

Part B Insider

News & Analysis on Part B Reimbursement & Regulation

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DIAGNOSIS CODING

Transition to ICD-10 Code Set Could Be Just 3 Years Away

► *The transition won't happen overnight — but will require some time to learn the ropes*

You've got just over a month left before you need to update your diagnosis codes — and you've only got three years left until the ICD-9 series is replaced by the new, overhauled ICD-10 codes, according to a recent HHS announcement.

Although the countdown to Oct. 1 — the date you'll need to institute the new ICD-9 codes — is fast approaching, the **Dept. of Health and Human Services (HHS)** delivered a whammy earlier this week with its announcement that ICD-10 codes aren't too far behind.

On Aug. 15, HHS announced its proposal to replace the ICD-9 codes with the ICD-10 series effective Oct. 1, 2011. Not only would the new code set completely overhaul your claims systems, software and super-bills — but it could require vast training for your staff.

Here's why: The ICD-9 code series includes 17,000 codes. The ICD-10 code set, however, contains over 155,000 codes that you'll have to wrap your brain around if it's implemented as HHS hopes it will be.

"We recognize that the transition to ICD-10 will require some upfront

costs, but each year of delay would create additional costs, both because of the limitations of ICD-9 and because of the need to employ the greater precision that ICD-10 codes provide to support value-based purchasing of health care and other initiatives," said CMS Acting Administrator **Kerry Weems** in a statement.

Many medical practices were surprised by the news of the impending ICD-10 implementation, despite the fact that CMS has been building the new code set for years.

"We've been thinking of ICD-10 as this far-away prospect that may never take hold," says **Heather Corcoran** with **CGH Billing**. "The new announcement sort of brings us back to the reality that this will indeed take effect."

The HHS is currently seeking comments on the proposed ICD-10 code set and transaction standards by Oct. 21. To read more, you can visit the CMS Web site at www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage. ■

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PART B MYTHBUSTER

Failing to Report X-Rays During the Global Will Cost You Money

► *Depending on how many x-rays you write off, you could be losing thousands*

Myth: X-rays that you shoot or interpret during the global period are not billable to Medicare because payers include these charges in the surgical package.

Reality: Practices that don't bill their x-ray charges are throwing away thousands of dollars in rightful reimbursement.

Scenario: An established patient reports to your office with pain, swelling and tenderness of the left wrist and forearm. The physician diagnoses the patient with a buckle fracture of the wrist, which he stabilizes with a splint before sending the patient home. The patient returns four weeks later and the physician takes two follow-up x-rays of the patient's forearm.

Bill Those Follow-Up X-Rays

The challenge: You should report fracture care (25600, *Closed treatment of distal radial fracture [e.g., Colles or Smith type] or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation*) and any x-rays performed for the initial visit. But can you report the follow-up x-rays?

The solution: Go ahead and report those films. If your practice performed and interpreted the x-rays, report 73090 (*Radiologic examination; forearm, two views*).

X-rays determine the patient's condition and the course of care, so they are never included in global packages. You can also report any follow-up x-rays separately. If you don't separately report the x-rays, you risk losing significant reimbursement, says **Leslie Follebout, CPC-ORTHO, PCS**, coding department supervisor at **Peninsula Orthopaedic Associates** in Salisbury, Md.

Because Medicare payers will reimburse about \$35 each time you report 73090, failing to report the x-rays could be an expensive mistake over the course of a year.

"When a fracture care code is selected, this only includes the initial casting and all follow-up visits within the 90 day global period," says **Kara Hawes, CPC-A**, of **Advanced Professional Billing, LLC**, in Tulsa, Okla. "All x-rays, subsequent castings and supplies are not included in the fracture care code. These services and supplies are not considered as edits or mutually exclusive codes by NCCI," she advises.

Billing x-rays outside of the global period doesn't apply only to fracture care claims. In fact, diagnostic services are not considered part of the global package in general, and may be billed separately. ■

CARDIOLOGY

CCI Rescinds Controversial Policy Restricting Only One PV Intervention Per Vessel

► **Watch out: You will still have problems with the reinstated policy, experts say**

No more will you have to limit your physician's peripheral vascular (PV) intervention to one vessel, when the initial intervention (for instance stent, atherectomy and angioplasty) failed.

Many societies, including the **American College of Cardiology**, protested Medicare's bundling policy, and their persistence paid off — literally.

Niles Rosen, MD, Correct Coding Initiative (CCI) medical director, announced the change in an Aug. 6th letter to the **Society of Interventional Radiology (SIR)**, AMA and coding consultant **Stacy Gregory, RCC, CPC**, of Tacoma, Wash.-based **Gregory Medical Consulting Services**, in response to letters about the controversial policy.

"This response is extremely significant because it provides an answer to the question many of us were left asking after Oct. 2007: Do we continue to bill for these services despite Medicare's revised guidelines in the hopes they will be reversed, or do we eliminate billing for angioplasty/atherectomy/stent in the same peripheral vessel as a result of this CCI policy?" Gregory says.

CCI Plugs In Old Verbiage

The CCI will temporarily reinstate old language in the next release

(version 14.3 published on Oct. 1, 2008). It will state:

"When percutaneous angioplasty of a vascular lesion is followed at the same session by a percutaneous or open atherectomy, generally due to insufficient improvement in vascular flow with angioplasty alone, only the most comprehensive atherectomy that was performed (generally the open procedure) is reported (see sequential procedure policy, Chapter I, Section M)."

Note: The change is retroactive to Oct. 2007. However, Gregory recommends a "wait and see" approach to following up/re-billing claims.

"First, the change won't be effective until Oct. 1, so you need to wait to resubmit claims until after this date," Gregory says. "Also, I get the impression we have not heard the last about this issue from CMS and CCI, as the letter says CMS will temporarily reinstate the new paragraph. It seems like they are still in the process of finalizing their decision," she explains.

Indeed, the Aug. 6th letter indicates, "CMS remains concerned about this issue and has encouraged national healthcare organizations to work with other interested parties to address coding for reporting atherectomy, angioplasty, and stenting in non-coronary arteries."

Policy Is Still Vague

Be forewarned: This old policy remains problematic. In a sense, "we are back where we started; we have a vague policy that people will interpret in numerous ways," says **Jim Collins, CPC-CARDIO, ACS-CA, CHCC**, president of **The Cardiology Coalition** in Saratoga Springs, N.Y.

Like before, "this policy excerpt fails to address the deployment of stents; it only suggests you should not separately report an angioplasty if followed by percutaneous or open atherectomy," Collins points out.

Even if the CMS policy fails to explain what to do for an angioplasty and stent placement of the same lesion, you still have standards to follow.

"The medical record must establish that angioplasty was the physician's primary intent," Collins says. "According to SIR, an angioplasty is not a viable primary intervention for the treatment of ostial renal lesions. The report must also establish that a sub-optimal result was identified and that it is what led to the doctor's decision to treat the lesion with a stent. These restrictions prevent us from billing for multiple interventions more times than not." ■

PART B BILLING

Know the Rules About Collecting Deductibles Up-Front

► *Navigate your way when carriers give you conflicting advice about deductibles, but use business sense as well as compliance know-how*

Collecting deductibles from patients has never been more difficult — between determining whether the patient has secondary coverage and seeking answers on whether they've already met their deductible, you could lose an hour of your time.

Payer confusion only adds more difficulty to the process. One subscriber wrote to the *Insider* and explained that her carrier told her it was illegal to collect a deductible from a patient before receiving an EOB from the insurer.

Is this accurate? No, says **Joan Gilhooly, CPC, CHCC**, president of **Medical Business Resources, LLC**.

Compliant point of view: “From a compliance standpoint, if the practice knew without a doubt that the patient’s deductible had not been met, there is nothing that prohibits the practice from collecting it at the time of service prior to sending the claim to Medicare,” Gilhooly says.

Business point of view: Even if it’s legal to collect a patient’s deductible at the time of service, however, it may not be a good business practice.

“In the distant past, people may not have had secondary payers and it may have made good sense to collect the deductible in January,” Gilhooly says. “But now that Medicare pays so promptly and so many people have secondary plans, it’s very uncommon

to find someone whose deductible you need to collect up-front.”

Secondary payers will usually pay you the cost of the patient’s deductible, and the secondary payment often arrives at your office before you even receive your Part B reimbursement, Gilhooly says.

Refunds: “Some practices collect the deductible up-front as a rule, especially if they see the patient early in January, and then figure they’ll just issue a refund later if necessary,” says **Jay Neal**, a coding consultant in Atlanta. “But generating all of those refunds can be a headache when February rolls around,” Neal adds.

Not to mention costly: What you collect from the patient up-front probably isn’t as much as you’d spend processing a refund, Gilhooly says. “Given the extraordinary expense of processing refunds, I generally recommend that practices don’t collect the deductibles, and instead, they should simply wait the two weeks (assuming electronic claims filing) to find out if the patient really does owe any money,” she advises.

Even if you can predict what the Medicare EOB will say (which is nearly impossible), the odds of knowing whether the patient will owe you his deductible get worse and worse every day after January first, “and that’s before you start to factor in the implications of the patient hav-

ing a Medigap policy you weren’t aware of that would have picked up the deductible for the patient in the first place,” Gilhooly advises.

Example: Suppose you see a patient on January 15. She tells you that she hasn’t seen any other physicians yet during the year. She also mentions during the history portion of the E/M visit that she performs her glucose test daily and that she just received a new box of glucometer strips the day before, so she is prepared to continue testing her blood sugar.

Reality: Although this patient has not seen a Medicare physician, she probably did pay some money toward her deductible when she ordered the glucometer strips.

“The deductible accounts for all services, including durable medical equipment (DME),” Gilhooly says.

“I once did the billing for a practice that collected a deductible from every single patient they saw from Jan. 1 through Feb. 1,” Neal says. “It was their policy and they had no intention of changing it — until we had to bring in a temp. for a month to help us process all of the refunds.”

Bottom line: Determine whether collecting that deductible is really worth your while from a business standpoint before you ask the patient to pay it at the time of service. ■

READER QUESTION

One Size Doesn't Fit All When Reporting Bilateral Procedures With Modifiers

► Payer policy reigns when it comes to selecting the right modifier

Question: *We performed a bilateral x-ray. Can we append modifier 50 to the code or should we bill it some other way?*

Answer: Although some experts advise using modifier 50 (*Bilateral procedure*) on all bilateral x-ray claims, that isn't always accurate. Although your payer may sometimes require you to use modifier 50 for bilateral claims, this is not true for all bilateral x-ray claims.

Modifier 50 tells the payer that the provider performed a unilateral procedure (described by a unilateral CPT code) bilaterally during the same session.

If a code includes the word "bilateral" in the descriptor, you should not add a modifier to show that the test is bilateral.

Example: Code 73520 (*Radiologic examination, hips, bilateral*) includes the word "bilateral" and instructs you that you need two views of each hip to use the code. You should report 73520 without a bilateral modifier to indicate a bilateral service.

But even knowing this isn't enough. You should know how to report the appropriate codes and modifiers when you do report a unilateral code bilaterally.

Option 1: Medicare typically requires you to report the relevant CPT code with modifier 50 on one line only.

Example: You report a bilateral x-ray (73620, *Radiologic examination, foot; two views*) service to a payer, requiring you to follow this one-line reporting rule. You would

submit 73620-50 in this specific one-line scenario.

Option 2: Other payers may instruct you to list the procedure code twice and append 50 to the second code. If this were the case with the example above, you would report 73620 and 73620-50.

Option 3: Still other payers want you to report the code twice, using modifiers RT (*Right side*) and LT (*Left side*). This is the most common method for reporting bilateral x-rays, such as 73620-RT and 73620-LT.

Lesson: Get your payers' preferences in writing, and apply them every time. ■

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Modifier 25 Isn't Always the Answer for Same-Day E/M Visit

► **Keep E/M documentation apart to demonstrate the service's 'separate' status**

To report an E/M service that prompts a follow-up procedure, you must append either modifier 25 or modifier 57 to the appropriate E/M service code. Which modifier you select, however, depends not only on the nature of the E/M service but also on the length of the global period associated with the follow-up procedure. Here are the facts you'll need to make the choice easy.

Extra motivation: The Office of Inspector General (OIG) has targeted “services within the global period” — including E/M services with modifiers 25 or 57 — for special investigation as part of its 2008 Work Plan.

Call on 57 for ‘Major’ Follow-up Procedures

You should append modifier 57 (*Decision for surgery*) to an E/M service that occurs on the same day, or on the day before, a major surgical procedure, and which results in

the physician’s decision to perform the surgery, instructs **Raemarie Jimenez, CPC**, director of exam content for the **AAPC**.

CMS guidelines identify a major surgical procedure as any procedure with a 90-day global period. Note that the global period for a major surgical procedure begins one day prior to the procedure itself.

Direct from the source: Medicare’s *Internet Only Manual*, section 40.2, tells carriers, “Pay for an E/M service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses CPT modifier 57 to indicate that the service was for the decision to perform the procedure.”

Example 1: A surgeon receives a request to evaluate a patient for acute right-upper quadrant pain and tenderness. Following a full evaluation, the surgeon decides to remove the gallbladder and schedules an immediate cholecystectomy (47562,

Laparoscopy, surgical; cholecystectomy).

In this case, the surgeon may claim both the surgical procedure (47562) and the examination that led to the decision to perform the surgery (for example, 99243, *Office consultation for a new or established patient ...*). Because the cholecystectomy is a major procedure, you should append modifier 57 to 99243. The available documentation should specifically note that the E/M service resulted in the decision for surgery.

Use modifier 57 if the claim meets all of the following criteria:

1. The E/M occurs on the same day of or the day before the surgical procedure.
2. The E/M service directly prompted the surgeon’s decision to perform surgery.

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3. The surgical procedure following the E/M has a 90-day global period

4. The same surgeon (or another surgeon with the same tax ID) provided the E/M service and the surgical procedure.

Example 2: The surgeon schedules cholecystectomy (47562) for a patient with a diseased gall bladder. On the day prior to surgery, the surgeon meets with the patient for a final evaluation, to answer any questions the patient has and to provide additional instructions for recovery.

In this case, you cannot charge separately for the E/M service. Because the surgeon already decided to perform surgery at a previous encounter — and because the E/M service occurs within the surgery’s global period — you should bundle this final presurgery E/M service into the cholecystectomy.

Don’t look for a loophole:

Scheduling pre-op services two or more days before surgery will not necessarily make the services payable, Jimenez warns. Insurers may consider such services to be

screening exams unless there is some specific indication, such as hypertension or diabetes. The documentation for these visits must substantiate medical necessity and not just a routine/requirement of the physician or the hospital.

Call on 25 for ‘Minor’ Procedure

For a separate and significantly identifiable E/M service that occurs on the same day as a minor procedure (any procedure with a zero- or 10-day global period), you should append modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service*) to the appropriate E/M service code, Jimenez confirms.

Don’t mix your modifiers:

The IOM specifically instructs carriers not to pay for an E/M service “billed with the CPT modifier 57 if it was provided on or the day before a procedure with a zero- or 10-day global surgical period.”

Remember: All procedures, from simple injections and common diagnostic tests to the most complicated surgeries, include an “inher-

ent” E/M component, according to CMS guidelines. When trying to decide if an E/M service is separate and significantly identifiable, ask yourself, “Can I pick out from the documentation a clear history, exam and medical decision-making apart from any other procedures the physician performs on the same day?” If so, you’ve probably got a billable service with modifier 25, offers **Joyce Matola**, a billing manager in Cherry Hill, N.J.

Use modifier 25 if the claim meets all of the following criteria:

1. The E/M occurs on the same day as the surgical procedure.
2. The procedure following the E/M does not have a 90-day global period.
3. The E/M service is both significant and separately identifiable from any inherent E/M component included in the procedure.
4. The same physician (or one with the same tax ID number) provided the E/M service and the subsequent procedure. ■

PHYSICIAN NOTES

CMS ‘Cooked the Books’ And Reported An Inaccurate Error Rate, New OIG Report Indicates

► **Plus: Practices that are part of CMS’ Physician Practice Group Demonstration Project earned a total of nearly \$17 million in bonuses**

CMS may have boasted that it slashed inappropriate spending in 2006, but the agency allegedly overlooked nearly \$2.8 billion in improper Medicare spending, according to a late-breaking new report.

On Aug. 21, the *New York Times* reported that the OIG will soon issue a document indicating that CMS “told outside auditors to ignore government policies that would have accurately measured fraud.” If the auditors had properly reviewed the records, they would have found about \$2.8 billion more in improper spending by DME suppliers, the *Times* article indicates.

Congress members are outraged by what they refer to as CMS’ attempt to “cook the books.”

Look to the *Insider* in the coming

weeks for more information when the OIG issues its final report on this subject.

In other news ...

• **CMS appears to be getting its feet wet in pay-for-performance, announcing high marks for the participants of its PGP program.**

In an Aug. 14 news release, CMS announced that each of the 10 groups participating in the Physician Group Practice (PGP) program “improved the quality of care delivered to patients with congestive heart failure, coronary artery disease, and diabetes mellitus during performance year two of the demonstration.”

Because the participating groups met their pre-set benchmarks, they

collected bonus payments totaling \$16.7 million.

“We are paying for better outcomes and we are getting higher quality and more value for the Medicare dollar,” said CMS Acting Administrator **Kerry Weems** in the statement.

Weems also appeared to confirm what many analysts had already suspected — that the pilot program is simply an “audition” for a move to pay-for-performance.

“These results show that by working in collaboration with the physician groups on new and innovative ways to reimburse for high quality care, we are on the right track to find a better way to pay physicians.”

For more on the program, visit www.cms.hhs.gov. ■



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