLETT: An oral painkiller, but
5 incisional-related. Some of the hospitals are saying it
6 is integral, I don't know the answer.
7 MS. WELLHAM: Well, we haven't defined it down
8 to that level, to be quite honest, at the Central Office.
9 I mean, our staff here, we're not completely aware of
10 all the possibilities. But I think, as we have issued
11 this Final Rule and the related PM, and have started to
12 receive some more specific questions, I think we are
13 going to be looking, in the near future, to see whether
14 we need to and can provide some more specific direction
15 to you all, the fiscal intermediaries, which would then
16 be issued to the providers.
17 MS. _____: Do you have any other examples?
18 MS. MARTLETT: They also talked about patients
19 who come in with chest pain, and occasionally they will
20 give them an aspirin. Some of the hospitals said that is
21 procedure and it is oral. Is that integral?
22 MS. _____: In ER.
23 MS. MARTLETT: In the ER. And we weren't

1 asking them for more examples like that, because we just
2 couldn't respond without your input.
3 MS. _____: Well, it helps us to have those
4 specific kinds of examples.
5 MS. MARTLETT: Ditto.
6 MS. _____: If you can provide those. In the
7 meanwhile, I think, largely, until we issue something
8 definitive to the intermediaries, we would ask that you
9 use the guidelines that we have established in the Final
10 Rule in the PM.
11 MS. MARTLETT: So, what do you think about
12 those two cases? Are you undecided? What do I tell
13 them?
14 MS. _____: We don't have any clinical staff in
15 the room at the present time, and I think we need to
16 consult with clinical staff to give you an answer on
17 those two particular items.
18 MS. MARTLETT: Okay, great. Do you need me to
19 Email them to you?
20 MS. _____: Not those two, but if others arise,
21 or anyone else on the call that has specific examples
22 such as the two you just mentioned. The aspirin given
23 for chest in the ER, and the oral painkiller related to

1 incisional pain in the recovery area, those are good
2 specific examples I think we need to kind of roll out to
3 our medical advisors and assess, within the context of
4 the policy, and see.
5 MS. MARTLETT: Who do you want those to go to?
6 MS. _____: Could you send them to Sabrina
7 Ahmed, and I will let her give you her address.
8 MS. AHMED: It is sahmed@cms.hhs.gov.
9 MS. MARTLETT: Great. Thanks.
10 MR. COPE: I guess I'm going to get back to
11 that 97601 issue again, and I understand we may not be
12 able to answer it today. The other side of that question
13 is, presuming that, yes, those 97 codes are therapy
14 issues only, that would raise the question of how a
15 similar procedure done by someone other than a therapist
16 might be coded.
17 Prior to outpatient PPS, there was a lot of CPT
18 procedure codes that were viewed as physician-only codes,
19 but many of those codes, I think, now are used for
20 procedures done by non-physicians. For example, the
21 debrisments done by nurses in an outpatient department.
22 So I guess, really, the question is to,
23 specifically, those debrisment codes. But maybe someone

1 could comment on the issue of "physician-only" codes. In
2 outpatient PPS's, isn't it true that in many instances we
3 can kind of drop the physician concern?
4 MS. _____: Could you define what a "physician-
5 only" code is, and what the source of that determination
6 is?
7 MR. COPE: Well, I wish I could. I think that
8 is part of the confusion. I will give you a specific
9 example that was thrown at me this week. It is this
10 wound debrisment codes. The only choices that I know of
11 are either those 97601 and -02 codes, or the series that
12 begins 11040 through about -44, but I wouldn't expect a
13 non-physician to do more than a -41, maybe -42.
14 There are many around the country who view
15 those 11 codes as codes that can only be billed by a
16 physician. However, in an outpatient department, if a
17 nurse were doing this under the supervision of, and I
18 will put that phrase in quotes, a physician, would those
19 be appropriate codes, I guess?
20 MS. WELLHAM: This is Janet Wellham. In the
21 hospital outpatient setting, we are paying for the
22 facility piece.
23 MR. COPE: Yes, I agree. I guess maybe I

1 should apologize. Maybe I'm using this as a forum here,
2 but believe me, there is great confusion around the
3 country, both in contractors and in providers about this
4 exact issue. There are policies that say that nurses
5 providing wound care must use the 97 codes and should not
6 use the 11 codes.
7 I think you made the right comment, from my
8 understanding, that we are paying for the facility fee,
9 therefore who is doing the procedure isn't really the
10 issue.
11 Is that a reasonable way to say that?
12 MS. WELLHAM: Let me back up again and say that
13 there are certain codes that stand out, like maybe the
14 therapy that you were talking about that may have to be
15 done by a physical therapist. We may have some rules
16 along those lines, and if we don't, then we draw back to
17 state licensing laws, and if the state requires it, what
18 level of practitioner is necessary to do some services.
19 I wouldn't say that we never care about --
20 there are things like clinic visits in a physician's
21 office, where it is performed by a physician. I'm not
22 certain of that, but in a hospital outpatient setting, a
23 nurse could really see a patient and do some low-level

1 clinic visits.

2 MR. COPE: Well, right, I agree. I didn't mean

3 to imply we never care. Obviously, I don't expect to see

4 a nurse doing a cervical laminectomy, for example. But I

5 think we are in agreement, let's put it that way.

6 Another example is, the various places, as Greg

7 alluded to earlier, that we are occasionally allowing the

8 99212 code to essentially provide payment for codes that

9 otherwise have none. That is an E&M code that maybe

10 isn't being used entirely properly from a correct coding

11 standpoint.

12 But again, I guess I would say that the coding

13 of these debrisments is an issue around the country, and

14 I think there is a lot of confusion. I think that is

15 enough said from my end. Thank you.

16 QUESTION: On those 1100 codes, when those

17 first came out on the outpatient rehab list for

18 therapists to be able to do those, the problem it

19 presented was it was changing it to an ASE type of bill,

20 and therefore paying big bucks compared to what a

21 therapist would normally do.

22 When that got taken off the list of the

23 outpatient rehab, it really helped considerably in

1 getting identified that it was not an actual operating
2 room procedure, which those codes tend to imply and
3 therefore pay before APCs, and now as an ASE procedure.
4 So that is one comment.
5 The other is on the oral meds, our hospitals
6 were very concerned about compliance with this, and have
7 in fact even sent in some voluntary overpayment for
8 things that we just kind of wished they drop, like the
9 eye drop thing. Sometime back, we did receive
10 clarification that oral meds self-administered are oral
11 meds, and until the law changes, even those that are part
12 of the pain medication for incisional pain are in fact
13 oral.
14 So we went with a bulletin telling our
15 providers that. So they have been very conscientious
16 about the self-administered. This PM is a really
17 effective rule change so that we can tell them things
18 that are integral to a procedure they can bill.
19 Also, it seems like the PM talks mostly about
20 procedures. If you start talking about every emergency
21 room possibility, we will be having to provide lists of
22 things that say okay/not okay, and I'm not sure that that
23 is feasible.

1 That's all.

2 MS. READ: Could I just clarify? When you were

3 talking about ASE procedures in the debrisment, I assume

4 you were referring to a pre-OPPS era when we had a blend

5 for certain surgical services.

6 QUESTION: Right. When we had the ASE, it

7 changed it to that bill type, to pay under one of the ASE

8 groups, but even with OPPS, my understanding is that CMS

9 took that off of the outpatient rehab list because it was

10 paying way too much. It is paying as a surgical

11 procedure.

12 MS. READ: I'm sorry, the codes --

13 QUESTION: The 1100 codes within the surgical

14 procedure sections of the CPTs.

15 MS. READ: Right. I mean, they are regarded as

16 a surgically significant procedures, right?

17 QUESTION: Yes, but when a therapist does them,

18 they were paying as a surgical procedure, which it is

19 really not right. They are doing a debrisment, but

20 certainly not at that physician's surgical level.

21 MS. READ: Okay. Well, it sounds like there

22 may be an issue with respect to how the codes are being

23 used or whether or not the codes can represent different

1 levels of service. I don't think anybody in here is
2 qualified to respond to that, but we will make note of it
3 and see if anyone can help us to resolve that after we
4 consult with people who work on the therapy fee schedule,
5 as well as our clinical and coding experts.
6 DR. McKINNEY: I have a comment. It is not my
7 original question, but about the 1100 series, the CPT
8 manual is pretty explicit that those are physician
9 services under general anesthesia. We do not allow non-
10 physicians to perform those codes.
11 Having said that, I have a question about the
12 "certain drugs." I think part of the loophole in this PM
13 is that it says "integral to a treatment," and a lot of
14 providers are going to argue that a lot of drugs are
15 integral to a treatment, and that would spill over into
16 the emergency room visit, i.e. our aspirin example.
17 The other examples would be for procedure for a
18 patient that is hypertensive and they get there for their
19 procedure and the blood pressure is up, the
20 anesthesiologist may slap a catapres patch on him or give
21 him some clonidine PO to bring their blood pressure down,
22 which, some would argue is integral to having a procedure
23 performed.

1 I think it produces a loophole, that we have to
2 start itemizing all this stuff. I know that it is not an
3 easy subject, but there are certainly going to be avenues
4 for people to come question whether something is covered
5 or not.
6 I will say, having been on some of the self-
7 administered drug talks, if we are not going to cover
8 insulin IV in the emergency room, I cannot not see how we
9 could cover an aspirin.
10 MS. READ: This is Cindy Read. I understand
11 and share your concerns. That is why I think we need to
12 get some additional guidance out to you all that you can
13 use when you speak with your providers and educate them.
14 DR. McKINNEY: That would be great. Thank you.
15 MS. READ: We certainly did not intend this to
16 circumvent all of the nonself-administered drug rules.
17 We just wanted to make sure that where there was a
18 particular item that was absolutely critical to the
19 provision of a particular service. We wanted you to know
20 that it was packaged.
21 DR. McKINNEY: Thank you.
22 MS. READ: Thanks.
23 MS. LADD: Hi. It's Carol Ladd with Empire. I

1 have a general question. Many of the questions, that
2 were very good questions, are going to be taken offline.
3 Will the answers to those questions be shared at one of
4 the future conference calls, or is there anything going
5 to be put out in writing so that we all can benefit from
6 the resolution?
7 MS. READ: This is Cindy Read. I know there
8 were a couple of instances where people were asked to
9 call directly, but I would say in general those questions
10 that we weren't able to answer today because we don't
11 have all of the right people, or issues that require
12 further development, will definitely result in some
13 general and widespread distribution of that information.
14 How that information is disseminated will
15 depend on the nature of it. If it is something that is
16 simple, that we can refer back to on previously issued
17 instructions, then perhaps in our next call, we can just
18 state that or do something through a Q&A.
19 MS. KOABEL [ph]: Hi. This is Jenny Koabel
20 from Empire. I have a question back on that wound
21 debrisment HCPCS discussion, the 11040 through -44 codes.
22 We have found that the C rates are being provided from
23 CMS on the rehab abstract file. Because of those rates,

1 it leads to a lot of confusion as to when the C rate is
2 considered a therapy and when it is not.
3 I wonder if somebody could just elaborate on
4 that topic. We realize an APC is applied when an
5 outpatient hospital bill would bill these codes, but for
6 example, if a SNF were to bill these codes, they would
7 get the therapy fee rate.
8 Is this proper and correct?
9 MS. ASHBY: Jenny, this is Faith Ashby. We do
10 have instructions in, I think, 3653 of the Intermediary
11 Manual, and those codes are paid under the physician's
12 fee schedule when provided by other than a hospital
13 outpatient department, but since there has been a lot of
14 concern over those codes and how they should be paid and
15 who should be billing for them, I think we have to, like
16 Cindy said earlier, look at this and talk to our clinical
17 people and see if we are going to be making any changes
18 or not. Currently, you would have to follow the
19 instructions that are in place.
20 MS. KOABEL: I don't think they are listed
21 there, and that is where our confusion is.
22 MS. ASHBY: If it is not listed there, then
23 they are not part of the rehab fee schedule. I don't

1 have the instruction in front of me, so I can't look it
2 up at the moment.
3 MS. KOABEL: Okay. We will discuss it further,
4 then.
5 MS. ASHBY: At one time, they were there. I
6 don't know if we removed them or not.
7 MS. KOABEL: The most recent copy does not
8 include them. The question is, on the fee schedule -- I
9 just, two hours ago, was looking at the fee rates for
10 2003 on this group of codes.
11 So again, we were given rates in 2002, and here
12 we are in 2003. I am not sure they belong on the file,
13 or if they are appropriate for anybody.
14 MS. ASHBY: If there are any instructions that
15 should be on the file, if we have a discrepancy, we will
16 have to fix that.
17 MS. KOABEL: There you go. That is what we
18 would like to know about. There is a discrepancy.
19 MR. COPE: I am trying not to beat this one
20 into the ground, and by the way, I am planning on calling
21 you later. I agree with what Dr. McKinney said about the
22 CP definition of those 11 codes. However, I have just
23 this week, although I don't have it in front of me,

1 discovered somewhere -- I think it is in the Federal
2 Register -- a discussion about those codes and the fact
3 that they were not meant to include that part about
4 anesthesia, especially since the two lower of them are
5 pretty simple, basic debrisment procedures.
6 Certainly, when I find that reference, I will
7 get it to you, Gregg. If anyone is interested at the
8 Central Office, I can certainly get that for you, too.
9 Just to highlight where this has been going,
10 this was brought to my attention this week because some
11 instruction we have given to a provider in the recent
12 past, they didn't seem to like our answer, and suddenly I
13 got a call from a fairly high up physician at the Central
14 Office, wanting to know all the details.
15 So it has come round about, back to your
16 Baltimore offices. I guess, just to reiterate that we
17 need to work this out as soon as we can.
18 MS. _____: Do you know who the physician was?
19 MR. COPE: Sure, Bill Rogers, though I guess he
20 is technically in Washington.
21 MS. _____: Okay. Thanks.
22 MR. COPE: I must say that one of the things he
23 sent me that he had gotten was something from the, what

1 are they called, the woundostomy/continence nurses, and
2 they seem to want to use the 97 codes.
3 By the way, it is interesting because the 11
4 codes pay about twice what the therapy codes pay.
5 MS. _____: Well, again, clearly this is a
6 matter of widespread concern that we are going to need to
7 -- with other folks who are involved in this and try and
8 catch up. It is not something, I don't think, that was
9 much on our radar screen.
10 MS. DeUNATO [ph]: This Theresa DeUnato with
11 Riverbend. I have a question in regards to the
12 outpatient billing for dialysis. You gave three bulleted
13 circumstances in which they could bill. My question is,
14 would it also be appropriate for the hospital to allow
15 for this if the patient is being refused to be seen by
16 all ESRD clinics due to the fact of possible danger to
17 them?
18 MS. MERRITT-NIXON: This is Lynn Nixon again.
19 This disruptive patient issue that you are referring to
20 is one that we don't have a good solution for, but the
21 section of the outpatient PPS would apply only if the
22 patient were in an emergency situation. It is not meant
23 to be abused for routine treatment three times a week.

1 So we are aware of the issue of patients being
2 blackballed by chains. It is a growing problem, and we
3 are hoping to address the issue in the upcoming
4 regulations in the conditions recoverage, but until then
5 we don't have a good solution to the problem.
6 MS. DeUNATO: Okay, thank you.
7 MS. WIGLEY [ph]: This is Tina Wigley of the
8 Provider Education and Training with United Government
9 Services. We have got to wind up this conference call.
10 I just have a question regarding the provider
11 education training piece of this program memorandum. Is
12 this training something that we are doing in addition to
13 what we already have scheduled, when it comes to
14 educating providers in our service area?
15 MS. LEWIS: Hi. This is Suzanne Lewis. You
16 should be training your providers about the changes in
17 OPPS from 2002 to 2003. What we are going to provide
18 from Central Office will be some resources that you can
19 use, such as the Training Guide, and also a PowerPoint
20 presentation, and the video should also give you some
21 good examples that you can use when you are training your
22 providers.
23 So these are the things that will be outlined

1 in the PM in terms of how to access the resources from
2 the Web.
3 MS. WIGLEY: Okay, but with that said, are you
4 saying to us that this is separate training? Because at
5 least at UGS, we have scheduled out our training sessions
6 already for provider types. So we have workshops already
7 out on our website and tentative workshops scheduled.
8 So my question is, is this in addition to what
9 we are doing right now?
10 MS. LEWIS: Part of what you have already
11 scheduled, is that on these changes that have occurred
12 within OPPS?
13 MS. WIGLEY: No, but when the PM came out, we
14 are already meeting on incorporating new items and things
15 into our workshop. The first workshop was done the first
16 quarter because it begins in October, but with the
17 addition of the PM we are, as I speak to you, going to
18 meet in terms of what we need to add to our presentation
19 when we do go out.
20 MS. LEWIS: These resources would be additional
21 things that you can use in your existing training that
22 you have scheduled.
23 MS. WIGLEY: Okay, that's what I needed to

1 know. Thank you.

2 MS. LEWIS: You're welcome.

3 OPERATOR: Ms. Lewis, at this time, there are

4 no further questions.

5 MS. LEWIS: Okay, thank you. I just want to

6 take a minute to have those that are around the table

7 here at CMS who didn't introduce at the beginning of the

8 call do that now.

9 MS. JOHNSON: Antoinette Johnson, Division of

10 Institutional Claims Processing.

11 MS. ATKINS: And [inaudible] Atkins, Division

12 of Institutional Claims Processing.

13 MS. MERRITT-NIXON: Lynn Nixon in the Division

14 of Quality Management. We are responsible for ESRD

15 coverage and payment.

16 MS. LEWIS: Thank you for all of you who

17 participated. I also want to remind you that the next

18 call is scheduled for Wednesday, February 19th.

19 OPERATOR: Excuse me, Ms. Lewis, we do have one

20 more question.

21 MS. LEWIS: That's fine, one more question.

22 MS. FIELD: This is Jane Field with Cahaba in

23 Des Moines. I wonder, is there an avenue where we can

1 send questions ahead of time for the next call?
2 MS. LEWIS: If you have questions for the next
3 call, you can just ask them live during the next call.
4 If there are things that are urgent --
5 MS. SANOW: No, no, no. I'm thinking if there
6 are questions, that we would have a little bit of advance
7 notice. So that, for example, if it is a very specific
8 issue that it would involve -- Lynn graciously came, but
9 it was at the very last minute. If there are particular
10 issues that involve expertise, for instance, to know
11 about therapy services that interplay or intersect with
12 OPPS, it would be helpful to know so then we can have
13 them here.
14 MS. FIELD: That's correct. That is what I was
15 going to ask.
16 MS. LEWIS: Joan will give you an Email
17 address. Those of you on the call, you can jot this
18 down, if you have questions for the next call.
19 MS. SANOW: A person on our staff who isn't
20 here today but I think would be a good point of
21 collecting such Email, and it would be helpful if you
22 could identify the Emails.
23 What are we calling these calls?

1 MS. LEWIS: Well, OPPS Q&A Conference Call. If
2 you could work the date of the next call in the subject
3 line of your Email, February 19th OPPS Q&A Call, that
4 would be helpful.
5 MS. SANOW: Yes. That would be helpful, just
6 so we can sort of screen out the ones that we need to be
7 attentive to for the next call from other inquiries that
8 come in.
9 The staff person's name is Sheryl Ackerman-
10 Ross. Her Email is sackermanross.
11 MS. LEWIS: Could you do that one just one more
12 time?
13 MS. SANOW: Sheryl Ackerman-Ross,
14 sackermanross.
15 MS. FIELD: Thank you. I appreciate that.
16 MS. SANOW: We can't promise that we will have
17 the whole agency here, but if we get -- clearly, it would
18 have been helpful to have someone here who could talk a
19 little bit more about these therapy codes today. So we
20 will try and finger folks if a particular question comes
21 up.
22 MS. LEWIS: Thank you. Operator, are there any
23 other calls?

1 OPERATOR: At this time, ma'am, there are no
2 further questions.
3 MS. LEWIS: Thanks. Then we will end our call
4 now, and again, thank you for your participation. Have a
5 good day.
6 [Whereupon, at 2:55 p.m., the teleconference
7 was concluded.]
8 + + +