AAPC
June 2010

CODING edge

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Features

On the Cover: *Plant lovers Nancy G. Higgins, CPC, CIRCC, CPMA, CPC-I, CEMC, of Charlotte, N.C. and Lori Hendrix, CPC, CPC-H, CIRCC, CPC-I, of Dallas, Ga. hold flowers native to their hometowns in recognition of their achievements as 2009 award winners. Photos taken by Matthew Pace (www.mattpace.com) in Charlotte, N.C. and Connie Locklear (www.locklearphotos.com) in Dallas, Ga.*

AAPC CODING edge
June 2010

In Every Issue

Education

People

Coming Up

2009 Chapter of the Year

Abdominal Wall Reconstruction

Don't Change the Code

Drug Waste

Whipple Procedures

Serving 92,000 Members – Including You

Serving AAPC Members

The membership of AAPC, and subsequently the readership of *Coding Edge*, is quite varied. To ensure we are providing education to each segment of our audience, in every issue we will publish at least one article on each of three levels: apprentice, professional and expert. The articles will be identified with a small bar denoting knowledge level:

APPRENTICE	Beginning coding with common technologies, basic anatomy and physiology, and using standard code guidelines and regulations.
PROFESSIONAL	More sophisticated issues including code sequencing, modifier use, and new technologies.
EXPERT	Advanced anatomy and physiology, procedures and disorders for which codes or official rules do not exist, appeals, and payer specific variables.

advertising index

AAPC CODING edge

June 2010

Address all inquires, contributions and change of address notices to:
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Audit Needed Now More Than Ever

Health care is and will be changing—a lot. Because of rising costs, we believe pressure on medical necessity and reimbursement rates will intensify. As a result, we'll see a major emphasis on practice efficiency and ensuring all work is properly paid for. We also forecast fewer small practices (1-3 physicians), more consolidation into larger practices and/or hospital owned practices and a higher ratio of non-physician clinicians to each physician as physicians leverage their valuable time.

Because of these dramatic changes, there is increased emphasis by payers and providers to ensure each claim is accurate and properly paid. Compliance and audit work is needed more than ever. For example, the Centers for Medicare & Medicaid Services (CMS) uses both Recovery Audit Contractors (RACs) and Medicaid Integrity Contractors (MICs) to reduce fraud, abuse, and innocent errors at a cost of about 20 cents for each dollar returned. Yet, with improved practice procedures, including low cost internal audits done regularly, that cost could become less than 5 cents per dollar incorrectly billed.

AAPC recently launched a new division to deliver audit services to both health plans and providers across the country. Members will perform the audits on a fee basis for the AAPC. There are requirements to becoming an auditor for AAPC—Certified Professional Medical Auditor (CPMA™), experience, test, etc.—and we hope to have a small army of auditors with expertise in all specialties available for work as required. AAPC will assume all liability, review audit findings, and provide the tools necessary for each auditor.

Our range of services will include coding, compliance, accounts receivable, and appeal audits. Audits can be performed for numerous reasons:

- Assurance of compliance or awareness of deficiencies

- Inoculation against potential financial recovery
- Uncover lost revenue and/or improve collections
- Validation of internal audit (audit the auditor)
- Education and peace of mind

For health plans, we will provide a full range of audit services including independent audits, validation of health plan audit findings, independent reviews, and expert witness testimony.

Typical AAPC audit findings will include error rates, determination of overutilization patterns, financial impact to the clients, documentation tips, improvement recommendations, and a live conversation with the client to discuss the findings. Our audits are reasonably priced and come with AAPC's full commitment and satisfaction.

If you have audit experience and a desire to be one of AAPC's auditors, please go to www.aapc.com to send your information into us. If your practice or plan needs an audit of any kind, please call us at 801-626-2633, ext.156 or email us at audits@aapc.com.

Sincerely,

Reed E. Pew
CEO and President

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"The sessions were of a good mix, allowing learning on many important issues and changes that are pertinent to all practices."

Julia Lowe, CPC
President
Affiliated Medical Billing, LLC
(Yeo and Yeo CPA)
Saginaw, MI

"This was an excellent conference. I have attended many other conferences offered by other organizations and this event has been the best in terms of value, venue, and information delivered."

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Tireless Effort Saves Conference

As this month's 2010 national conference attendees know by now, AAPC had to make an emergency venue change in early May. Due to severe flooding on May 3, the Gaylord Opryland Hotel in Nashville, which was to host our national conference, was evacuated because of extensive water damage that is expected to take months to repair.

We feel terrible that so much damage occurred to Nashville and want every member in Nashville and surrounding areas to know how much we regret making this necessary move to a new location.

Conferences take a year or more to plan and AAPC staff had less than 30 days to come up with a new location and hotels, along with helping each registrant change plans. All departments at AAPC were affected by this and pulled together. With the efforts of Reed Pew, David Maxwell, Bevan Erickson, Melanie Mestas, Amy Evans, Sandra Nestman, and other staff, a new conference plan came together within five days.

The goal of AAPC was to keep the same agenda, schedule, and dates. Surrounding cities such as Louisville, Knoxville, and Chattanooga could not accommodate us. AAPC exhausted all options for locations and Jacksonville, Fla. was the best solution. That way, AAPC could keep the same dates without disrupting attendees', presenters', or exhibitors' schedules. We also were mindful that many members rely on the conference not only for education and networking, but for CEUs.

AAPC staff did all it could to keep the inconvenience and disruptions to a minimum.

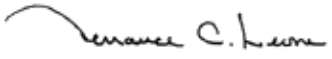
Moving to Jacksonville allowed AAPC to provide some advantages to attendees:

- There is a savings in housing.
- Attendees get some money back.
- Jacksonville is a beautiful Atlantic coast city close to the beach.

We are extremely grateful to the chapters around Nashville for their help. We are also appreciative of the local chapters and members around Jacksonville as they make us welcome in our new location.

It has been frustrating, worrisome, and inconvenient for all, but less so thanks to AAPC staff's dedication to assuring members enjoy what we believe is the most informative, best conference ever for our members. If you are joining us in Jacksonville, please take a moment to acknowledge the staff. AAPC and its National Advisory Board (NAB) will continue to work our hardest to provide you with the high quality conference you are accustomed to and deserve.

Sincerely,



Terrance C. Leone,
CPC, CPC-P, CPC-I, CIRCC
President, National Advisory Board

coding news

Now Payment for Repairs

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6914, "Addition of Repair Codes to the List of Healthcare Common Procedure Coding System (HCPCS) Codes Payable Under the Instructions Provided in Change Requests (CR) 6573 and 5917" to revise the HCPCS Level II codes that contractors use to determine the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items that may be billed under CR 6573 and CR 5917 guidelines.

DMEPOS suppliers may bill separately "in addition to the codes for replacement parts, accessories, and supplies for prosthetic implants and surgically implanted DME" for repair codes:

K0739 Repair or non-routine service for durable medical equipment other than oxygen equipment requiring the skill of a technician, labor component, per 15 minutes

L7500 Repair of prosthetic device, hourly rate

L7510 Repair of prosthetic device, repair or replace minor parts

L7520 Repair prosthetic device, labor component, per 15 minutes

L8627 Cochlear implant, external speech processor, component, replacement

L8628 Cochlear implant, external controller component, replacement

L8629 Transmitting coil and cable, integrated, for use with cochlear implant device

Q0506 Battery, lithium-ion, for use with electric or electric/pneumatic ventricular assist device, replacement only

Contractors must reprocess any claims submitted by DMEPOS suppliers for these repair codes with dates of service of Jan. 1 through the implementation date, Oct. 4, and according to the guidelines in CRs 5917 and 6573.

Read the entire CR at www.cms.gov/transmittals/downloads/R695OTN.pdf.

Capitalize on Discarded Drugs

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 6711 to update *Medicare Claims Processing Manual* policy, which describes when to use modifier JW *Discarded drug not administered* for unused, discarded drugs.

Effective July 30, physicians, hospitals, suppliers, and other providers who bill Medicare contractors (carriers, fiscal intermediaries (FI), Part A/B Medicare administrative contractors (MACs), and durable medical equipment Medicare administrative contractors (DME MACs)) for administering or supplying drugs and biologicals should use modifier JW as indicated here:

"For example, with a single use vial labeled to contain 100 units of a drug where 95 units are used and billed and paid on one line, the remaining 5 units will be billed and paid on another line using the JW modifier. The JW modifier is only applied to units not used. **NOTE:** Multi-use vials are not subject to payment for discarded amounts of drug or biological."

For more information, see CR 6711 (www.cms.gov/Transmittals/downloads/R1962CP.pdf) and *MLN Matters* article MM6711 (www.cms.gov/MLNMattersArticles/downloads/MM6711.pdf) on the CMS website.

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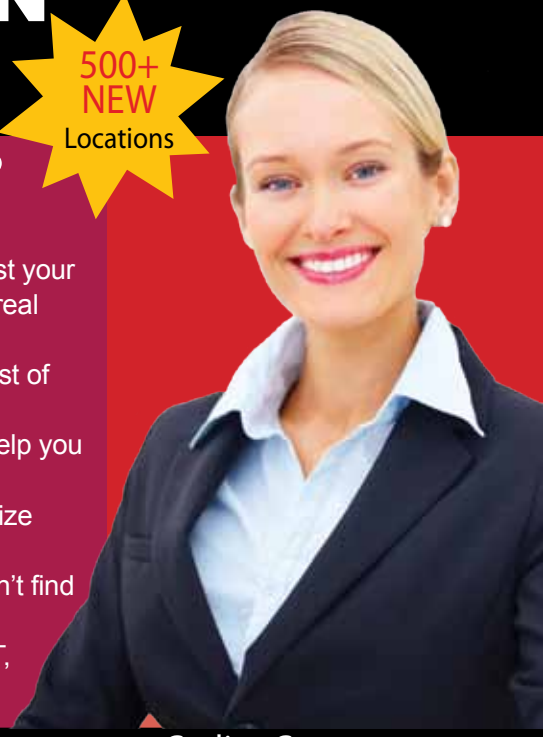

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Please send your letters to the editor to: letterstotheeditor@aapc.com.

Letters to the Editor

Children Under 2 Shouldn't Receive Intranasal Flu Vaccine

I am a student coder and have much to learn. While I am a student, my day job is an immunization nurse at Central District Health Department in Boise, Idaho. It was with interest that I read April's article, "Don't let Vaccines Poke Holes in Your Practice's Pocket." I feel it would be a disservice to not point out to your readers that your coding example on page 21 had a six-month-old patient receiving an intranasal influenza vaccine. Intranasal flu vaccine is not licensed for children under age two years. It is correct to give this child a flu vaccine, but it must be an injectable influenza vaccine.

Sharon Brown, LPN

Thank you, Sharon, for pointing out this important clinical consideration. The Centers for Disease Control's (CDC) fact sheet for the live attenuated intranasal vaccine (LAIV) specifies that the vaccine is "licensed for people from 2 through 49 years of age." The CDC further specifies that the LAIV should not be given to "children younger than 2 and adults 50 years and older."

Had the child in the example you cite been given a preservative-free, intramuscular injection (as would be appropriate compared to the LAIV), coding for the influenza vaccine portion of the service would be:

90655 Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use

+90472 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

The following coding for the given example is incorrect:

90660 Influenza virus vaccine, live, for intranasal use

+90474 Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

Author Lisa Jenson, MHBL, FACMPE, CPC, adds: Code 90655 describes a preservative free vaccine, which is the most common choice for influenza vaccine; but there are still occasions with vaccine shortages that parents will authorize non-preservative free influenza vaccine, CPT® code 90657 *Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use.*

Coding Edge

Eliminate Preventive Medicine Services Separation Anxiety

I read your feature, "Take Four Steps Toward Preventive Medicine Coding Success" in April 2010, and wanted to comment. On page 31, regarding separate services, the article states that hearing and visual screens are considered part of the preventive visit. Our office provides audio and visual screenings to our pediatric patients during well visits, and charges them as separate procedures. This is based on CPT® guidelines regarding preventive visits, which state that screening tests—such as vision or hearing—identified with a specific CPT® code are reported separately.

Kerrie Johnson Amos

The American Medical Association (AMA) added the new language to the Preventive Medicine Service guidelines to CPT® in 2009, stating, "Vaccine/toxoid products, immunization administrations, ancillary studies involving laboratory, radiology, other procedures, or screening tests [e.g., vision, hearing, developmental] identified with a specific CPT® code are reported separately." If you perform hearing assessments using calibrated electronic equipment or use graduated visual stimuli to facilitate quantitative analysis of visual acuity, for instance, there are specific CPT® codes that can be assigned to these services as appropriate.

For example, for use of a Snellen chart, SureSight Vision Screener, or other instrument to test a patient's visual acuity during a well visit, report 99173 *Screening test of visual acuity, quantitative, bilateral* in addition to an appropriate preventive medicine service code. For a hearing screening involving pure tone audiometry (at a single decibel level), you may report separately 92551 *Screening test, pure tone, air only.*

As the article stated, services with an identified CPT® code can be billed separately from the preventive medicine code. Note,

however, qualitative estimations are part of the physician's evaluation and management (E/M) service and not separately billable.

Beverly Welshans, CPC, CPC-I, CPC-H, CCS-P

Fourth Digit Correction for Neoplasm Code

Regarding "Skin Neoplasm Codes" in April's *Coding Edge*, the example on page 31 is incorrect. The correct code for a neoplasm of uncertain behavior of the earlobe is 238.2 *Neoplasm of uncertain behavior of skin*, rather than 238.1 *Neoplasm of uncertain behavior of connective and other soft tissue*. There are two ways to get to this code in the Neoplasm table, by looking to:

1. Neoplasm, earlobe, or

2. Neoplasm, skin, ear, (external)

Teri E. McConkey, CPC

Thanks for the catch, Teri. As you note, 238.2 is the better code selection in this case.

Same Severity Lesions at Same Location May Call for 59

I have been teaching my Healthcare Financial Management Association (HFMA) and community college coding students to use modifier 59 *Distinct procedural service* to report multiple, separate lesion excisions—as illustrated in the November 2002 *CPT® Assistant*. The April 2010 *Coding Edge* article, "Skin Neoplasm Codes," on page 31, indicates, however, that modifier 51 should be used. Could you please clarify this point?

Deb Lee, MBA, BSN, BSAe, RN, CPC, CPC-H, CPC-P, CPCU, FLMI, HIAA, LTCP, MHP

The author of the article responds: I knew this would gain some controversy. Everyone knows that modifier 59 normally will help bypass Correct Coding Initiative (CCI) edits, but this does not mean that it is the most appropriate modifier to use for claim submission—and for some payers it may not make it past the edits.

Because CPT® allows for modifier 59 with a "separate incision/excision," people automatically assume they can append this to all incisions/excisions and up their reimbursement! Modifier 59, however, is for a "distinct procedural service," the meaning of which is subject to interpretation (by payers) and supporting documentation in the patient's chart. Removing more than one lesion at an encounter just does not meet the criteria for some payers.

My example in the article uses codes that are of the "same site" and excised by the "same provider" on the "same day of service;" therefore, (for some payers) modifier 51 *Separate procedure* is more appropriate.

It is important to note that some payers recognize modifier 51 and some do not. For example, some Medicare carriers *do not* want modifier 51 appended on the claim form because it is added on automatically during the claims adjudication process; whereas other payers *do* want it appended.

As you note, the November 2002 *CPT® Assistant* supports the use of modifier 59 with multiple lesion excision in the same anatomic area through the use of the following clinical vignette:

"A malignant lesion with an excised diameter of 1.5 cm is excised from the left arm, and another malignant lesion with an excised diameter of 2.0 cm is excised from the right arm. As indicated in the excision-malignant lesions guidelines, each malignant lesion excised should be reported separately. The appropriate method of reporting the excision of the malignant lesion from the left arm with an excised diameter of 1.5 cm and the excision of the malignant lesion from the right arm with an excised diameter of 2.0 cm would be with code 11602, *Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 1.1 to 2.0 cm*, reported two times. Modifier '-59,' *Distinct procedural service*, would be appended to the second code to indicate that a distinct procedure was performed on a different anatomical site."

Although the above will apply for those payers who follow AMA guidance, if the separate lesions are in different anatomic areas (or if the lesions differ in pathology), individual payers may want you to report the removals separately using modifier 51, or without a modifier. Check your payers' preferences.

Trina Cuppett, CPC, CPC-H CE

The AAPCCA Board:

What it Was, Is, and Will Be

By Suzan Berman, CPC, CEMC, CEDC

Vision: \'vi-zhən\: an idea; a dream; foresight; the ability to see

AAPC President Reed Pew had a vision: calling on the AAPC Chapters Association (AAPCCA) board to help our chapters grow.

The vision took shape when 16 people were appointed to enhance local chapters and help them flourish. After a series of bumps and hurdles, the board began working to develop policies, by-laws, processes, and other items. The vision became reality for the first time at the 2008 National Conference in Anaheim, Calif. All the official documents were finally implemented.

At the 2009 National Conference in Las Vegas, the board rotated eight member spots. This new mix of members continued developing, defining, and improving what was started, including a process for new board appointments, further defining the roles of officers and committees, the new tiered local chapter assessment, changes to the *Local Chapter Handbook*, and processes involved with starting or closing a chapter.

Looking at the Present

AAPCCA assists more than 450 local chapters. The chapters are divided into eight regions with two representative board members each. All board members help chapters when situations arise, chapter visits are requested, or help is needed. All board members have the opportunity to visit chapters, and have been welcomed to speak on behalf of AAPC and the AAPCCA.

The Conference Committee will showcase its work at the expanded "Local Chapter Officer Training" and "Get to Know Your Local Chapter" events at the 2010 National Conference in Nashville. Work from the Handbook Committee is already on display in the *2010 Local Chapter Handbook*. We will be visible in our purple shirts in Nashville.

Our vision hasn't been myopic. We've looked around to see how we can help chapters help others. As a result, we now proudly sponsor AAPC Local Chapters Aiding People of the World in Crisis donation program to help those affected by recent natural disasters.

The Future is Bright

We, **Janet Dunkerley, CPC, CPC-I, Linda Hallstrom, CPC, CPMA, CPC-I, CEMC, Reba Harrison CPC, CEDC, CEMC, and Diana Yates, CPC, CPC-H, CPC-I, CPEDC** will rotate off in June. We welcome five new members and and feel confident in passing the dream we kept alive into the hands of the 2010-2011 AAPCCA board of directors, who will bring fresh ideas, visions, and change.

Your AAPCCA board of directors will continue to be here for *you* the members, *you* the local chapters, and *you* the future of AAPC.

Suzan Berman, CPC, CEMC, CEDC, is senior manager of coding and compliance for the Departments of Surgery and Anesthesiology at the University of Pittsburgh Medical Center. She is past president of the Central Pittsburgh AAPC and the national AAPCCA board of directors, and serves on Ingenix advisory boards.

Eight Requirements Satisfy Medicare Blood Test Screening Benefit

By G. John Verhovshek, MA, CPC

Review the defined guidelines to receive no coinsurance, copayment, or deductable for services.

PROFESSIONAL

The Centers for Medicare & Medicaid Services (CMS) will reimburse providers for screening cardiovascular blood tests, but only for those beneficiaries and services meeting strictly-defined requirements, and only for those claims documented and coded appropriately.

Screening blood tests determine a patient's cholesterol and other blood lipid levels, and may indicate whether he or she is at high risk for cardiovascular disease. Citing the risks and health care costs associated with heart disease, Congress established the cardiovascular blood test screening benefit as part of the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003. Coverage is provided as a Medicare Part B benefit. The beneficiary pays nothing for the blood test; there is no coinsurance, copayment, or deductible.

To meet benefit requirements under the MMA, all of the following conditions must be met:

- **The screening must be "for the purpose of early detection of cardiovascular disease,"** according to the *Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Healthcare Professionals* (www.cms.gov/mlnproducts/downloads/psguid.pdf). CMS recommends all eligible beneficiaries to take advantage of the coverage.
- **The patient must be asymptomatic.** The beneficiary "must have no apparent signs or symptoms of cardiovascular disease," the *Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Healthcare Professionals* explains.

Although the patient must have no apparent signs or symptoms of cardiovascular disease to qualify for the screening, he or she may exhibit one or more risk factors for cardiovascular disease, such as:

- Diabetes
- Family history of cardiovascular disease
- High-fat diet
- History of previous heart disease
- Hypercholesterolemia (high cholesterol)
- Hypertension
- Lack of exercise
- Obesity
- Smoking
- Stress

- **The screening may take place no more often than once every five years** (more precisely, at least 59 months after the last covered screening tests). To stress this point, the *Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Healthcare Professionals* offers two examples of when Medicare may deny coverage of cardiovascular screening blood tests:
  - The beneficiary received a covered Lipid Panel during the past 5 years.
  - The beneficiary received the same individual cardiovascular screening blood test during the past five years.
- **The documentation must show that the screening tests were ordered by a physician or non-physician practitioner (NPP).** Under CMS guidelines as they pertain to these screenings, a physician is defined as "a doctor of medicine or osteopathy," while a qualified NPP is defined as "a physician assistant, nurse practitioner, or clinical nurse specialist."
- **The beneficiary must fast for 12 hours prior to the test.** This is required because the foods we eat and drink can affect the values obtained.

To discuss this article or topic, go to www.aapc.com

- **An appropriate HCPCS/CPT® procedure code must be reported.** Cardiovascular screening blood tests covered under the benefit include:
  - total cholesterol test (82465 *Cholesterol, serum or whole blood, total*)
  - cholesterol test for high-density lipoproteins (83718 *Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)*)
  - triglycerides test (84478 *Triglycerides*)

All other cardiovascular screening blood tests are non-covered, stresses the *Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Healthcare Professionals*.

Although any of these three tests may be ordered separately, more commonly they are ordered at the same time as part of a full lipid panel (80061 *Lipid panel*). Note that 80061 bundles 82465, 83718, and 84478; the individual tests are not reported in addition to 80061.

Under CMS guidelines, "laboratories must offer the ability to order a lipid panel without the low-density lipoprotein (LDL) measurement." If the screening lipid panel shows results that require a further direct LDL measurement, the physician may order the test to arrive at a diagnosis and treatment plan.

Be aware also the five-year frequency limit, mentioned earlier, applies for each test regardless of whether the physician ordered the tests individually or in a panel.

- **An appropriate diagnosis code must be reported.** A screening diagnosis V code should be linked to the claim. ICD-9-CM codes specifically covered under the Medicare screening benefit for cardiovascular blood tests include:

V81.0 Special screening for ischemic heart disease

V81.1 Special screening for hypertension

V81.2 Special screening for other and unspecified cardiovascular conditions

You may report more than a single V code, but always list the primary reason for the screening first. Because patients obtaining the screening are by definition asymptomatic, physicians must indicate in the medical record the primary reason for the test(s).

Individual payers may accept diagnoses not listed above. For example, some payers may accept diabetes (250.x) as a covered diagnosis under the benefit. Check with your payer(s) for details.

- **All of the above requirements must be documented in the medical record.** Always remember: You can't code or bill what hasn't been documented.

When in Doubt, Consider an ABN

Occasionally, a patient may request or agree to a screening that does not meet the aforementioned requirements. For instance, the service may exceed frequency limitations as defined by the screening benefit (for example, two screenings within a five-year period). In such a case, the provider should ask the patient to sign an Advance Beneficiary Notice (ABN) to ensure reimbursement.

Under CMS rules, as explained in the *Guide to Medicare Preventive Services for Physicians, Providers, Suppliers, and Other Healthcare Professionals*:

"If the item or service meets the definition of the Medicare-covered benefit, Medicare still may not pay for the item or service if the item or service was "not reasonable and necessary" for the beneficiary on the occasion in question or if the item or service exceeds the frequency limitation for the particular benefit or falls outside the applicable time frame for receipt of the covered benefit."

"In these instances, an ABN may be used to shift liability for the cost of the item or service to the beneficiary."

If an ABN is not issued properly in such a case, the provider may be held liable for the cost of the screening unless the provider "is able to demonstrate that they did not know and could not reasonably have been expected to know that Medicare would not pay for the item or service."

For more information on the ABN and its proper use, visit the CMS website at: www.cms.hhs.gov/BNI/02_ABNGABNL.asp.

G. John Verhovshek, MA, CPC, is AAPC's director of editorial development.

New Radiology Supervision Guidelines Require Interpretation

By Janice G. Jacobs, CPA, CPC, CCS, ROCC, and G. John Verhovshek, MA, CPC

Broader rules grant NPPs a supervisory role but restrictions apply.

The Centers for Medicare & Medicaid Services' (CMS') 2010 Outpatient Prospective Payment System (OPPS) Final Rule revised guidelines that define physician supervision of services performed in a hospital outpatient department, while leaving rules for services performed in free-standing centers/physician offices unchanged. The new guidelines, "Policies for Direct Supervision of Hospital and CAH Outpatient Therapeutic Services," begin on page 264 of the final rule.

Resource Tip: View the 2010 OPPS Final Rule online at: http://edocket.access.gpo.gov/2009/pdf/E9-26499.pdf.

Midlevel Providers May Supervise Therapeutic Procedures

Under the 2010 OPPS Final Rule, CMS has broadened the rules for supervision of therapeutic procedures in the hospital outpatient setting to permit direct supervision by non-physician practitioners (NPPs), to include the following health care professionals:

- physician assistants (PAs)
- nurse practitioners (NPs)
- clinical nurse specialists (CNS)
- certified nurse-midwives (CNMs)
- licensed clinical social workers (LCSWs)

Eligible NPPs may supervise only those therapeutic services "that they may perform themselves under their state license and scope of practice and hospital-granted or CAH-granted privileges." In other words, an NPP may supervise only those services he or she can perform personally under the applicable guidelines.

Therapeutic services falling under the new rules are those such as outpatient psychiatric group therapy, physical therapy (PT), speech therapy, and occupational therapy (OT).

For example, a LCSW may now supervise outpatient psychiatric group therapy sessions because he or she is qualified and trained to perform that service. That same LCSW may not prescribe medications or perform other services for which only the attending or other psychiatrist is qualified.

CMS guidelines define direct supervision to mean the supervising provider must be "immediately available to furnish assistance and direction throughout the performance of the procedure." Specifically, "immediate availability" requires that:

- The supervising provider must not be "performing another procedure or service that he or she could not interrupt."
- The supervising provider must not be "so physically far away on the main campus from the location where hospital outpatient services are being furnished that he or she could not intervene right away."
  - For therapeutic procedures performed on a hospital's main campus, the supervising physician or practitioner must be present "on the same campus." The supervisor may be located anywhere on the campus, including a physician's office, an on-campus skilled nursing facility (SNF), or other nonhospital space.
  - For therapeutic procedures performed in an *off-campus provider-based department* (PBD), the supervising physician or practitioner must be present in the PBD during the procedure.
- In addition to being able to provide the service/procedure under his or her state license, scope of practice, and hospital-granted or critical access hospital (CAH)-granted privileges, the supervising provider "must be prepared to step in and perform the service, not just respond to an emergency."

A coding example of interactive group therapy provided by a LCSW would be CPT® code 90857 *Interactive group psychotherapy* billed on the CMS-1500 form under the LCSW's own provider identification number (PIN).

Pay attention to payer requirements: Although these supervision guidelines apply specifically to Medicare patients/services, contractual 'non-discrimination clauses' with private payers may require hospitals (and participating physicians) to apply the same rules for *all* patients.

Diagnostic Services Specify Different Requirements

Supervision requirements for diagnostic services—such as computed tomography (CT), magnetic resonance imaging (MRI), nuclear medicine, positron emission tomography (PET), ultrasound, and X-rays—differ from those for

Therapeutic services falling under the new rules include outpatient psychiatric group therapy, physical therapy (PT), speech therapy, and occupational therapy (OT).

therapeutic services, as described above. NPPs *may not supervise diagnostic tests provided to hospital outpatients*. The required supervision can be provided only by a physician (MD or DO).

CMS guidelines specify, "All hospital outpatient diagnostic services provided directly or under arrangement, whether provided in the hospital, in a PBD of a hospital, or at a nonhospital location, follow the physician supervision requirements for individual tests as listed in the [Medicare Physician Fee Schedule] MPFS Relative Value File."

In the Relative Value File, in the "Physician Supervision of Diagnostic Procedures" column, CMS assigns a physician supervision indicator to each CPT®/HCPCS Level II code representing a diagnostic service.

Resource Tip: The Relative Value File is available online at: www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=4.

The indicators and definitions are:

0	Procedure is not a diagnostic test or procedure is a diagnostic test which is not subject to the physician supervision policy.
1	Procedure must be performed under the general supervision of a physician.
2	Procedure must be performed under the direct supervision of a physician.
3	Procedure must be performed under the personal supervision of a physician.
4	Physician supervision policy does not apply when procedure is furnished by a qualified, independent psychologist or a clinical psychologist or furnished under the general supervision of a clinical psychologist; otherwise must be performed under the general supervision of a physician.
5	Physician supervision policy does not apply when procedure is furnished by a qualified audiologist; otherwise must be performed under the general supervision of a physician.
6	Procedure must be performed by a physician or by a physical therapist (PT) who is certified by the American Board of Physical Therapy Specialties (ABPTS) as a qualified electrophysiologic clinical specialist and is permitted to provide the procedure under state law.
6a	Supervision standards for level 66 apply; in addition, the PT with ABPTS certification may supervise another PT but only the PT with ABPTS certification may bill.
7a	Supervision standards for level 77 apply; in addition, the PT with ABPTS certification may supervise another PT but only the PT with ABPTS certification may bill.
9	Concept does not apply.

CMS defines "general," "direct," and "personal" supervision requirements in the *Medicare Benefit Policy Manual*, chapter 15, section 80:

General Supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually performs the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

Direct Supervision (in the office setting) means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure (for example, the physician must not be performing another procedure that cannot be interrupted, and must not be so physically far away that he or she could not provide timely assistance). This does not require that the physician must be present in the room when the procedure is performed, however.

Personal Supervision means a physician must be in attendance in the room during the performance of the procedure.

For example: The MPFS relative value unit (RVU) file assigns the technical portion of CPT® 77014 *Computed tomography guidance for placement of radiation therapy fields* a "2" physician supervision indicator. This means the service requires direct physician supervision when performed in the hospital radiology department, in a hospital-owned imaging center that is defined as a PBD, or in a physician office under arrangements with the hospital (that is, an outside imaging facility bills the hospital for exams it performs on hospital patients).

Janice G. Jacobs, CPA, CPC, CCS, ROCC, is a director at Huron Consulting Group and licensed in Pennsylvania as a certified public accountant with experience in hospital accounting, auditing, and cost reporting. Her 25-plus years of health care and consulting experience includes working on numerous ambulatory payment classifications (APC), diagnosis-related groups (DRGs), and physician billing and coding projects, as well as chargemaster (CDM) reviews and various interim-staffing engagements, such as billing office manager and, most recently, director of compliance at a major West Coast academic medical center.

G. John Verhovshek, MA, CPC, is AAPC's director of editorial development.

Become a Successful Coder in the Classroom

By Beverly A. Haynes, CPC

Use your CPC® for a professional non-hands-on coding career.

Besides becoming educated for an in-the-trenches coding position, obtaining a Certified Professional Coder (CPC®) credential can open the door to other careers. Although I have never worked as a coder, I earn a decent living using my coding credentials. If you are having a difficult time landing a job in the coding industry due to the economy, let my story serve as inspiration.

Unchartered Territory

I started down my career path about 10 years ago sure of only one thing: I knew I wanted a career in the health care field. In what capacity, I had no idea. After taking pre-requisites for nursing at a community college and landing a part-time job in the local hospital's emergency room (ER), I knew for sure that I wanted more exposure to the medical field.

> I became anxious and doubtful of my decision to become a coder—I am glad I didn't give up.

Still with limited knowledge of coding and rules, issues, or guidelines, I went to work full time in the billing department for my state's workers' compensation insurance company. My quest for knowledge and my zeal for more coding exposure, however, inspired me to attend a CPC® prep coding boot camp and to sit for the exam.

My first attempt at taking the exam was a total disaster. I wanted to place blame on the exam; however, I knew the blame really lied within me. I became anxious and doubtful of my decision to become a coder—I am glad I didn't give up. With my second attempt, I passed the exam and with much delight, I entered the coding world.

Stake a Claim in the Coding World

I posted my resume and began applying for coding jobs. As you may know, however, novice coders often need to be extremely creative to land their first job in the field. I received calls for interviews, but most of them were for jobs 30 miles or more from my home. One call, however, came from Sterri Price, program director for a local technology college, who was very interested in interviewing me for the position of a medical billing/coding instructor.

Mrs. Price began the interview process by asking about my teaching experience. I explained to her that my greatest and most noteworthy experience came from being a mother and a grandmother. Those attributes, along with medical billing adjudicator experience and CPC® certification, helped me land a great position at the technology college.

The art of teaching can bring excitement to both the student and teacher. In the coursework, by incorporating coding mysteries and scenarios, codes are cracked and demystified. Billing issues are explored and resolved from an analytical approach. Teaching affords me the opportunity to share knowledge and experience with those who have no exposure to the health care industry or who are displaced workers from other careers and who share the common goal to learn. My role as instructor has two equally important rewards: teaching and learning. Success at learning is achieved by critical thinking, networking, and building relationships.

Immeasurable Success

Some of my most proud and exciting moments have come when students inform me of being hired from externships. I feel proud of the contributions I made to their accomplishments. It's not that I know everything there is to know about coding—no one does; it's just my willingness to impart knowledge that can make a difference in someone's life.

Success can be achieved in any area of billing/coding by applying hands-on knowledge in an office environment, a hospital, a clinic, or even in the classroom. No matter what the catalyst for teaching and learning is, the important thing is that it opens doors for everyone. Be encouraged, the opportunities are limitless.

Beverly A. Haynes, CPC, is medical billing adjudicator, and a billing/coding instructor.

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EXPERT

Ten Commandments of Coding Critical Care in the ER

When it's hard to distinguish between right and wrong in ED critical care, look for guidance.

By Holly J. Cassano, CPC

As a Certified Professional Coder (CPC®) who supports emergency department (ED) physicians, I am often asked how to code appropriately for the physician component of critical care services in the ED. In response, I created these 10 commandments of critical care coding.

1. Thou Shalt Know What Defines Critical Care

CPT® defines Critical Care Services (99291-99292) by three components:

1. A critical illness is an illness or injury in which "one or more vital organ systems" is impaired "such that there is a high probability of imminent or life threatening deterioration in the patient's condition."
2. A critical intervention involves "high complexity decision making to assess, manipulate, and support vital organ system failure."

Critical care time is "time spent engaged in work directly related to the individual patient's care," whether that time is spent at the immediate bedside or elsewhere on the floor or unit. These criteria assume the physician takes an ongoing and active role in managing that patient's care. Evidence that the above criteria were met must be present in the medical record with the physician's attestation that critical care was provided.

Some examples of vital organ system failure include:

- Central nervous system failure
- Circulatory failure
- Shock
- Renal, hepatic, metabolic, and/or respiratory failure

Critical care usually (but not always) is given in a critical care area such as a coronary care unit, intensive care unit, or the ED. Critical care may be provided in any location as long as the care provided meets the definition of critical care. Just because a patient is in the intensive care unit (ICU), does not mean you can code critical care—if the patient is stable, he or she does not meet the criteria for critical care.

2. Thou Shalt Know How CPT® and CMS Definitions Vary

In July 2008, the Centers for Medicare & Medicaid Services (CMS) released Transmittal 1548, which represents the most recent Medicare payment policy update for critical care services (99291-99292). Regarding critical care for Medicare patients, CMS guidelines state, "the failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition."

CMS goes beyond the CPT® description of critical care, adding critical care services must be reasonable and medically necessary … delivering critical care in a moment of crisis, or upon being called to the patient's bedside emergently, is not the only requirement for providing critical care service. Treatment and management of a patient's condition, in the threat of imminent deterioration; while not necessarily emergent, is required."

CMS gives several examples that may not satisfy the criteria, either because medical necessity was not met, or the patient does not have a critical care illness or injury and is not eligible for critical care payment:

1. Patients admitted to a critical care unit because no other hospital beds were available;
2. Patients admitted to a critical care unit for close nursing observation and/or frequent monitoring of vital signs (e.g., drug toxicity or overdose); and
3. Patients admitted to a critical care unit because hospital rules require certain treatments (e.g., insulin infusions) to be administered in the critical care unit.

Unlike CPT®, CMS not only requires the illness or injury to be of an urgent or emergent nature, but there be the added inclusion of high-level treatment(s) and interventions to satisfy critical care criteria. CMS criteria for critical care are not met if the emergency physician does not deem pharmacological intervention or another acute intervention (intubation, etc.) as necessary, and if the patient only receives coordination of care and interpretation of studies and is admitted or discharged.

To read Transmittal 1548, along with corresponding *MLN Matters* articles, go to: www.cms.hhs.gov/Transmittals/Downloads/R1548CP.pdf and www.cms.hhs.gov/MLNMattersArticles/downloads/MM5993.pdf.

3. Thou Shalt Properly Document Time

The duration of critical care services for CPT® and Medicare is based on the physician's documentation of total time spent evaluating, managing, and providing care to the critical patient. Time spent in documenting such activities is included in critical care time. Critical care time does not need to be continuous: Non-continuous time may be aggregated in reporting total critical care time.

To count toward critical care time, the physician must devote his or her full attention to the patient, either at the patient's immediate bedside or elsewhere on the unit, and the physician must be available to the patient immediately, as necessary. Critical care time also may be spent discussing the patient's case with staff or discussing with family members (or surrogate decision makers) specific treatment issues when the patient is unable or clinically incompetent to provide history or make management decisions.

Use CPT® code 99291 to report the first 30-74 minutes of critical care and CPT® +99292 to report additional block(s) of time up to 30 minutes each beyond the first 74 minutes of critical care. Critical care time less than 30 minutes is not reported using the critical care codes: Such service should be reported using the appropriate E/M code. For example, for critical care time of 35 minutes, report 99291. For critical care time of 115 minutes, report 99291, 99292 x 2.

The critical care clock stops whenever separately-reportable procedures or services are performed. Time spent performing separately-reportable services, or activities that do not directly contribute to the treatment of the critical patient, may not be counted toward the critical care time.

Distinguish Critical Care from Upper-level ED

What distinguishes a case where critical care services are billed from a case that's coded as an upper-level ED service (99285 *Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history*; *A comprehensive examination; and Medical decision making of high complexity*)? CPT® defines 99285 as "*Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.*" The medical decision making (MDM), medical necessity, and documentation requirement for 99285 must support "high complexity," a characterization sustainable even when a provider's therapeutic intervention is absent. The graduation between a comprehensive level of evaluation and management (E/M) service and critical care service is distinguished by CMS as: 1) "Treatment and management of a patient's condition, in the threat of imminent deterioration; while not necessarily emergent, is required;" and 2) "The failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition."

4. Thou Shalt Know the Key Elements

To report 99291–99292, both the illness or injury and the treatment being provided must meet the critical care requirements, as previously described. Clinical reassessments and documentation must support the critical care time aggregated, and should include:

- a description of all of the physician's interval assessments of the patient's condition;
- any impairments of organ systems based on all relevant data available to the physician (i.e. symptoms, signs, and diagnostic data);
- the rationale and timing of interventions; and
- the patient's response to treatment.

5. Thou Shalt Not Report Critical Care in the ER with an E/M Code for a Medicare Patient by the Same Physician on the Same Calendar Day

CMS Transmittal 1548 specifically addresses this situation for the ED, stating when critical care services are required upon arrival in the ED, only critical care codes (99291-99292) may be reported. An ED E/M code (99281-99285), when provided by the same physician (which includes any physician of the same specialty in the same group) to the same patient, may not be reported additionally. Under Medicare rules, however, critical care may be provided on the same day as an inpatient or outpatient E/M service.

The critical care clock stops whenever separately-reportable procedures or services are performed. Time spent performing separately-reportable services, or activities that do not directly contribute to the treatment of the critical patient, may not be counted toward the critical care time.

For example: A Medicare patient presents to the ED and receives a level five ED workup (99285). Later during the same encounter, the patient deteriorates unexpectedly and requires critical care services. CMS states that the "same" ED physician can only report either the ED E/M service or the critical care service—not both.

To confuse matters, CPT® allows separate reporting for both an E/M service and a critical care service on the same day; however, CPT® does *not* distinguish the site of service or which service comes first. Check with your state's medical policy and your commercial payers' medical policy on correct reporting of critical care services to maintain compliance.

Some payers may require modifier 25 *Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service* to be appended to the same day, non-critical care E/M service, when coded.

6. Thou Shalt Not Bundle

CPT® and CMS consider several services to be included (bundled) in critical care time when performed during the critical period by the same physician(s) providing critical care. Do not report these services separately. CMS specifies the relevant time frame for bundling to include the entire calendar day for which critical care is reported, rather than limiting the time to just the period the patient is critically ill or injured during that calendar day, as CPT® does.

Both CPT® and CMS bundle to critical care the following:

- Interpretation of cardiac output measurements (93561, 93562)
- Pulse oximetry (94760, 94761, 94762)
- Chest X-rays, professional component (71010, 71015, 71020)
- Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data - 99090)
- Gastric intubation (43752, 91105), Transcutaneous pacing (92953)
- Ventilator management (94002-94004, 94660, 94662)
- Vascular access procedures (36000, 36410, 36415, 36591, 36600)

Any services performed that are not listed above may be reported separately. Physicians are encouraged to document time involved in the performance of separately-reportable procedures. These may not be counted toward critical care time.

For some examples of ER billing and coding go to: http://emcrit.org/190-201/197-ed.billing.htm.

7. Thou Shalt Remember to Code Everything Separately Allowed

The critical care clock stops when performing non-bundled, separately-billable procedures. Some examples of common procedures that may be performed for a critically ill or injured patient include:

92950 Cardiopulmonary resuscitation (eg, in cardiac arrest)

31500 Intubation, endotracheal, emergency procedure

36555 Insertion of non-tunneled centrally inserted central venous catheter; under 5 years of age

36556 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

36680 Insertion of cannula for hemodialysis, other purpose (separate procedure); vein to vein

32551 Tube thoracostomy, includes water seal (eg, for abscess, hemothorax, empyema), when performed (separate procedure)

33210 Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter (separate procedure)

93010 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only

8. Thou Shalt Know the Appropriate Use of Modifier 25

CPT® does not require modifier 25 when billing for critical care services and/or separately billable (non-bundled)

procedures; however, CMS and other commercial payers may require modifier 25 on the same day the physician also bills a non-bundled procedure code(s). Check your payers' medical policies in your state.

For example, for those payers who specify the use of modifier 25 with 99291–99292: If endotracheal intubation (31500) and cardiopulmonary resuscitation (CPR) (92950) are provided, separate payment may be made for critical care in addition to these services if the critical care was a significant, separately-identifiable service and was appended with modifier 25.

9. Thou Shalt Correctly Report CPR and Critical Care During Same Patient Encounter

CPT® and CMS agree that both CPR (92950) and critical care may be reported, as long as the requirements for each of these services are satisfied and are delineated clearly in the medical record.

CPR encompasses supervising or performing chest compressions, adequate ventilation of the patient (e.g., bag-valve-mask), etc. CPT® does not list a typical time to qualify CPR as a provided service and qualifies it as a separately-reportable service that may be reported with critical care. **Remember:** Time spent providing CPR cannot be counted toward calculating total critical care time.

10. Thou Shalt Ensure Teaching Physician Criteria Is Properly Documented

Teaching physicians may tie into the resident's documentation and may refer to the resident's documentation for specific patient history, physical findings, and medical assessment when documenting critical care. The teaching physician must include a statement about the total time he or she personally spent providing critical care. The statement must include that the patient was critically ill when the teaching physician saw the patient, why and what made the patient critically ill, and the nature of the treatment and management provided by the teaching physician.

Consider This Critical Care Coding Example

A 35-year-old female presents to the ED having multiple severe thoracic and abdominal injuries after being struck by a bus in the street. The ER doctor documents 45 minutes of critical care. The ER doctor performed various other interventions, including a gastric intubation, which went over the 45 minutes of critical care time documented. The ER doctor also performed emergency intubation when the patient went into respiratory failure due to chest trauma.

In this scenario, the only separately-reportable service is the emergency intubation (31500). Also reported would be 45 minutes of critical care, 99291, with modifier 25 appended. Although performed, gastric intubation (43752, 91105) is not billed because it is included in the critical care.

CMS provides the following vignette as an example of acceptable documentation: "Patient developed hypotension and hypoxia; I spent 45 minutes while the patient was in this condition, providing fluids, pressor drugs, and oxygen. I reviewed the resident's documentation and I agree with the resident's assessment and plan of care."

Note: Time spent alone by the resident performing critical care activities in the absence of the teaching physician is not counted toward critical care time. Only time spent performing critical care activities by the resident and the teaching physician together, or by the teaching physician alone is counted toward critical care time.

Bonus Tip: If a Meal is Consumed, Critical Care Isn't Happening

Critical care has passed when a patient's septic shock has ended, acute respiratory failure has ended, and if other acute situations are well controlled. If a patient is sitting up and eating a meal and drinking regular beverages, that patient is not critically ill. In any case, you can't go wrong with strong and supportive documentation, combined with medical necessity that encompasses not just an acute diagnosis, but also emergent interventions.

Holly Cassano, CPC, has been certified for more than three years and has been involved in practice management, coding, auditing, teaching, and consulting for multiple specialties for the past 13 years. She served two terms as an AAPC local chapter officer and has written several articles for Justcoding.com and has a monthly column devoted to Fighting Fraud, with *Advance for Health Information Professionals*. She is the coder and physician educator for emergency room physicians at the Cleveland Clinic Florida. You can reach her at hjcpmg@yahoo.com.

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Improved prices, usability, and content make CEUs easier to earn.

By Michelle A. Dick

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[Michelle A. Dick is senior editor at AAPC.]

Upholding a Hi

2009 Standards Are Exceeded

Congratulations and thanks go to 2009 Coder of the Year, **Nancy G. Higgins, CPC, CIRCC, CPMA, CPC-I, CEMC**, and 2009 Networker of the Year, **Lori Hendrix, CPC, CPC-H, CIRCC, CPC-I**. Awardees will be honored at the 2010 AAPC National Conference.

The annual awards recognize members who represent high coding standards set by AAPC. The Coder of the Year recognizes the member with high quality coding expertise, strong leadership skills, and who is actively involved in the coding community. The Networker of the Year represents the AAPC member who best shares the benefits of being a member with fellow coders and promotes coding excellence to the highest degree.

By Michelle A. Dick, Senior Editor

gher Standard

Nancy Higgins: 2009 Coder of the Year

When Nancy received AAPC CEO and President Reed Pew's congratulatory call, she could hardly contain her excitement.

"I was absolutely thrilled," Nancy said. "When I heard him on the phone, I was just stunned … I was trying so hard to sound like a rational person on the phone with him, but I was actually jumping up and down at my desk."

Despite her recognition and achievement, Nancy remains humble.

From Humble Beginnings

Nancy's career in the medical field started as part-time front-desk help in a psychiatric practice at age 19. Her first exposure to coding happened when the biller for the practice quit and Nancy took over her job. This was in the days when nothing was computerized. Everything was either handwritten or typed—including claim forms. She worked for that practice for several years while studying accounting.

Once Nancy earned her Certified Public Accountant (CPA), she worked as a practice management consultant for two large CPA firms. She was responsible for chart audits, coding and documentation training, practice assessments, and practice start-ups, to name a few. This was a great opportunity for her to learn a lot about the inner workings of physician practices.

In 2000, Nancy became especially interested in coding when her boss, **Mickey Smith,** now CEO of a hospital in Brookesville, Fla., asked her to teach a 10-week coding class. She took it as an opportunity to focus on a broad range of coding issues. Then, in 2003, she opened a consulting firm and spent the next four years as a physicians' consultant. Nancy said she loved the consulting world but had to stop due to the extensive traveling, which interfered with family life. She went on to work as a compliance specialist for Carolinas Healthcare System (CHS). Nancy says she loves auditing medical records to verify that documentation supports the selected codes and training providers on coding and documentation issues.

Although Nancy is no longer a CPA, she continues to apply her past certification and accounting/auditing experience to her coding expertise.

An Honor Well Deserved

When **Patricia L. Hinson, BSN, M.ED., CPC, CIC,** coworker at CHS Corporate Compliance nominated Nancy at the local chapter meeting, applause reportedly broke out from those in attendance. Patricia said, "I think that says it all. We appreciate her, honor her, and want her to get this well-deserved recognition."

Throughout 2009, Nancy's ambition for correct coding proved to be and instrument of coding excellence to students in the classroom, members at local chapter meetings, and physicians in the workplace.

Former student of Nancy's, **Patsy Sellers, CPC,** said, "Through her teaching and guidance she instilled in me the knowledge, confidence and desire to take the CPC certification, which I passed." Sellers added, "Many people are called teachers but only a few truly have the gift of teaching and Nancy Higgins possesses that gift … She is the most deserving candidate for Coder of the Year."

In 2009, as senior compliance specialist for CHS, Nancy:

- Was responsible for auditing documentation for more than 100 physicians.

- Trained physicians on an ongoing basis to improve their documentation and coding.
- Served as a resource for fellow employees with coding questions.
- Lead instruction for teaching new providers.
- Conducted follow-up training sessions at the request of new providers who wanted to learn more about documentation and coding.
- Was ranked with the highest performance level by providers, indicating she had expertise in the most complex coding issues.
- Furthered her coding know-how by earning the Certified Interventional Radiology Cardiovascular Coding (CIRCC®) credential while maintaining Certified Professional Coder (CPC®), Certified Professional Medical Auditor (CPMA™), Certified Professional Coder-Instructor (CPC-I®), and Certified Evaluation and management Coder (CEMC™) credentials.
- Taught a 10-week basic coding class and 16-week advanced coding class. Many students took their certification exam and passed.

As Charlotte Local Chapter president, Nancy:

- Coordinated monthly meetings making 2009 the first year for the chapter to meet all 12 months and have their first evening meeting.
- Taught six CPC® exam review classes to her local chapter at no charge and taught another CPC® exam review class at a discounted fee to the Monroe, N.C. Chapter.
- Was a keynote speaker at seven local chapter meetings.
- Spearheaded the development of Coding Jeopardy with other Charlotte Chapter officers to make learning fun.
- Led officers and chapter members in a wide variety of educational opportunities.
- Proctored a special Sunday exam session as requested by AAPC.

As a leader, Nancy:

- Was recognized as a leader and offered a position on the University of North Carolina at Charlotte (UNCC) Medical Office Programs Advisory Board.
- Was recognized by CHS Corporate Compliance by being promoted to Senior Compliance Specialist II, serving as a leader, resource, and role model to other departmental staff.
- Wrote two articles for *The Link*, CHS compliance internal newsletter: "Echocardiology Code Changes for 2009," and "Diagnosis Codes for Sleep Studies."

Couldn't Have Done it Without You

Nancy attributes her success to **Mickey Smith**, who gave her the opportunity to teach her first coding class and pushed her to learn as much as possible about every facet of coding. She said, "If he hadn't needed someone to teach that class, I don't know if I would have taken this path."

Others have been instrumental in Nancy's achievements, as well. She said, "**Belinda Stanley, CPC,** taught me so much about interventional radiology coding and her instruction helped me pass the CIRCC® exam." Nancy said her coworkers and several former students, especially **Martha Matheny, CPC, CPC-P, CIRCC**, are an invaluable source of information when she has questions or needs someone's opinion.

Nancy said, "**Pam Benet Rowell, RHIA, CPC, CHCO, CCEP,** (vice-president, CHS), my current boss, has given me many wonderful opportunities to expand my knowledge in targeted areas. I am just so grateful to everyone who has shared their expertise and/or given me opportunities to learn more."

If There Were More Hours in the Day

Having a career in the coding world can be a challenge even for Coder of the Year. Nancy said, "My biggest challenge has been balancing my work life with my family life. I just wish there were more hours in a day."

The little free time Nancy has is spent with family. She has three daughters and a 3-month-old granddaughter. She also enjoys reading and gardening. Nancy said, "You will probably think this is nuts, but I would love to work at Lowe's in the garden center. Maybe when I retire from the coding world in 15 or 20 years, I will get a job there."

Lori Hendrix: 2009 Networker of the Year

According to *For the Record Magazine*, Feb. 15, AAPC's Networker of the Year Award recognizes members "who represents the higher standards of coding set by the organization and who shares the benefits of being a member with fellow coders." Lori did exactly that, by recruiting a phenomenal number of coders to become AAPC members.

March-August 2009, the AAPC's *Drive to 100K* encouraged its current members to refer colleagues and other medical coders to join AAPC. As part of the drive, top referrers could earn rewards and prizes that accumulated based on the number of referrals he or she logged on the AAPC website.

After learning about the membership drive, Lori thought the deals for new members were too good to pass-up and encouraged individuals who were considering taking the coding exam to take advantage of the new member benefits. Lori enthusiastically referred colleagues to become active AAPC members. As a result of her hard work, she had the top number of membership referrals and was named Networker of the Year for the second time. She earned this prestigious recognition in 2003, as well.

With the award, Lori also received a complimentary registration to the 2010 annual conference, a waiver for annual membership dues, and a set of 2010 codebooks, among other prizes. Lori, however, didn't do it for the win. She said to Assistant Editor Cheryl McEvoy of *Advance for health Information Professionals*, "I always suggest that people get certified through a national certification, and I always recommend the AAPC. So that kind of led to it."

Networking Excellence x 2

When Lori found out she won 2009 Networker of the Year, she was "shocked, then very happy," She said. "I feel that I am richly blessed to have received this honor twice."

Lori eagerly shares her experience and knowledge with her colleagues at Georgia's WellStar Health System and other coders where she works as the coding coordinator for the hospitalists program. She also is a member of the company's coding assurance team in the compliance department, providing routine monitoring and auditing to ensure hospitalists comply with federal coding and billing regulations.

Destiny Reveals Itself

Lori never intended to be a coder, but soon realized she loved the coding world when she "was working as a nurse technician at Wellstar and was asked to help set up the long term care medical records department" by the nursing supervisor. Lori didn't know much about the field, but she liked the career outlook. "I went in there and thought, I can work Monday to Friday, no patients? I'm liking this," she recalled to McEvoy.

Lori said, "I discovered that I enjoyed reviewing charts and assigning codes but did not realize there were people who did only coding. A few weeks later, I visited my niece at her new job and discovered that she was coding." Lori applied at the company where her niece, **Tiffany H. Pope**, worked and stayed there for 10 years.

Lori admits she owes her coding career to her niece and Coding Strategies. She said, "My niece, Tiffany, opened my eyes to the career … The individuals at Coding Strategies gave me the tools to excel in the profession."

Lori is back at WellStar Health System and performs audits for hospitalists and educates physicians about good documentation practices. She also is part owner of Compass Coding Services. One of her sisters is her partner and another sister is an employee. Like a true networker, Lori is always recruiting new members into the coding field—including family!

For now, Lori says, she is where she wants to be and can't see herself doing anything else. She said, "For the first time in my life, I do not think of wanting to do a different job. I love my profession."

Vocal About Coding

Lori is the founding president of the Dallas, Ga. Chapter. Since its inception, she has served many roles within the chapter and proctors exams. Lori says the chapter and coding community is a second family to her; she relies on the coding community for support, guidance, and friendship; and the annual conference is like a giant family reunion to her.

Lori co-led the crusade to bring Professional Medical Coder's Day to Georgia, which recognizes coders for their contributions to health care and the integrity of their high standards.

Networks with Caution

Although Lori has taken the crown twice for networking, she said her biggest issue as a coder is "locating authoritative guidance on challenging coding scenarios." She admits that networking is not the best solution for seeking coding answers. She warns new coding professionals not to rely too heavily on coding community websites. They are great tools but are the opinions of other coders—not facts. Hendrix said in the McEvoy article, "Never take anything at face value and always research." Open up a book and check any guidance you've received in a networking setting.

Steps Outside the Coding World

Besides coding, Lori loves planting flowers. She also is interested in history and genealogy, and is an active member of the Paulding County Historical Society.

This isn't the first time, nor the last time, you'll see Lori promoting coding. She said, "I would love to get involved at a national level now that I have the time to make the commitment." CE

[Michelle A. Dick is senior editor at AAPC]

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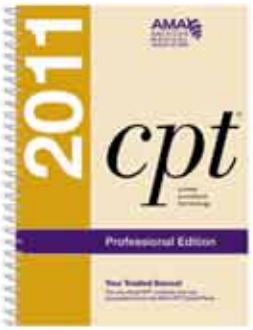

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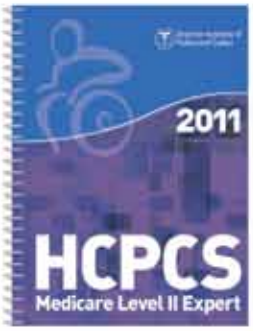

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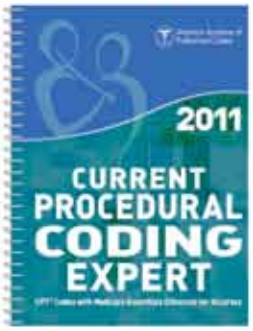

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Warning:

Hospital Systems Can Buy Out Your Practice

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By Dorothy Steed, CPC-H, CHCC, CPC-I, CPUM, CPUR, CPHM, CCS-P, CEMC, CFPC, ACS-OP, RCC, RMC, PCS, FCS, CPAR, CPMA

More and more, hospital systems are buying physician practices, and offering physicians lucrative deals to include regularly-scheduled hours, salary plus incentives, and payment of malpractice premiums. For those physicians who have become weary of business administration responsibilities, or who desire more personal and family time, such offers may be very tempting.

If your physician office becomes part of a hospital system, what would it mean for you, the coder or biller in the physician office?

Get the Facts

As soon as you are aware that a purchase arrangement is under consideration, you need to obtain the facts and quickly clarify how you will be affected. Your role depends on the business and legal structure of the arrangement. If the practice will be renting space from the hospital at fair market value, and the practice continues to operate independently—including personal ownership of equipment, independent purchasing of drugs and supplies, and full responsibility for employees—your role within the practice may not change. If this is not the case, however, your situation is likely to change.

Where Do You Stand?

If the practice is under hospital ownership, the physician(s) are hospital employees and will be hiring staff for clinics that are operated by the hospital. Do not be surprised if hospital finance administrators take a critical look at the practice's business operation—including current accounts receivable, aging of accounts, rejected claims, and dollars billed versus revenue. It is likely they will consider these areas when determining whether to bring the business staff (including coders and billers) onboard as hospital employees. If your revenue is strong, your claims rejections are well-controlled, and your billed charges-to-reimbursement ratio is adequate, you'll make a positive impression.

Although certain problems may be attributed to a specific managed care contract, most shortcomings will be taken at face value. If revenue is below the norm and rejected claims are not being worked out, these indicators will raise red flags to hospital administration. Short-term problems that are actively being worked on for a solution will be weighted differently than long term, unresolved issues. Significant deficiencies in these functions will be viewed negatively in negotiations for hospital positions.

Match Your Skills to New Structure

If you are to be a hospital employee and no longer employed by the physician(s), understand that the structure of hospital business operations is considerably different than a physician business structure.

Regardless of the position that you hold in a physician practice, hospital hiring managers will attempt to match skills to available positions. Each position will have a specific job description with stated skill requirements. Take a look at posted positions and requirements, and determine which match your current skills. You may be required to apply for a hospital position, to undergo mandatory skills testing, and to meet the same requirements as any new applicant or in-house transfer. You may be subject to the standard 90-day probationary period. Human Resources (HR) management must be certain they assess fairly all employees for requirements as stated in the official job description.

To discuss this article or topic, go to www.aapc.com

Know also that there are differences in hospital coding protocol. The hospital coding manager will assess your skills carefully and determine if you will be able to handle inpatient coding, when necessary. Understand inpatient claims are "where the money is" for hospitals, and these records will take priority over outpatient records. It may not be possible for the coding manager to hire for just outpatient coding. If not, it is likely that the manager will need to be comfortable in your ability to code inpatient records, and to meet productivity and accuracy standards, if you are to be considered for a coding position.

Understand Hospital Charges

In a hospital-operated clinic, two claims usually are generated. The first is the UB-04 for the hospital charges, and the other is the CMS-1500 for the physician charges. If you are hired as a biller, you may be required to handle both claims. The duties are not necessarily divided. You'll need to understand how charges are generated to the UB-04 and to determine strategic areas that are high-risk for error. This includes erroneous departmental charging, incorrect number of units, missing charges, and missing modifiers. Errors must be corrected prior to releasing the claim to the payer.

If you are hired to work in the clinic and are responsible for entering charges, you must be clear about the correct division of charges for each claim. Typically, drugs are requisitioned from the hospital pharmacy and supplies are requisitioned from central supply. These are hospital charges, not physician charges. Errors in this charging function create claims rejections and are time-consuming and costly to correct. Charges that utilize hospital equipment and staff are hospital charges. You must be diligent to charge the technical component to the UB-04 and the physician component only on the CMS-1500.

When physicians are staffing in-house clinics and other service areas, it is typical that those nurses and technicians who assist the physician are hospital employees. If they are salaried by the hospital and withholding is reported on these staff members by the hospital, services that they provide are hospital charges. Because the physician does not bear the cost of practice expense, the incident-to concept does not apply. The physician will provide required levels of oversight and supervision.

Business as Usual

Another direction a buy-out may take is that the practice will continue to operate as usual, but your physicians also may be responsible for rotation staffing in certain hospital clinics. The hospital may assume financial responsibility for the entire operation and develop a type of network. It is typical for a hospital-management-level employee to be your contact for business decisions. If the hospital assumes financial responsibility, it's likely you'll no longer arrange service and repairs, but will be required to issue a work order that's handled by the hospital. They may require all staffing changes to be directed to their HR department, who handles applicant screening. You may be set up on their pay scale and annual performance evaluation requirements.

Be mindful that when your physicians are on rotation in a hospital clinic, technical and professional components apply. When POS 22 *Outpatient hospital* is placed on your claim, your payer will edit accordingly for that environment.

Prepare for Future Trends

Hospitals, particularly large ones, do quite a bit of strategic planning. They have a pulse in their medical community and seek avenues to increase their strength. They are aware that the upcoming financial implications of ICD-10, implementation of electronic records, and Recovery Audit Contractor (RAC) investigations are of concern to physician practices, and that some physicians—particularly those in a solo practice or nearing retirement—may be considering other options. If the system is interested in pursuing physicians, the time may be soon.

If your physician(s) negotiate a buy-out, look upon it as a new chapter in your health care career. Do not become too focused on position labels. Instead, assess your current skills and learn the standard requirements for hospital positions. There are multiple positions in hospitals that may be a good match for you. In addition to coding and billing, there also are positions in patient access (registration), benefits verification, payment posting, managed care contractual adjustments, denial management, customer service, surgery scheduling and claims follow-up, to name a few. Although all hospitals have these functions, each hospital has its own internal structure. Benefits packages for hospital employees often are stronger due to the hospital's ability to negotiate large employer rates. You'll have the opportunity to learn new skills, transfer between departments, and make new industry contacts.

Understand that health care changes often, and those who adapt to change quickly will continue to have a strong presence.

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Rev Up Reimbursement with Modifier

By G. John Verhovshek, MA, CPC

APPRENTICE

Modifier compliance enables providers to reach optimal financial performance.

Used appropriately, modifier 59 *Distinct procedural service* is a powerful reimbursement tool allowing for separate payment of distinct services that, under usual circumstances, would not be billed together. For this same reason, the modifier also allows ample opportunity for misuse and abuse. The competent coder will apply modifier 59 to ensure optimal cash flow with absolute compliance.

Separate/Different May Warrant 59

Basic instruction for applying modifier 59 may be found in CPT® Appendix A.

> "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances."

In other words, when the circumstances warrant, modifier 59 gives you the power to unbundle. Circumstances that may call for unbundling include a documented:

- Different session
- Different procedure or surgery
- Different site or organ system
- Separate incision or excision
- Separate lesion
- Separate injury (or area of injury in extensive injuries)

Appendix A requires the different/separate circumstance to be "not ordinarily encountered or performed on the same day by the same individual."

Be aware that a "separate location" does not include treatment of contiguous structures of the same organ. For example, according to instruction provided by the Centers for Medicare & Medicaid Services (CMS) (located online at www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf), "treatment of the nail, nail bed, and adjacent soft tissue constitutes a single anatomic site." Likewise, "treatment of posterior segment structures in the eye constitutes a single anatomic site."

Note also that a different/separate diagnosis is not included among the circumstances supporting modifier 59. The aforementioned CMS guidance is explicit on this matter, stating, "different diagnoses are not adequate criteria for use of modifier -59." By the same token, however, neither are different diagnoses required to report services separately with modifier 59.

For example, you would not commonly report 38221 *Bone marrow; biopsy, needle or trocar* and 38220 *Bone marrow; aspiration only* at the same time: The aspiration is bundled to the biopsy. But if the procedures occurred at different sites (for example, on contralateral iliac crests, or the iliac crest and sternum), via different incisions, or at different encounters, modifier 59 is appropriate to allow for separate payment (38221, 38220-59).

Similarly, typically colonoscopy with biopsy (45380 *Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple*) would be bundled to a more extensive removal (e.g., 45385 *Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique*). If, however, the two procedures are performed on separate lesions or at separate patient encounters, separate reporting of the "lesser" service with modifier 59 is appropriate (45385, 45380-59).

Two additional examples illustrating appropriate application of modifier 59 for different/separate circumstances may be found in the July 2000 and June 2002 *CPT® Assistant*, respectively.

1.) If a lesion is removed from the forehead, resulting in a 5.2 sq cm defect, and another lesion is removed from the neck, resulting in a 7.3 sq cm defect, and both require rotational advancement flaps to provide closure, then CPT® code 14040 *Adjacent tissue transfer or rearrangement, forehead, cheeks, chin mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less* would be reported twice, with modifier 59 appended to the second code. Although both anatomic sites fall into the same anatomic classification as defined by the code descriptor for code 14040, the defects do not have contiguous margins and represent separate and distinct defects.

2.) If multiple bacterial blood cultures are tested, including isolation and presumptive identification of isolates, then use code 87040 *Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)* to identify each culture procedure performed. Append modifier 59 to the additional procedures performed to identify each additional culture performed as a distinct service.

Identify Bundled Procedures

CPT® codes most often subject to bundling are those designated as:

- Separate procedures (i.e., 44180 *Laparoscopy, surgical, enterolysis (freeing of intestinal adhesion) (separate procedure)*);
- Lesser services within the same code family (e.g., when biopsy is bundled to removal, as in the example of 45380/45385, above); or
- Codes within the same code family describing alternate methods or approaches (e.g., colonoscopy with removal by snare (45385) and colonoscopy with removal by hot forceps (45384 *Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery*).

CPT® section notes and parenthetical instructions often provide guidance on when procedures may be bundled. For example, CPT® section notes for "Excision - Malignant Lesions" specify, "Excision of lesion (11600-11646) is not separately reportable with adjacent tissue transfer" at the same location.

For Medicare and those payers who follow CMS guidelines, the simplest way to know if two codes are bundled is to consult national Correct Coding Initiative (CCI) edits. If any two codes are listed as "mutually exclusive" or paired together as "column 1" and "column 2" codes, the procedures are bundled and would not normally be reported together. The first listed code always is the "more extensive" procedure, into which the second-listed code would be bundled. If circumstances warrant the use of modifier 59 to indicate a separate incision/excision, etc., always append the modifier to the "lesser" procedure.

Using 59 to Override CCI Edits

Before appending modifier 59 to override a CCI edit, you must be certain that unbundling is allowed for the particular code pair you wish to report as separate/distinct procedures. Each CCI code pair edit includes a correct coding modifier indicator of "0" or "1," as indicated by a superscript placed to the right of the column 2 code. A "0" indicator means you may not unbundle the edit combination under any circumstances. An indicator of "1" means you may use a modifier to override the edit if the procedures are distinct from one another.

For example, 11400 *Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter 0.5 cm or less* is mutually exclusive of 10060 *Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle or paronychia); simple or single*), according to the CCI. Code 11400 is the "column 1" (more extensive) procedure. For incision and drainage and lesion excision at the same location, report only 11400 because 10060 is bundled to the excision.

This code pair contains a "1" modifier indicator, however, and you may dismiss the edit if the procedures are distinct from one another. For instance, for incision and drainage and lesion excision at different locations, you would report 11400 and 10060-59. Note the placement of 59 on the "lesser" procedure.

When Not to Use 59

CPT® instruction is clear that modifier 59 doesn't apply to evaluation and management (E/M) codes. CPT® Appendix A, for instance, instructs, "Modifier 59 should not be appended to an E/M service.

Never append modifier 59 if documentation does not support the separate/distinct nature of the procedures, and never append modifier 59 to override CCI edits in an attempt to increase reimbursement without justification.

To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25." CMS and CCI guidelines stress the same points.

CPT® and CMS guidelines agree that modifier 59 should be the "modifier of last resort." As CPT® Appendix A explains, "Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used."

For example, a patient receives an excisional breast biopsy (19120 *Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion (except 19300), open, male or female, one or more lesions*), which returns positive for malignancy. Several days later, the patient undergoes a modified radical mastectomy (19307 *Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle*).

CCI bundles 19120 to 19307, but because documentation indicates the biopsy led to the decision to perform the mastectomy, the biopsy is separately payable. In this case, however, modifier 59 is inappropriate. Rather, modifier 58 *Staged or related procedure or service by the same physician during the postoperative period* better describes the circumstances of the staged/more extensive procedure. Proper coding would be 19120, 19307-58.

A second example of when another modifier would apply before modifier 59 comes from the June 2002 *CPT® Assistant*:

"For example, if three subsequent potassium level blood tests are ordered and performed on the same date as the initial test to obtain multiple results in the course of potassium replacement therapy, then report code 84132 *Potassium; serum*, once for each blood test performed, and append modifier 91 *Repeat clinical diagnostic laboratory test* to the subsequent test codes to identify the repeat clinical diagnostic laboratory tests performed."

Microbiology guidelines in the microbiology subsection of CPT® clarify the appropriate use of modifier 91, versus modifier 59, in this situation:

Modifier 59 Checklist

Before appending modifier 59 *Distinct procedural service*, the claim must meet the minimum following conditions:

- The two service/procedures are provided for the same patient by the same physician
- The two services/procedures ordinarily are not encountered on the same day
- Neither of the services/procedures is an evaluation and management (E/M) service
- For the two services/procedures, documentation supports a different/separate
  - ❍ Session
  - ❍ Procedure or surgery
  - ❍ Site or organ system
  - ❍ Incision or excision
  - ❍ Lesion
  - ❍ Injury (or area of injury in extensive injuries)
- For those payers who follow national Correct Coding Initiative (CCI) edits, the bundled code pair includes a "1" modifier indicator
- No other modifier better describes the circumstances

"Presumptive identification of microorganisms is defined as identification by colony morphology, growth on selective media, Gram stains, or up to three tests (eg, catalase, oxidase, indole, urease). Definitive identification of microorganisms is defined as an identification to the genus or species level that requires additional tests (eg, biochemical panels, slide cultures). If additional studies involve molecular probes, chromatography, or immunologic techniques, these should be separately coded in addition to definitive identification codes (87140-87158). For multiple specimens/sites use modifier -59. For repeat laboratory tests performed on the same day, use modifier -91."

Lastly, never append modifier 59 if documentation does not support the separate/distinct nature of the procedures, and never append modifier 59 to override CCI edits in an attempt to increase reimbursement without justification. This is abusive and likely fraudulent coding that quickly will garner payers' attention. CE

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Road Map to ICD-10-CM
Don't Let Your Practice Bury Its Head in the Sand

Don't Let Your Practice Bury Its Head in the Sand

Without proper ICD-10 implementaion, revenue comes to a grinding halt.

By Deborah Grider,
CPC, CPC-I, CPC-H, CPC-P, CPMA, CEMC, COBGC, CPDC, CCS-P

We are seeing very little movement by physicians and physician's groups in the industry regarding ICD-10-CM preparation. Health plans and government payers are working on their implementation plan and hospitals are beginning the process, but physician and physician groups of varying sizes continue to wait. It is somewhat understandable in many respects. With the current state of health care reform, it's unknown how this will affect them. President Obama's Stimulus Plan, which includes incentives for physicians to move to electronic health records (EHRs), makes ICD-10 seem like just another mind boggling and overwhelming task in health care.

One thing is for sure, the message from the U.S. Department of Health and Human Services (HHS) is clear. The final rule, published more than 16 months ago, and ICD-10 are a reality. Get moving and begin the implementation process, as there will be NO delay.

Reluctance Brings Financial Ruin

To put the impact of delaying into perspective, here is a scenario that can happen if the necessary steps aren't taken to implement ICD-10:

It's Dec. 1, 2013 and Sarah Reid's practice has not received payment from any of her payers since ICD-10 implementation occurred on Oct. 1. Because Sarah's medical group did not take the time to properly implement ICD-10, many payers now ask for documentation and every claim submitted is either suspended or denied. Sarah's medical group relied on their vendor for software and did nothing else. The vendor mailed Sarah the software but never tested it end-to-end, so now many of the claims are bouncing all over the place.

An impact analysis wasn't done and hardware wasn't upgraded, so now Sarah's practice management system is so slow it takes 10 minutes to pull up a patient in the system. The insurance carrier policies weren't reviewed, and the staff wasn't trained. For the past two months everyone has been guessing in regards to the codes. Ironically, every code the doctors select are unspecified codes. For claims the payers did receive, countless requests for documentation are piling up on Sarah's desk. Why? The use of the unspecified codes triggered a pattern of misuse and overutilization, which is one of the reasons for migration to ICD-10—detail and specificity. The entire office is a mess. The practice is now financially strapped and the physicians have told the staff they might have to close.

Don't let this to happen to your practice. Without payment from your payers, the financial health of your practice is at risk. How long will you or your medical practice survive without revenue?

Have a Firm Process in Place

I can't reiterate this enough: ICD-10 implementation is not just a software update or a software fix. Systems and processes need to be in place and functional. This will take a few years to accomplish, and YES this will be expensive, for which we must budget carefully. Otherwise, your practice just might end up like Sarah's—financially devastated and a real mess!

Help is Here

AAPC has developed a couple of really valuable ICD-10 tools available at www.aapc.com/ICD-10/, which are at no cost, and very few people are using them:

Benchmark Tracker, as shown in **Figure A**, is a guide to help you with implementation. It lists the steps necessary for implementation based on your practice size and/or health plan.

ICD-10 Code Translator, as shown in **Figure B**, is a simple electronic version of the General Equivalency Mapping (GEM) files from the Centers for Medicare & Medicaid Services (CMS). You can enter an ICD-9-CM code and it will list all the possible ICD-10-CM codes. You also can enter an ICD-10-CM code and it will map backwards to ICD-9-CM. This is helpful for implementation, especially if you continue to use a superbill to see code choices in ICD-10. Payers can use these files to map their systems and policies, as well.

These tools were developed to assist AAPC members and their providers with successful implementation.

Educate Now for the Future

Attend an ICD-10 Implementation Bootcamp, offered by AAPC. The first day of the boot camp focuses on coding to help you get the documentation in your office up to speed and the second day focuses on implementation.

Take the ICD-10 Implementation distance learning course and webinar. Distance learning does the same as bootcamp, only in the comforts of your personal computer. Either method is a good first start in getting your practice ready for the future.

Don't let what happened to Sarah's practice happen to you. Get up from your desk and have a good heart-to-heart with your doctors now, and bring ammunition with you when you go. Don't forget to show them the final rule, articles on ICD-10, and share with them what the impact could be if they decide to bury their heads in the sand. So get going!

Deborah Grider, CPC, CPC-H, CPC-I, CPC-P, CPMA, CEMC, COBGC, CPC-D, CCS-P, is the AAPC's vice president of strategic development and the former AAPC National Advisory Board president. Deborah is the author of *ICD-10-CM Implementation Guide, Make the Transition Manageable*, American Medical Association Press, 2009.

LEGAL Edge

ASK THE LEGAL ADVISORY BOARD

HOW DOES HITECH AFFECT HIPAA?

Question: Recently, the following questions were raised during one of our AAPC chapter meetings:

A patient presents to the office with, for instance, Kaiser insurance, but asks the office not to file the claim to Kaiser. He wants to do self pay at the time of service. Is the provider obligated to file the claim if they are contracted with Kaiser? Does a patient have the right to decide which visits they want to submit to insurance? Is there anything in writing that would explain this in simple terms?

The questions prompted much discussion, with one chapter member responding:

Under the Health Information Technology for Economic and Clinical Health (HITECH) Act Section 13405(a), effective Feb. 17 a covered entity must grant a request for a restriction if:

(1) the disclosure is to a health plan for purposes of either payment or health care operations, and

(2) the personal health information (PHI) pertains to a service for which the patient paid in full, out-of-pocket.

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule currently permits an individual to ask a covered entity to restrict the usual manner in which the covered entity makes disclosures for treatment, payment, and health care operations. However, the covered entity is not required to agree to the request. HITECH now requires a covered entity to grant an individual's request not to disclose PHI to a health plan for a health care item or service where the individual has paid in full, out-of-pocket.

If this is true, would the HITECH act override anything in our payer contract? Does the HITECH rule apply to Medicare and/or Medicaid?

Deb Lewis, CPC
President, Pikes Peak AAPC Chapter

Answer: This is an excellent question, and not an uncommon one. These are the assumptions I am drawing from the question:

1. The Kaiser plan is a state regulated commercial insurance plan and the provider is a contracted provider.
2. The provider contract requires the provider to bill covered services on behalf of the beneficiary.

In response to your inquiry and as a general matter:

Is the provider required to bill if the patient asks the provider not to?

Absent an express contractual requirement to the contrary, the answer is no. These provisions in the contract are designed to protection the subscriber/patient. I have never seen a carrier complain that a service was not billed to them. This provision is raised generally only as a result of complaints by the patient.

Understand that the patient always has the right not to use their insurance benefit. If he or she does not want a covered service billed, he or she can direct the provider not to. Where this occurs, the provider is alleviated from the contractual burden they have to submit covered services on the patient's behalf. "On the patient's behalf" implies the patient wants the services billed in the first place.

Does the HITECH Act impact the analysis and effectively trump the contractual provision?

In short: The answer is yes to both parts of the question.

Because billing creates the potential for disclosure of health information and the patient's autonomy over whom his or her records may be disclosed, directing the provider not to bill where the patient is willing to pay out-of-pocket for the service creates a question as to whether the provider is able to refuse the request and submit the charges anyway. Under the prior HIPAA regulations, I would have advised against it—but it would technically be permissible. HITECH prevents the provider from billing in this circumstance.

The HITECH provision you cite is an interesting one. I have long held the belief under HIPAA that a provider could not disclose records for services not billed to a carrier under a Treatment/Payment/Healthcare Operations (TPO) request without violating HIPAA. HITECH supports this conclusion, especially where the patient makes a request restricting disclosure. Asking you not to bill could be construed as such a request.

Although HITECH does not address the billing issue directly, the effect of the patient paying for the service out-of-pocket and directing that records not be disclosed would be to prevent you from billing because PHI is disclosed as a result of submitting a claim. If you did bill it, it would be an unauthorized disclosure constituting a breach subjecting the provider to a penalty; which, if recklessness is found, could be quite substantial. As such, you could say that when the patient makes such a request, HITECH trumps your contractual duty to file a claim because you could not do so without violating a federal law. A contractual provision that requires you to violate a law generally.

Understand that the patient always has the right not to use their insurance benefit. If he or she does not want a covered service billed, he or she can direct the provider not to.

The difference between the old regulations and the new provisions under HITECH is that, in the past, you could ignore the patient's request not to file the claim. Under HITECH, you cannot.

My practical advice is: If a patient pays for service and does not want it billed, be sure to have the patient sign a request that information relative to that service not be disclosed. That would absolutely preclude the provider from being able to bill and protect the provider from any allegation regarding breach of the provider contract for not billing by the patient—although it is not likely that such a complaint would ever be made by the carrier. Just remember, you must flag these records somehow so they are not disclosed to the health plan should the health plan make a request. Be certain also, if sending the records to another provider (which is permissible), to flag the records so the other provider knows that they cannot be sent to the health plan due to patient request. A big red "stamp" on the record would probably suffice.

Finally: Does the HITECH rule apply to Medicare and/or Medicaid?

HITECH applies universally. The carrier that services are being billed to (Medicare, Medicaid, TriCare, state commercial insurance plans, Employee Retirement Income Security Act (ERISA) regulated plans), or the lack of a carrier, has nothing to do with your obligation under HIPAA, as amended by HITECH to protect the integrity of protected health information. CF

Michael D. Miscoe, JD, CPC, CASCC, CUC, CHCC, is president of Practice Masters, Inc. and the founding partner of Miscoe Health Law, LLC. He is a past member of the AAPC National Advisory Board (NAB) and current member of the Legal Advisory Board (LAB). He is admitted to the Bar in the state of California as well as to the practice of law before the U.S. District Courts in the Southern District of California and the Western District of Pennsylvania. Mr. Miscoe has nearly 20 years of experience in health care coding and over 13 years as a compliance expert testifying in civil and criminal cases.

HITECH in a Nutshell

Handle personal health record disclosure requests properly.

By Stacy N. Harper, JD, MHSA, CPC

APPRENTICE

HIPAA Privacy Rules grant individuals the right to request additional restrictions on the uses and disclosures of their protected health information (PHI). Until Feb. 17, it was entirely at the discretion of the health care provider whether to grant this request. This is no longer the case.

The HITECH Act, part of the American Reinvestment and Recovery Act (ARRA) passed in February 2009, implemented funding for development of electronic record systems and added new breach notification requirements to HIPAA, triggering a wealth of discussion in the health care community. In a more subtle development, the act also restricted covered entity's discretion related to the granting of patients requests for additional restrictions.

If an individual requests that a covered entity restrict disclosures to a health plan for purposes of payment or health care operations, the covered entity must grant the request if the individual pays for the item or service out-of-pocket, in full. This requirement does not apply to disclosures for treatment.

Consider the following example:
Patient Jane Smith has been a patient of your organization for a number of years. Her visits have always been covered by her private insurance. Jane was seen in the clinic on Feb. 20, March 1, and March 15. Without providing explanation, Jane requested that the clinic refrain from submitting any information regarding the March 1 visit to her insurance company for payment or health care operations. She paid in full for the visit. At the March 15 visit, the physician referred Jane to a specialist and requested records transferred. In May, the clinic receives a request from the insurance company for records on all visits for Jane in February and March for a utilization review.

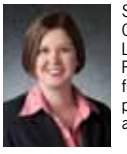
Jane's March 1 visit is a part of the medical record for your organization. Because of her request, a claim cannot be submitted to her insurance company for the March 1 visit. The medical record documentation for the March 1 visit can be included in the disclosure to the specialist, but not to the insurance company.

The new restriction of provider discretion requires covered entities to implement policies and procedures to ensure compliance. Procedures need to be created to identify these requests and ensure the information is available to your billing and medical records staff. These policies and procedures include:

- Revision of the policy and procedure for patients to request additional restrictions to incorporate the new language, and clearly providing that requests will be granted in these situations.
- Steps to ensure a request to restrict disclosure to the insurance company is forwarded in a timely manner to the billing office, so charges are entered appropriately and no claim is submitted to the insurance company.
- A notification procedure to alert workforce members that a particular visit or service cannot be disclosed to the health insurer if a later request is made related to health care operations.

When policies and procedures have been developed or revised, it is imperative they be communicated adequately to the staff. After a request for additional restrictions on disclosures has been granted, a failure to comply with the request is an unauthorized disclosure and violation of the Privacy Rules, and potentially is subject to penalties. Further, as an unauthorized disclosure, the inadvertent response to a request for records by a workforce member who is not aware of the restriction may amount to a breach, triggering the notification requirements.

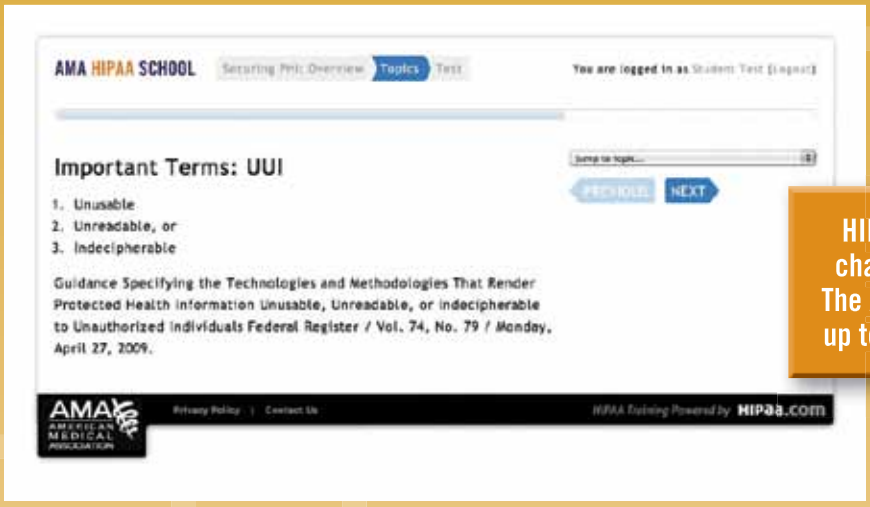
As in all areas of HIPAA, the best approach is a proactive one. Implementing policies, procedures, and workforce education is the only way to identify these requests properly, and to prepare staff for the interruption of their normal workflow.



Stacy N. Harper, JD, MHSA, CPC, is an attorney with Forbes Law Group, LLC in Overland Park, Kan. Ms. Harper's practice focuses on assisting health care providers with regulatory compliance and reimbursement issues.

AMA HIPAA SCHOOL

An online solution to achieve HIPAA and HITECH compliance



HIPAA rules have changed for 2010. The AMA can get you up to speed quickly!

Ensuring HIPAA compliance doesn't have to be another demanding administrative task. *AMA HIPAA School*—a practical new online training resource from the American Medical Association (AMA)—makes it easy for health care professionals to satisfy the new HIPAA and HITECH Act 'awareness and understanding' training requirements of the American Recovery and Reinvestment Act of 2009 (ARRA).

AMA HIPAA School breaks down the complex legislative regulations into three online courses. Each course includes a multiple choice test that can be used to help prove compliance. Users can complete each course at their convenience. The courses cover:

- **Securing PHI Overview:** HIPAA privacy, security, enforcement, and new HITECH Act 'Breach Notification' rules
- **HIPAA Privacy Compliance:** Use, disclosure, access, and administrative standards of the HIPAA Privacy Rule
- **HIPAA Security Compliance:** Administrative, physical, and technical safeguard standards, and new HITECH Act PHI encryption guidance

Test results can be printed, e-mailed, saved and/or sent to a designated privacy and security official at your workplace. Office managers can also use the results to benchmark staff understanding. Other features include:

- Content prepared by Carolyn P. Hartley, MLA, and Edward D. Jones III, nationally-recognized HIPAA and EHR experts and authors of the bestselling AMA publication *HIPAA Plain and Simple*
- Independent third-party validation in case of an audit. Test results are archived by HIPAA, LLC, for six years and can be provided as proof of compliance
- Easy-to-understand language and key definitions
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AAPC
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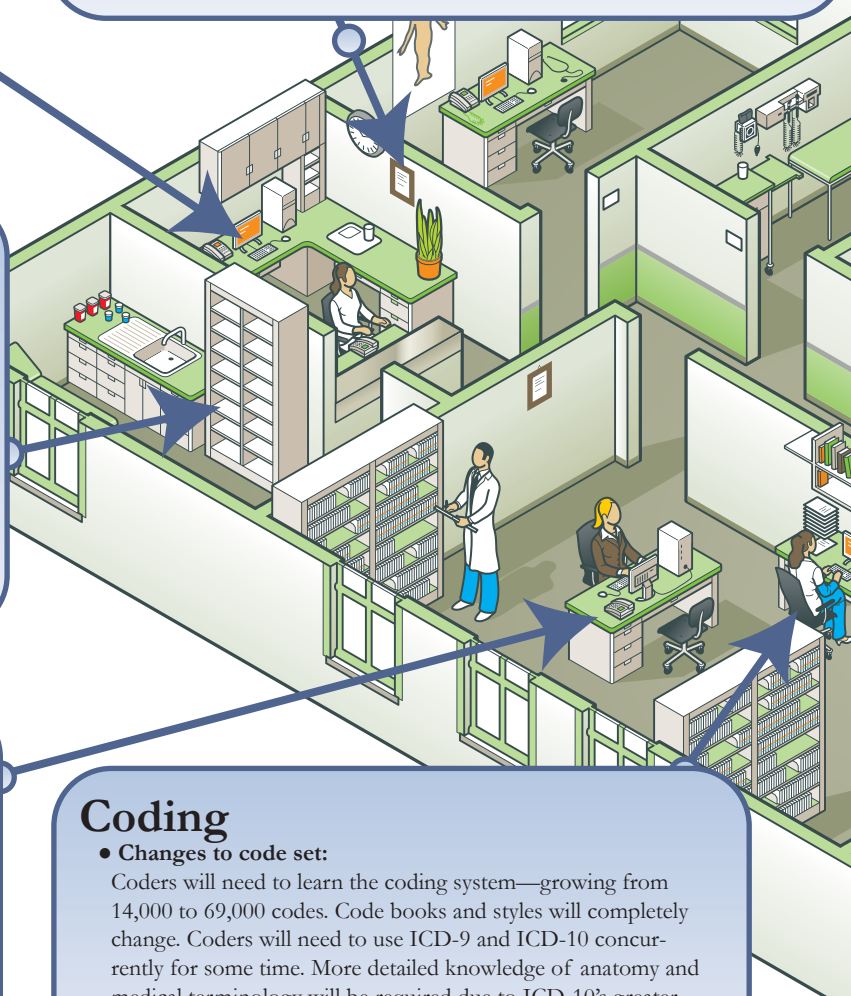
ICD-10 is going to

Nurse's Station

- **Changes to forms:**
  Every single order will need to be changed. Anything ordered through the hospital, such as treatment plans or services, will need to be redone. ABNs will need to be completely revised.
- **Changes to documentation:**
  As with physicians, nurses will need to make sure to document with increased specificity.
- **Changes to prior authorizations:**
  Health plans will revise coverages. Because of this, all policies on prior authorizations may change, requiring training and updates to all forms currently in use.

Physician's Office

- **Changes to documentation:**
  The need for specificity will increase dramtically: physicians will need to document laterality, stages of healing, weeks in pregnancy, episodes of care, and much more.
- **Code training:**
  ICD-10 CM will be going from 14,000 codes to 69,000, requiring much greater specificity and documentation. Physicians will need to be trained on the new code set and begin work on any documentation issues. This could result in loss of productivity (and profitability) if not started early enough.



Lab

- **Changes to documentation:**
  Labs will need to educate offices on what will be required with the new code set and the greater levels of specificity so that they can continue to get paid for services.
- **Changes to forms:**
  Labs will need to change all order forms and provide education to anyone filling them out.
- **Changes in reporting:**
  Labs will need to work with all health plans to ascertain new requirements for ordering and reporting of services in order to continue receiving payments.

Billing

- **Policies and procedures:**
  All payer policies regarding reimbursement may be revised, which will create payment hurdles. 5010 will require new electronic procedures and formatting, requiring downtime and testing time as well as new ANSCI reporting features.
- **Training:**
  Billers will need to be trained on new policies and procedures and the ICD-10-CM code set. This will result in a loss of productivity during training if not started soon enough.

Coding

- **Changes to code set:**
  Coders will need to learn the coding system—growing from 14,000 to 69,000 codes. Code books and styles will completely change. Coders will need to use ICD-9 and ICD-10 concurrently for some time. More detailed knowledge of anatomy and medical terminology will be required due to ICD-10's greater level of specificity. Coder will need to work with physicians to help with documentation hurdles as well.

Will you be ready?

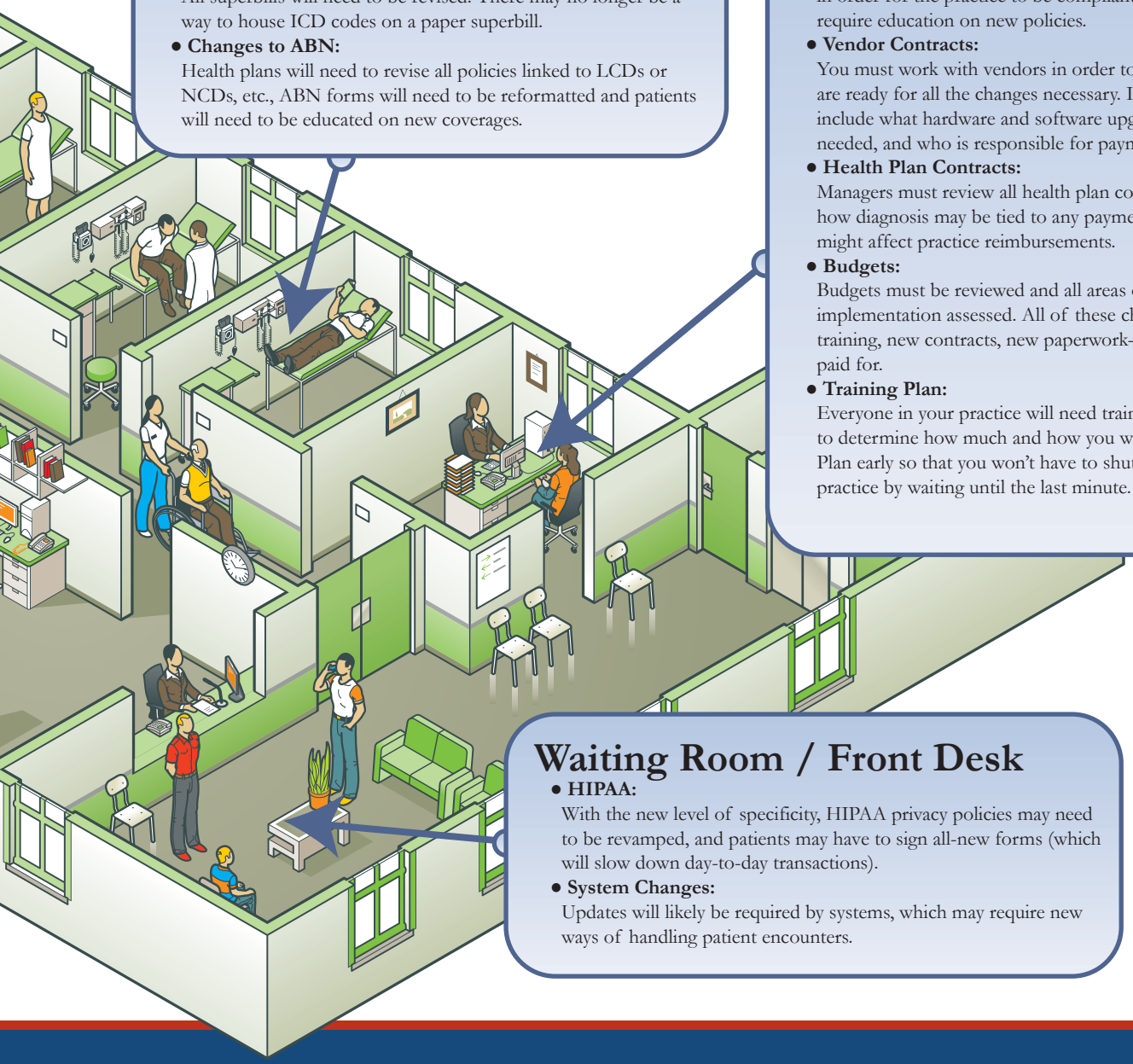
change everything.

Clinical Area

- **Changes to patient coverage:**
  Patients will need to be educated on health plan policies, payment limitations for services rendered and new ABN forms.
- **Changes to superbills:**
  All superbills will need to be revised. There may no longer be a way to house ICD codes on a paper superbill.
- **Changes to ABN:**
  Health plans will need to revise all policies linked to LCDs or NCDs, etc., ABN forms will need to be reformatted and patients will need to be educated on new coverages.

Manager's Office

- **New Policies and Procedures:**
  Any policy or procedure tied to a diagnosis code, disease management, tracking or PQRI will need to be changed in order for the practice to be compliant. Everyone will require education on new policies.
- **Vendor Contracts:**
  You must work with vendors in order to make sure you are ready for all the changes necessary. Issues to consider include what hardware and software upgrades will be needed, and who is responsible for payments.
- **Health Plan Contracts:**
  Managers must review all health plan contracts to see how diagnosis may be tied to any payments and how this might affect practice reimbursements.
- **Budgets:**
  Budgets must be reviewed and all areas of ICD-10 implementation assessed. All of these changes—software, training, new contracts, new paperwork—will have to be paid for.
- **Training Plan:**
  Everyone in your practice will need training. You'll need to determine how much and how you will get it done. Plan early so that you won't have to shut down your practice by waiting until the last minute.



Waiting Room / Front Desk

- **HIPAA:**
  With the new level of specificity, HIPAA privacy policies may need to be revamped, and patients may have to sign all-new forms (which will slow down day-to-day transactions).
- **System Changes:**
  Updates will likely be required by systems, which may require new ways of handling patient encounters.

AAPC can help with every aspect of your practice's transition to ICD-10. Whether you just want the basics or need complete implementation training, AAPC has a solution to fit your needs.

For more information, visit www.AAPC.com/change

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APPRENTICE

Reserve V42.0 as a Secondary Dx

Even if a payer reimburses V42.0 when it's listed first, that doesn't make it correct.

A Massachusetts member asks *Coding Edge*: I have been advised that some payers allow V42.0 *Organ or tissue replaced by transplant; kidney* as a primary diagnosis for renal transplant patients seen for routine follow-up after surgery recovery, when there is no other sign/symptom/medical diagnosis to report. ICD-9-CM guidelines, however, designate V42.0 as a "secondary only" diagnosis. Reporting V42.0 as primary seems incorrect to me. For renal transplant patients who are taking immunosuppressive medications and are following up with renal medicine physicians, is it appropriate to report aftercare code V58.44 *Aftercare following organ transplant?*

Debra Mitchell, MSPH, CPC-H, responds:

As you note, ICD-9-CM guidelines specifically designate V42.0 as a secondary-only allowed code. Just because some carriers reimburse a claim when this code is sequenced first does not make the coding correct.

If the patient is returning for monitoring of his or her immunosuppressive drugs, I would recommend reporting V58.83 *Other specified procedures and aftercare; encounter for therapeutic drug monitoring* for therapeutic drug monitoring, followed by the V58.69 *Long-term (current) use of other medications* for long-term or current other high-risk medication use, with V42.0 as the final code. With this ICD-9-CM code assignment, the claim should match the documentation to explain that the patient presented for therapeutic drug monitoring due to being on a high-risk medication because he or she has had an organ transplant.

If the visit is a general follow-up to check the patient's overall status, report a follow-up code from the V67.x *Follow-up examination* category, followed by V42.0. Code V58.44 *Aftercare following organ transplant* for aftercare is appropriate only if the provider performs acute, post-surgical management, such as a dressing change or checking drainage tubes.

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We look forward to seeing you in November!

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